Midwife, Ms B

A Report by the

Health and Disability Commissioner

(Case 00HDC02637)

Parties involved

Ms A	Consumer
Ms B	Provider / Midwife
Ms C	Consumer's friend
Ms D	Social Worker at the hospital
Ms E	Ambulance Officer
Mr F	Ambulance Officer
Mr J	Area Manager for the ambulance service

Complaint

On 9 March 2000 the Commissioner received a complaint from the consumer, Ms A, about midwife Ms B. The complaint is that:

- *Midwife Ms B was Lead Maternity Carer for Ms A during her pregnancy and the birth of her son. During her pregnancy Ms A examined Ms B on only one occasion. Ms B did not take Ms A's blood pressure or test her urine.*
- *On 30 November 1999, Ms A phoned Ms B to tell her she was bleeding. Ms A was approximately 23 weeks' gestation. Ms B did not visit Ms A at this time.*
- *On 1 December 1999, Ms A contacted Ms B at around 2.00am and informed Ms B that she had sharp pains and further bleeding. Ms B asked Ms A to drive herself to a public hospital. Ms A advised Ms B that this was not possible. Ms B told Ms A she would visit but arrived about ten minutes after Ms A had delivered her baby alone at 3.00am.*
- *When Ms B arrived she seemed to be in shock at the events and it was Ms A who suggested that they should get her baby to hospital. Ms B then phoned the ambulance and dialled 911. Ms A advised her that it was 111 she should be dialling.*
- *Ms B did not explain to Ms A the prognosis for a baby born at 23 weeks' gestation.*
- *Ms B did not give Ms A the option to keep her baby at home with her if there was no hope for his survival.*
- *After the birth, Ms B appeared not to know what to do and Ms A's friend, Ms C, organised for Ms A to take a shower. It was in the shower that Ms A delivered the placenta.*
- *Ms B placed the placenta in a plastic bag for removal. Ms C asked Ms B if the placenta should be sent to the laboratory for analysis and Ms B seemed surprised by this suggestion.*
- *At about 4.40am Ms B telephoned the hospital to ask how the baby was. Ms B said in a surprised voice, "He's still alive?" followed by, "Oh, at 3.50am." This conversation intimated that the baby had passed away and was insensitive to Ms A, who was within hearing range and had not yet been informed that her baby had died.*
- *Ms B provided no postnatal follow-up and no referral for grief counselling.*

- *Ms B did not give Ms A any information or support in relation to legal procedures required for her baby's burial.*
- *Ms B kept no records of the antenatal or delivery care provided.*
- *Ms B did not arrange for a post-mortem to be conducted or for the placenta to be tested.*

An investigation was commenced on 16 May 2000.

Information reviewed

- Ms B's midwifery records
- Relevant medical records
- Ambulance records
- Interviews with parties involved
- Expert advice from an independent midwife, Ms Jenny Woodley.

Information gathered during investigation

Summary
In the early hours of 1 December 1999, Ms A, who was about 21-22 weeks pregnant, went into premature labour. At the time Ms A's lead maternity carer ("LMC") was midwife Ms B. (LMC refers to the general practitioner, midwife or obstetrician who has been selected by the pregnant woman to provide her with comprehensive maternity care, including the management of her labour and birth.) Ms A's baby was born at home and transported to the hospital, where he died shortly after arrival.

Antenatal care
In 1999 when Ms A became pregnant with her third child she chose an independent midwife, Ms B, as her LMC. Ms A had recently separated from her husband, who had moved to a city. Ms A and her two children, aged about 9 and 11 respectively, lived about 15-minutes' drive from the main town. Ms A worked as a homeopath in a local health food shop at the time.

Ms B's midwifery records show consultations with Ms A on 23 and 30 September 1999 and 8 and 23 November 1999. Ms A disputes this and states that she saw Ms B only once after her initial visit on 23 September 1999.

Ms A found Ms B to be "laid back" in the care she provided. Ms B did not take her weight or feel her abdomen during antenatal visits, as had occurred in her previous pregnancies. Ms A was under the care of a doctor during her previous pregnancies and this was her first experience with a midwife as LMC. Ms A said she monitored her own blood pressure as, apart from the initial visit, Ms B never took her blood pressure during any consultation.

Ms A said that at her initial visit, Ms B gave her about five dipsticks to test her own urine for protein and glucose. Although Ms A did not consider this very professional, she had some medical knowledge herself and knew how to interpret the dipsticks. However, Ms A had no concerns about Ms B as she presumed this was what midwives did and she did not require someone to "hold her hand".

At the initial visit on 23 September 1999, Ms B arranged blood tests and an ultrasound. The full blood count was normal. Urine tests for protein and glucose were recorded as negative. Ms B did not record Ms A's blood pressure or weight. An ultrasound, performed the same day at a radiology clinic, showed no abnormality and confirmed a gestation of 12 weeks with an expected delivery date of 31 March 2000.

At the next recorded visit on 30 September 1999 Ms B noted that Ms A felt well and Ms B was happy with her progress. Ms B recorded that she would arrange a further scan at 18-20 weeks' gestation. Urine results for protein and glucose were not recorded. Ms A's blood pressure and weight were not recorded.

On 8 November 1999 (19 weeks' gestation) Ms B recorded that Ms A's urine protein and glucose were not tested. Ms A's blood pressure was recorded as 120/80. Under 'Remarks' Ms B recorded "For scan next week. No problems." An ultrasound taken at the radiology on 19 November 1999 (21 weeks' gestation) showed satisfactory and symmetrical foetal growth consistent with dates.

On 23 November 1999 Ms B recorded Ms A's blood pressure as 110/60. Urine protein and sugar were not recorded. Under 'Remarks' Ms B recorded "no problems".

Ms B informed me that Ms A wanted a natural birth, was very "hands off" and dictated everything during the pregnancy. Ms B said Ms A seemed happy with everything during the pregnancy, wanted to do things herself and did not require much input from a midwife. Ms B did not mind this as Ms A was trained in homeopathy.

Day prior to miscarriage

On 30 November 1999, about midday, Ms A telephoned Ms B and told her she was bleeding. Ms B did not visit Ms A at this time. Ms A did not specifically request that Ms B visit as she trusted what Ms B told her and Ms B did not volunteer to visit. There were conflicting accounts as to what was said during this call.

Ms A said she told Ms B that she was bleeding "like a period" with enough bleeding to require a sanitary pad. Ms B advised her to rest and to wait and see if the bleeding settled. Ms B said that, if the bleeding did not settle, she would arrange a scan for the following day.

Ms B recalled asking Ms A if the bleeding was about a teaspoonful and that Ms A replied that it was. Ms B said she asked Ms A if the bleeding was red or brown and Ms A replied it was red. Ms B said that after some discussion they both decided there was nothing to worry about and Ms A told her she was "fine". Ms B told Ms A to get back to her if there were any problems. Ms B's notes record the telephone call as follows: "Telephone call

from [Ms A] to my clinic in […] – slight pinkish vaginal discharge. No cramping. [Ms A] and myself not too concerned re the baby."

Ms C, who lives in the main town, is a close friend of Ms A. Ms C said Ms A rang her about 10.00am on 30 November and asked her what it was like to miscarry. Ms C asked her why she wanted to know this and Ms A told her that she was bleeding. Ms C asked how bad the bleeding was and if it was just spotting. Ms A replied no and informed her that it was "like a period". Ms C asked her if she had informed Ms B. Ms A told her she had and that Ms B told her to wait and see if the bleeding settled and then, if it had not, she would arrange an ultrasound. Ms C was rather surprised to hear that the midwife had not suggested an examination to determine the reason for the bleeding.

After her miscarriage Ms A noticed that in the notes from the hospital Ms B had noted that Ms A had been "spotting" the day prior to the miscarriage. (The hospital notes record: "Show + in the previous 24 hours.") Ms A said this was not true as she would not have been concerned about spotting but was concerned by the amount of bleeding she was experiencing.

Birth

In the early hours of 1 December 1999, Ms A awoke in "total agony" with lower back pain and pain underneath her belly. She initially telephoned her husband in the city as she thought she was sick and was unaware that she could be in labour. She then telephoned Ms B. Ms A said that in her notes taken after her miscarriage she recorded the time of this call at 2.45am, but on reflection believes it was closer to 1.45am as Ms B arrived just after 3.00pm and Ms A estimated Ms B took about an hour to arrive after the call.

Ms A stated:

> "Birth Experience. Woke at 2.30am with lower back pain and pain underneath my belly. Rung [husband] while I was in labour even though at the time I didn't realise this was what was happening. Rung midwife at 2.45 who asked me whether I could drive in and see her. I knew I couldn't and asked her to come out. Talked to [my husband] again in pain until midwife arrived just after 3.00am."

Ms A said Ms B sounded half-asleep when she called but Ms A felt this was understandable, as it was the middle of the night.

There were conflicting accounts from Ms A and Ms B concerning the content of this call.

Ms A said Ms B initially asked her if she could drive in to see her. Ms A was unsure whether Ms B meant she wanted her to drive to Ms B's home or her midwifery practice rooms but she assumed Ms B to mean the latter. Ms A was in pain and knew that she was unable to drive and also she could not leave her two sleeping children. She explained this to Ms B and asked her to come and visit her. Ms A said Ms B never mentioned the hospital to her and that she would have been unable to drive there anyway. Ms A said she made only one call to Ms B that night. Ms A was asked for a copy of her telephone account during the investigation but was unable to produce it as she had disposed of it.

Ms B was asleep when Ms A rang her at about 2.30am and told her she was still bleeding but now had abdominal pains. Ms B said she advised Ms A to go directly to the hospital and Ms A asked her what they would do there. Ms B said she told Ms A that they would try to stop the labour using medications. Ms A refused to go to hospital. Ms B felt that the one way they could have saved the baby was to keep it inside her. Ms B said she could have arranged to meet Ms A at the hospital. Ms B said Ms A told her she had no one to look after the children. Ms B said she was half-asleep and not quite "with it" so ended the conversation, then rang Ms A back a few minutes later.

During this second phone call Ms B said she again suggested to Ms A that she should go directly to the hospital but Ms A refused, as she did not want to have any medical intervention. Ms A told her that she could not leave her children so Ms B left immediately to see her. Ms B estimated the journey took about 15 minutes.

Ms B's notes record only one phone call at 2.30am on 1 December 1999 as follows:

> "Call from [Ms A] c/o abdominal pain, ? contractions and larger pinkish discharge. Advised to call ambulance and transfer to hospital – refused as nobody to mind children. Advised to take children with her – [Ms A] refused. I left immediately to see her."

At counselling some weeks after Ms A's miscarriage (early December 1999), Ms D, a social worker, wrote on behalf of Ms A as follows:

> "In the early hours of the following morning [Ms A] awoke with sharp pains and further bleeding. She phoned her LMC at around 0200 hours to advise her of this and the LMC asked her to drive over to [the main town] to the hospital. [Ms A] advised her this was not possible as she had her two other children at home and could not leave them alone."

The birth

There was conflicting evidence about the circumstances surrounding the birth.

Ms A said that she gave birth alone to a baby boy, on the couch in the lounge, about 10 minutes before Ms B arrived. The baby was still attached by the umbilical cord when Ms B arrived. Ms A said Ms B seemed in a daze and seemed to have no idea what to do. Ms A presumed the baby was stillborn but Ms B wrapped the baby in a blanket and informed her he was still alive. Ms B then used Ms A's cordless phone to telephone for an ambulance. Ms A said Ms B dialled 911 initially and then asked Ms A what the emergency number was. Ms A informed her it was 111.

Ms B provided contradictory and conflicting evidence concerning the delivery of the baby. At interview during the investigation, Ms B said that when she arrived Ms A had just delivered the baby. Ms B said the baby was "perfect" and was still breathing and she wrapped him up. Ms B's notes record that at 3.00am she arrived and found "[Ms A] in obvious labour and feeling urge to push. Progressed to rapid delivery of live small male infant gasping." Ms B said Ms A had not called the ambulance before she arrived and it was left to her to telephone the ambulance.

Ms A said that her previous deliveries had been very quick – her older son's birth took 45 minutes. Ms A stated that she goes into shock after giving birth, shaking with the stress of it all, and so would not want a baby at home under those circumstances. Ms A said that on the morning the baby was born Ms B insensitively commented that she could have had a home birth. Ms A said she never told Ms B she wanted a home birth. A home birth was not an option for her because of her unusual blood type (B positive) and the risk of haemorrhage due to her quick deliveries, so she had always wanted to be in hospital.

Ms B said that the baby lived for only 20 weeks and that her notes should show that she did everything that she should have. Ms B's 'Labour and Delivery' record notes "Delivered By: Self – Rapid. [Ms B] present." Ms B recorded the baby's weight as 250 grams.

The hospital notes record the baby's weight as 540 grams.

Arrival of ambulance

Ms A said the ambulance service "seemed to take forever to arrive". Ms A said that when they arrived they did nothing and seemed very casual in their attitude. Ms A remained on the couch and Ms B dealt directly with the ambulance officers. Ms A said, "I was expecting action, he was alive!! But there was none." Ms A said Ms B did not give her any indication of the possible prognosis for a baby born at this gestation. Ms A was unable to accompany the baby in the ambulance, as her friend, Ms C, had not yet arrived to look after Ms A's two children, who were asleep in their bedrooms. Ms A felt the baby was just too young to be born and the irony was that if he had been born at 26 weeks instead of 23 weeks then maybe someone would have been rushing around and trying to save him.

Transfer of baby to ambulance

Ms A said Ms B never gave her the option of accompanying the baby in the ambulance and did not volunteer to stay with her children. Ms A felt the baby was taken to the hospital for no particular reason. No one was going to do anything as he was too premature and it would have been better if he had stayed at home and died in his mother's arms.

The ambulance officers who attended the call from Ms B that morning were Ms E and Mr F. Ms E is a volunteer and Mr F is one of three full-time paid officers at the main town's ambulance station. Mr F was the senior officer on duty that night. Mr F explained that he is slightly deaf and so he did not quite hear Ms B's conversation, which was directed at Ms E.

Ms E recalled the callout extremely clearly as she felt sympathy being a mother herself. They were called out at 3.12am. The 111 call from Ms B was initially directed to the […] Regional Operation Centre ("ROC") and the call was logged at 3.11.46. The call was then forwarded to a mini-pager which directs the ambulance officers to the caller's address. Ms E thought the pager message said premature baby but was not sure of this. The records note that the ambulance was en route at 3.17am.

The ambulance arrived at Ms A's home at 3.27am. Ms E said that when they arrived she entered and assessed the situation and Mr F followed with the resuscitation bag. Mr F said no treatment of any kind was being performed when they arrived. Mr F did not speak to

Ms A at all as the midwife was in control. Mr F said Ms B seemed quite normal, not upset or frantic, and seemed in control.

On entering Ms A's lounge, Ms E found Ms B waiting and holding the baby wrapped in a blanket. Ms E knew Ms B as she was the midwife who delivered Ms E's son. Ms E said Ms B did not seem under stress and appeared to be coping. Ms E said Ms B told her something about the baby being only 20 weeks old. While being handed the baby Ms E said she enquired about Ms A, who was lying on the couch in the lounge. Ms E said Ms B told her the mother had not yet delivered the placenta so would not be travelling with them. Ms E did not speak to Ms A but only to Ms B as she was the professional in charge at the time.

Ms E did not unwrap the baby as she knew it was important to keep the baby as warm as possible until they could get to an incubator. There was no incubator in the ambulance.

Mr F recalled that Ms B passed the baby to Ms E and asked them to take the baby directly to the hospital, which had been notified by Ms B to expect them. Ms B made no request for treatment of any kind but Mr F thought she hinted that the baby would probably not survive owing to its premature state.

Ms B said she gave Ms A the option of accompanying her baby in the ambulance. Ms B said Ms A told her she could not because she had the two other children to look after and there was no one else there. At interview, Ms B said, "Don't ask me why as I was there." Ms B thought Ms A's reaction could have been due to shock from the birth. At that time Ms A had not delivered the placenta, but Ms B said she considered that did not matter as the placenta could have been delivered in the ambulance.

Mr F said that in situations like this, as long as there is a normal healthy mother, the placenta can be delivered in the ambulance. He said this was not a problem as placentas have been delivered while the ambulance is on its way to hospital on other occasions. Mr F said normally they would have suggested that the mother accompany the baby in the ambulance but as the midwife seemed concerned that the placenta had not been delivered, it was not their role to insist.

The trip to the hospital

The ambulance service informed me that, at the time, it did not have in place any written protocols or instructions covering the transport of premature babies by ambulance. Mr F said they do not get call-outs involving premature babies very often so all they did was to keep the baby warm, give him oxygen, and transport him to hospital as quickly as they could. Ms E said she had never dealt with a premature baby before and was unaware of any policies or protocols for the ambulance service about dealing with premature babies.

Ms E took the baby to the ambulance. Records note that the ambulance left at 3.32am. Ms E said things happened really quickly and it took only a couple of minutes to get the baby and talk to the midwife, and then they were on their way back to the hospital. Ms E did not unwrap the baby, as she wanted to keep him warm. In the ambulance Ms E and Mr F detected breathing, although it was faint, so they decided to give the baby oxygen. They did not have an oxygen mask small enough to fit the baby so supplied oxygen via a tube to

the corner of his mouth. For the journey to the hospital they commenced oxygen at the rate of about 3-4 litres per minute.

Mr F drove the ambulance directly to the hospital while Ms E remained in the back on the stretcher holding and attending to the baby. Mr F radioed ahead to the hospital saying they were coming and the hospital control told him that they doubted the baby would survive. Mr F estimated that the ambulance took about 15-20 minutes to get to the hospital.

The hospital
When the ambulance arrived at the hospital about 3.42am, Mr F initially drove to the Maternity Department but was redirected to the Emergency Department by the night supervisor. There they waited for a paediatrician while a nurse who was present unwrapped the baby. The baby had not been unwrapped before this as Ms E and Mr F did not want to risk him getting cold.

The paediatrician arrived and put on ECG monitoring leads. The baby was barely alive with a heart rate of 30-35 beats per minute. Mr F said that the heart rate should have been about 133. The paediatrician asked them how premature the baby was and Mr F and Ms E said they thought about 20 weeks or so. The paediatrician, Dr G, told them the baby was not viable at that gestation.

The hospital notes written by Dr G record: "No mother to obtain history – history from midwife over the phone – as attached." The hospital records note that the baby was very premature and his weight was 540 grams. No resuscitation was commenced and time of death was recorded as 3.50am.

After Ms E handed over the baby's care to the hospital staff, she rang Ms B to check on Ms A and ask whether she wished to come to the hospital. Ms E said that they were prepared to drive back and bring Ms A to the hospital. Ms E said Ms B told her Ms A was having a shower and was staying at home with her other children.

At 3.15am Ms B's notes recorded:

> "[The ambulance service] notified baby still alive and gasping for breath – transferred to hospital. Rang friend and she arrived 15 minutes later. Made telephone call to hospital – Died in hospital ?0345-0400."

The ambulance returned to base at 4.11am.

Ms C
There is some inconsistency between Ms C's and Ms B's account of the actual time Ms C was called. Ms B said that when she arrived at Ms A's place on 1 December (at about 3.00am), Ms A asked her to ring her friend, Ms C. Ms B did so. Ms C recalled that Ms B telephoned her at about 2.50am (according to her bedroom clock). Ms C said that Ms B told her Ms A had had the baby and wanted her to come around. Ms C said she knew that Ms A had been bleeding during the day and so was prepared for anything. Ms C asked how the baby was and Ms B replied that he was still alive but gasping for breath. Ms C felt that Ms B was too relaxed and she hoped that she had taken the phone to another room as

the words Ms B used seemed too unguarded and insensitive to use in front of a woman who had just lost a baby.

Ms C arrived at Ms A's home about 15 minutes after the call from Ms B. As she arrived the ambulance was just pulling out of the driveway on its way to the hospital. Ms C said the ambulance seemed to be going very slowly so she assumed the baby had died. When she entered the house she was surprised to see Ms A still there, lying on the couch, with Ms B seated on a nearby chair. When Ms C learned that the baby was still alive she wondered why Ms A had not accompanied him to the hospital and asked Ms B why. Ms B informed her it was because there was no one to look after Ms A's other two children. Ms C wondered why Ms B failed to offer to look after the children, as she knew Ms C was on her way.

Ms C said Ms B appeared to be unsure what to do next. Ms C was bothered by the lack of direction from Ms B, who was the health professional present. Ms C said Ms B seemed bewildered and half asleep. She observed that Ms B made no suggestions of her own. Ms C noticed that when she arrived Ms B was using Ms A's cordless phone and all conversations were taking place in front of Ms A. Ms C felt that Ms B should have gone into another room to make these calls and then compose herself to comfort or attend to Ms A.

Ms C and Ms A talked and cried together. After some time, Ms C suggested to Ms B that the ambulance should have arrived at the hospital by now and asked that Ms B call and check how the baby was. Ms B telephoned the hospital and told Ms C that although the ambulance had arrived, there was no news. Some time later Ms C suggested Ms B ring again. Following the second call Ms B told them the baby was still alive but gasping for breath. Ms B told Ms A that if the baby had been three weeks older they would be trying to save his life but as it was they would just watch him. Ms B said she would not leave until Ms A had delivered the placenta but made no suggestions on how to go about doing that.

Ms C said the insensitivity of Ms B's telephone conversations in front of Ms A made her cringe:

> "When [Ms A] was back on the couch I suggested that [Ms B] phone the hospital again. So now the third suggestion to phone the hospital to find out [the baby's] status went like this … [Ms B] asking how the baby is, [Ms B] saying in a surprised voice, 'he's still alive?' [Ms B] saying, 'oh … at 3.50' (or thereabouts). I knew that at that point that [the baby] had already died some time before. I immediately wondered why the hospital hadn't phoned [Ms A]. I was very angry that [Ms B] hadn't been sensitive in choosing her words concerning [the baby]. In my opinion the calls to the hospital should have been made in another room where [Ms B] could have thought about what to say to [Ms A]. To give [Ms A] hope that [the baby] was alive and in a next breath say he isn't, is shocking. I was also very angry with the hospital for not phoning [Ms A] to tell her that her son had died. I know that they had [Ms A's] personal information because [Ms B] had given it to them with the first call."

Delivery of the placenta
Ms A said Ms B seemed "dazed" and did nothing about the delivery of her placenta and, eventually, Ms C instigated the placental delivery. Ms C noticed Ms B was doing nothing to assist in the delivery of the placenta, so took Ms A to have a shower to get "gravity going" to assist in the delivery of the placenta. Ms C accompanied Ms A to the shower in case she became light-headed or haemorrhaged. After a short time in the shower the placenta delivered. Ms C said the placenta looked healthy and good-sized. Ms B was not in the shower room at the time so Ms C called her.

Ms B's notes recorded that at 4.15am: "Managed to get [Ms A] up to the shower. Placenta still in situ."

There are conflicting accounts of what happened to the placenta.

Ms C told Ms B that the placenta had delivered and Ms B came and removed the placenta and placed it into a plastic bag. Ms C asked Ms B if the placenta would go to the laboratory for testing. Ms C said Ms B looked as if this was a very strange idea. Ms C felt from her own past experience that the placenta could be important to give a possible reason for the miscarriage. Ms A and Ms C have no idea what happened to the placenta and assumed Ms B disposed of it in some way.

At interview during the investigation, Ms B said she did not dispose of the placenta and did not send it to the laboratory. She left it with Ms A and Ms C as it was up to Ms A what she did with it. She said Ms A had told her to "chuck it away" as she did not want it. Ms B's notes record that at 4.20am: "Third stage complete and disposed of at [Ms A's] request. Blood loss minimal. Stayed with [Ms A] and friend to assist in cleaning up. [Ms A] told that funeral arrangements will have to be done later in the morning."

Funeral arrangements
Ms A said the funeral director, Mr H, was very helpful and gave her all the information that she believes Ms B should have. Mr H has since left the area and could not be contacted during the investigation.

Ms B said that she rang Ms A the morning after the baby's death and gave her information regarding the funeral and informed her there were three funeral directors in the main town, including Mr H. Ms B said Ms A did not want to know anything and Ms B put this down to immediate grief.

Ms B recorded in her notes that at 8.30am on 1 December she went to hospital to arrange the funeral with Mr H and that she rang Ms A to let her know this. At 11.00am Ms B went to the funeral parlour to fill and sign forms. The funeral took place on Friday 3 December.

Referral for grief counselling
Ms A felt she was left to cope with the aftermath of the baby's birth on her own. Ms A said she was unaware she would get breast milk. Ms A said she wanted to know the cause of the baby's death. As there was no post-mortem, the only reason she is left with is that the baby was premature.

In December 1999, Mr H referred Ms A to Ms D, social worker at the hospital, for grief counselling. Later that month Dr I, Ms A's general practitioner, referred her to the Paediatric Outpatients Clinic at the hospital "to sit down with a paediatrician and discuss the miscarriage".

Midwifery consultation records
There is conflicting evidence about whether Ms B kept midwifery records. Sometime shortly after the baby's funeral, Ms A rang Ms B and asked her for a copy of the hospital notes and Ms B's own notes. Ms A said Ms B returned her call and left a message on her answerphone informing her she would have to get her notes from the hospital herself as Ms B could not access them. The message informed Ms A that Ms B had no midwifery consultation records regarding Ms A's care. Ms A said she was very unhappy to hear this and left Ms B's message on her answerphone for about a week before deleting it as she felt it was not doing her any good emotionally.

Ms B thinks she rang Ms A once after the baby's birth. On 4 December 1999 Ms B recorded: "Rang [Ms A] – No answer."

Ms B said Ms A came to her practice rooms at the midwifery centre on 6 December 1999 and left a note requesting the baby's notes. Ms B did not talk with Ms A at this time. She saw Ms A leaving the clinic after she left the note but Ms A hurried away before Ms B could talk to her. Ms B said she then telephoned Ms A and left a message informing her that she could not access the hospital notes and that she (Ms A) would have to do that herself. Ms B said because of the tone of the note left at her rooms she assumed that Ms A did not want any postnatal care from her. Ms B did not produce Ms A's hand-written note during the investigation. On 6 December 1999 Ms B's records note: "[Ms A] called around to my clinic and left very quietly. Left note wanting the baby's notes from hospital. Rang [Ms A] to tell her I have no access to the baby's notes, but she could access them."

Ms B said she assumed Ms A did not want anything further to do with her and she considered herself at this point discharged from her services. On 8 December 1999 Ms B recorded in her notes: "[Ms A] did not want postnatal care so discharged from my care."

Ms B did not provide Ms A with a copy of her consultation notes when she requested them in December 1999. Ms B produced a copy of her consultation records on 15 November 2000 at the Commissioner's request.

The Death Certificate
The Death Certificate records the place of death as the hospital and that the baby died from "No obvious condition except prematurity". Under "name of certifying doctor" is written "[Ms B]".

Independent advice to Commissioner

An independent midwife, Ms Jenny Woodley, provided the following expert advice. (At the time of providing this advice Ms B had not provided her midwifery records to the Commissioner.)

> "I have read the following documentation supplied to me in regard to the complaint made by [Ms A] regarding the midwifery care provided by [Ms B], and enclose my professional opinion.
>
> Documentation examined
>
> (a) Letter of complaint written on behalf of [Ms A] written by [Ms D], […] Social Worker.
>
> (b) Documented phone conversation between [Ms A] and [the Investigation Officer] from the Health and Disability Commissioner's Office.
>
> (c) Copies of medical records submitted by [the hospital]. These include pregnancy scan reports for [Ms A], clinical notes written at the time of [the baby's] admission.
>
> Midwifery practice review including outline of expected practice standard
>
> **[Ms A] states that [Ms B] did not take her blood pressure or test her urine during antenatal checks.**
>
> Any antenatal care carried out by midwives for a woman includes taking blood pressure readings and testing urine for protein and sugar.
>
> These findings must be documented along with the information collected from the woman in relation to her general health, obstetric history and family health. There is no documentation submitted by the midwife [Ms B] to support this occurring.
>
> **[Ms A] rang [Ms B] to report vaginal bleeding the day before [the baby's] birth**
>
> Any bleeding reported to a midwife during pregnancy is required to be investigated by the midwife and the woman needs to be seen. As there is no documentation submitted by the midwife the description she obtained of the bleeding is not recorded. The midwife needs to know what type of bleeding, fresh blood or old, the amount of bleeding, any associated abdominal or back pain. Also the woman's general health immediately prior to the bleeding and whether she had suffered any injury such as a fall or blow to the abdomen that may have precipitated the blood loss. Vaginal bleeding is a serious sign that a pregnancy is not proceeding normally and the woman needs to be seen by the midwife or referred to an appropriate health professional such as an obstetrician.
>
> **[Ms A] had a premature birth of a live baby on her own at home the day after reporting the bleeding. Once the midwife [Ms B] arrived the baby was**

transferred unaccompanied to the hospital by ambulance. [Ms B] rang the hospital and found out that the baby had died.

[Ms A] had had two scans during her pregnancy that confirmed the estimated date of delivery of 31 March 2000. This would make the gestation of [the baby] at delivery 22 weeks and five or six days. Scans however can also vary in their accuracy according to the skill of the operator and a plus or minus of 10 days is considered reasonable when dating a pregnancy. The earlier the initial scans however the more accurate the estimated date of delivery can be determined.

A premature birth is very traumatic to the mother and the midwife needs to inform her as to what the outcomes are likely to be for the baby. At this gestation it is probable that most babies will die. Early gestation babies require a long period of intensive neo-natal care to enhance and enable their survival chances and even then there are some babies born prematurely at very early gestation who will suffer long term health difficulties. The difficulty lies with the babies born at about the time when some of them will survive. Current neonatal intensive care practice has this at 24 weeks. The survival rate for infants at this gestation is about 20% and the earlier the baby is born the less the chance of survival.

It is my opinion that if transfer to the hospital was decided on then [Ms A] and the midwife should have accompanied [the baby]. Alternatively if the midwife is certain that this baby is not viable, the baby could have been left with his mother at home. Decisions as to which choice to make are difficult and health professionals will at times make decisions in times of emergency that retrospectively could be considered inappropriate. Documentation by the midwife would have enabled a better understanding of her decision to separate mother and baby at this critical time. I can only speculate that the midwife would have seen how small the baby was and realised that the chances for survival are very slim indeed. However until the baby has died compassionate care is given to the infant. This would be gentle handling and warmth and may include oxygenation. Keeping mother and baby together enables women to come to terms with their loss more readily. Separation often intensifies their grief, as they know their baby died without their support and love. A factor that would have made the decision more difficult was the fact that there was not another adult in the house at the time and [Ms A] other children were sleeping.

Once the baby had been born it would seem from the letter written by [Ms D] social worker on behalf of [Ms A], that [Ms B] was uncertain of her decisions regarding appropriate transfer of the mother with the baby, and the delivery of the placenta. As [Ms B] has not submitted documentation of her care I cannot comment on her actions except again to say that midwives have a professional responsibility to document every episode of care they provide and all contacts between them and their clients.

The midwife [Ms B] did not provide postnatal care for [Ms A]

Following the birth of the infant it is usually the midwife or doctor who will discuss the option of having a post mortem examination conducted on the baby. The mother needs to consent to this. Also the midwife or doctor would advise the woman of the

funeral needs and who to contact if the woman and her family choose to have a funeral.

Postnatal care is considered part of normal midwifery practice no matter when the pregnancy ends. If the midwife was unable to carry this out because of her own circumstances she is ethically obliged to ensure that another midwife provides this follow up care. Women need to talk through unexpected birth outcomes at length, often several times, and have their questions answered, in order to be able to understand and begin to come to terms with the events that have occurred. This debrief is an essential part of the grief process. The midwife needed to refer [Ms A] appropriately if she herself felt unable to do this.

To summarise therefore I feel that [Ms B] did not provide midwifery care of an acceptable standard to [Ms A]. Because of these omissions it is likely that the impact of the premature birth and death of the baby on [Ms A] was much more traumatic than if reasonable midwifery care had been provided. It would seem that it was very unlikely that [the baby] would have survived given his gestation of under 24 weeks. Midwives do need to be aware of the emotional impact on women of premature birth and loss of a baby and support women or refer them to an appropriate agency if they are unable to provide this support.

The inappropriate billing of the ambulance service addressed to the baby on two occasions would have also added to the distress of [Ms A].

Because of the lack of documentation and follow up care I feel [Ms B] has not practised according to the following standards as defined in the New Zealand College of Midwives Handbook for Practice.

Standard 3
The midwife collates and documents comprehensive assessments of the woman and/or baby's health and wellbeing.

Standard 4
The midwife maintains purposeful ongoing updated records and makes them available to the woman and other relevant persons.

Standard 5
Midwifery care is planned with the woman.

Standard 6
Midwifery actions are prioritised and implemented appropriately with no midwifery action or omission placing the woman at risk.

Standard 9
The midwife dissolves the midwifery partnership.

I would like to express my sympathy to [Ms A] for the sudden loss of her baby. Sudden unexpected pregnancy loss is always very difficult for the woman and her family and I acknowledge the stress and emotional pain the baby's death has brought."

Further midwifery advice

On 15 November 2000, Ms B provided me with her consultation records. The records were provided to independent midwife Ms Jenny Woodley, who provided the following further expert advice:

> "I have received the following documentation for the above complaint file sent to me by your Office.
>
> (A) Letter from [a] Health Advocate, Letter from [Ms D] Social Worker, Copy of death certificate for [the baby] Copy of account from ambulance services. Personal account of birth from [Ms A] (the baby's [mother]) Personal statement from [Ms C] (friend of [Ms A]) Letter from General Practitioner Dr I to Paediatrician.
> (B) Transcript of phone conversation with [Ms A].
> (C) Copy of medical records from [the hospital].
> (D) Copy of Midwife [Ms B's] clinical notes.
> (E) Copies of statements from the ambulance service Ambulance officers.
> (F) Transcript of interview notes with Ambulance Officer [Mr F].
> (G) Transcript of interview with [Ms A].
> (H) Transcript of interview with [Ms C].
> (I) Transcript of interview with [Ms E], volunteer with [the ambulance service].
> (K) Transcript of interview notes with [Ms B].
>
> I have previously provided an opinion on this file dated 08/10/2000 and provide the following additional comment after reading the additional documents.
>
> <u>Prognosis for a 23 week gestation baby and options open to [Ms A] after [the baby's] birth</u>
> In addition to my comments in my previous report, a diagnosis of viability based on gestational age, particularly in relation to babies born around the age of viability of 24 to 26 weeks, is very difficult to make. Because of this it would probably not be considered normal practice for a midwife to make the decision as to whether a baby should be left home to die with his family rather than transfer to hospital. It was therefore reasonable for the midwife to arrange for transfer of care to a hospital. The suddenness of events and the fact that there was no other adult in the house and two other sleeping children complicated the decision and appeared to have contributed to the decision to transfer the baby unaccompanied.
>
> <u>Antenatal care</u>
> [Ms A] stated (B) she did not have her blood pressure recorded and had only seen [Ms B] once. [Ms B] (D) has documented 4 antenatal checks and the blood pressure recording is documented. To document events if they have not occurred is a serious offence for a health professional, as clinical documentation is a legal account of care provided. It is considered normal practice for the woman's blood pressure recording to be taken and recorded at each antenatal check.

The urine was not recorded (D) as having been tested and this is considered normal practice at antenatal checks. The woman's urine is checked at each antenatal check for the presence of protein and sugar.

The blood loss described by [Ms A] (G) was like a 'period' and she had to wear a pad. In the clinical notes (D) [Ms B] has documented a slight pinkish discharge. In the transcript of the interview with [Ms B] (F) she states that she asked [Ms A] if the blood was bright red or brown and [Ms A] replied it was red. Blood loss in pregnancy is always considered potentially serious and the cause, amount, type, colour of the blood needs to be fully investigated by the midwife and may require a referral to specialist care.

Postnatal care

Midwives should provide postnatal follow up and referral for grief counselling when there is an identified need. [Ms B] has recorded [Ms A] did not want postnatal care and was discharged from her care. This appears not to have been clear to [Ms A]. Midwives occasionally have women who no longer want to use their services for whatever reason, when this occurs the midwife needs to arrange with the woman for her needs to meet by another midwife. If another midwife is not available the woman could be referred to another health practitioner such as a district nurse or general practitioner. In times of stress, such as the events that occurred in this instance, it can occur that the midwife is so distressed by the situation that they are not able to provide care. Because of this they may not recognise the need to consider the emotional needs of the woman experiencing the sudden pregnancy loss.

Debrief is an essential part of the healing process for women and for midwives involved in critical or unexpected pregnancy events such as this. Debrief is recognised as an essential part of professional practice. Arranging this support and having good back-up systems in place protects midwives and ultimately benefits women when they receive care.

[Ms A] has stated she was alone when she had the baby. Documented by [Ms B's] in the clinical notes (D) is that she (the midwife) arrived before the baby was born: '[Ms A] was in obvious labour and feeling the urge to push. Progressed to rapid normal delivery of live small male infant gasping.'

This documentation states the midwife was present when the baby was born where as the woman has said she was not. Documentation of events in the clinical notes is considered an essential part of practice and the clinical notes must always accurately reflect events that have occurred. A breach of this is a serious breach of accepted practice by any midwife.

The transcript of the interview with [Ms B] (K) states when she arrived at [Ms A], [Ms A] had delivered the baby and that she ([Ms B]) was confronted by a baby already born.

Legal requirements for baby's burial

A medical practitioner is the health professional legally required to sign a death notification of any death including a baby. The midwife may not know the legal procedures for burial but can always seek advice on this from the bereavement team at the base hospital.

In summary

The main issue raised by the additional records of events is that the woman's and midwife's version of events are not the same. The midwife has written a personal account of the events that appears incomplete, this is attached to the back of the clinical documentation, document (D). The number of antenatal visits that were conducted by the midwife and what procedures were done at these are disputed by the woman. Antenatal visits were incomplete as urine was not tested. There is no record of a midwifery care plan being commenced with the woman. The bleeding prior to the premature labour was not investigated fully to exclude serious complications of pregnancy. A premature birth at home occurred and the live premature baby was transferred to the local hospital where he later died. Although the baby was transferred alone this decision was complicated by the fact that there were two other sleeping children in the house and no other adult present. Follow up postnatal care was not provided by the midwife or arrangements for an alternative midwife or health care practitioner made. Referral for grief counselling did not occur. Documentation in the clinical notes does not match with the interviewed records of both the midwife and [Ms A].

It is my opinion that [Ms B's] practice has fallen short of some criteria in standards four, six, and nine in the New Zealand College of Midwives handbook for practice.

Standard Four of the New Zealand College of Midwives Handbook for Practice

The Midwife maintains purposeful, on going, updated records and makes them available to the woman and other relevant persons

Criteria

The Midwife:

- Reviews and updates records at each professional contact with the woman;
- Ensures information is legible, signed and dated at each entry;
- Files reports appropriately, makes records accessible and available at all times to the woman and other relevant and appropriate persons with the woman's knowledge and consent;
- Ensures confidentiality of information.

Standard Six of the New Zealand College of Midwives Handbook for Practice

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

Criteria:

The Midwife:
- Ensures potentially life-threatening situations take priority;
- Identifies deviations from the normal and after discussion with the woman, consults and refers as appropriate;
- Has the responsibility to refer care to the appropriate health professional when she has reached the limit of her expertise;
- Demonstrates awareness of her own health status and seeks support to ensure optimum care for the woman is maintained.

Standard Nine of the New Zealand College of Midwives Handbook for Practice

The Midwife dissolves the Midwifery Partnership

Criteria:

The Midwife:
- Organises ongoing care from other health professionals and community agencies where necessary;
- Ensures the woman has had an opportunity to reflect on and discuss her childbirth experience;
- Informs the woman and her family/whanau of available community support networks."

Code of Health and Disability Services Consumers' Rights

The following Rights in the Code of Health and Disability Services Consumers' Rights are applicable to this complaint:

RIGHT 1
Right to be Treated with Respect

1) Every consumer has the right to be treated with respect.

RIGHT 4
Right to Services of an Appropriate Standard

1) Every consumer has the right to have services provided with reasonable care and skill.
2) Every consumer has the right to have services provided that comply with legal, professional, ethical, and other relevant standards.
3) Every consumer has the right to have services provided in a manner consistent with his or her needs.

RIGHT 6
Right to be Fully Informed

1) Every consumer has the right to the information that a reasonable consumer, in that consumer's circumstances, would expect to receive, including –

a) An explanation of his or her condition; and
b) An explanation of the options available …

Other Relevant Standards

The Relevant Standards referred to in this opinion are the New Zealand College of Midwives *Handbook for Practice*. The Standards referred to are set out in the independent advice.

Opinion: Breach – Ms B

Right 1(1)

Insensitivity on the phone while Ms A present
Ms A complained about the insensitivity of Ms B's conversations with the hospital on the morning that she spontaneously and prematurely gave birth to the baby.

Ms A had experienced an unexpected birth and was faced with a traumatic loss, which required sensitive handling. According to Ms C and Ms A the telephone conversations to the hospital about whether the baby was alive were conducted in front of Ms A.

Under Right 1(1) of the Code every consumer has the right to be treated with respect. This includes respect for the consumer's feelings. I agree that Ms B should have carried out these conversations in a quiet place and then sensitively informed Ms A, particularly as Ms B was using a cordless phone. Both Ms A and Ms C commented that Ms B acted dazed, as if she was in shock. I am sure Ms B was also traumatised by events but the difference was that she was the LMC in charge and, as such, was required to act in a professional way.

In my opinion, Ms B did not treat Ms A with respect and, accordingly, breached Right 1(1) of the Code.

Rights 4(1) and 4(2)

Inadequacy of antenatal care
There is conflicting evidence about the antenatal care that Ms B provided to Ms A during her pregnancy.

Ms A claims that during her pregnancy Ms B examined her on only one occasion after her initial visit on 23 September 1999. Ms B's midwifery records show four consultations with Ms A, on 23 and 30 September 1999 and 8 and 23 November 1999.

Ms B claims that, as Ms A was trained in homeopathy, she wanted a natural birth and did not require much input from a midwife. Ms B did not mind if that was what Ms A wanted. However, Ms A informed me that she always intended to have her baby in hospital, and although she did not require someone to "hold her hand", she was concerned as her previous pregnancies had resulted in rapid labours. She was also concerned about a greater risk of haemorrhage because she had a less common blood group, B positive.

Standard 5 in the New Zealand College of Midwives *Handbook for Practice* requires that midwifery care is planned with the woman. There is no record of a midwifery care plan prepared by Ms B for Ms A.

Ms A said that during her antenatal consultations, Ms B did not take her blood pressure so Ms A monitored her blood pressure herself. My midwife advisor noted that Ms B documented two blood pressure recordings during the four documented antenatal checks. My advisor considered it normal practice for a blood pressure recording to be taken and recorded at each antenatal check.

Ms A said Ms B did not test her urine for protein and glucose and instead provided her with five urine dipsticks to allow her to test her urine herself. Ms A said this was not a problem for her as she was familiar with how to interpret dipsticks. Ms A said she was given no direction from Ms B as to whether to contact Ms B with the results. At recorded visits on 23 and 30 September and 23 November 1999 Ms B has not recorded Ms A's urine protein and glucose. On 8 November 1999 Ms B recorded that Ms A's urine protein and glucose were "not tested". My advisor informed me that it is normal practice to check for the presence of urine protein and glucose at each antenatal visit.

Ms B did not take Ms A's weight at any documented visit. Ms A said her stomach was never palpated during the consultations. Ms B did not document any such examinations.

Although there are conflicting accounts of the number of consultations and what took place during these consultations, it is clear that Ms B failed to weigh Ms A or commence a midwifery care plan with her. She also did not test her urine or monitor her blood pressure at each visit in accordance with normal midwifery practice.

Regardless of the fact that Ms A did not need someone to "hold her hand" during her pregnancy, she did require the professional services of an LMC. The onus was on Ms B, as LMC, to practise according to the requirements of her profession. By failing to take Ms A's blood pressure, check her weight, or test her urine, or commence a midwifery care plan, Ms B failed to monitor Ms A in accordance with accepted midwifery practice. In my opinion Ms B did not provide midwifery services to Ms A with reasonable care and skill, and in compliance with professional standards, and breached Rights 4(1) and 4(2) of the Code.

Failure to visit on 30 November 1999
On 30 November 1999 Ms A, who was about 22 to 23 weeks pregnant, telephoned Ms B and informed her that she was bleeding. There are conflicting accounts about what was said during this call.

According to Ms A, Ms B was told that she was bleeding as if she had a period, with enough bleeding to require a sanitary pad. Ms A said that Ms B advised her to rest and to wait and see, and that she would give her a scan the following day if the bleeding had not settled.

On the other hand, Ms B said that she asked Ms A if the bleeding was about a teaspoonful and Ms A replied it was. Ms B asked if it was red or brown and Ms A replied it was red. However, Ms B's midwifery notes contradict this and record Ms A as having a "slight pinkish vaginal discharge". Ms B said that after some discussion they both decided there was nothing to worry about and she told Ms A to call her back if there were any problems. Ms A said Ms B told her to wait and see if the bleeding settled and that she would arrange an ultrasound if it did not. Ms B did not visit Ms A.

Ms C, a close friend of Ms A, provided an account consistent with Ms A's version. She said that later that morning Ms A rang her asking what it was like to miscarry and informed her she was bleeding. On questioning, Ms A said she was not spotting and described the bleeding as "like a period". Ms A told Ms C she had rung the midwife who told her to wait and see if the bleeding settled and then, if it had not, she would arrange an ultrasound. Ms C was concerned that the midwife had not suggested an examination to determine the reason for the bleeding.

My advisor informed me that any bleeding reported to a midwife during pregnancy is required to be investigated by the midwife, and the woman needs to be seen. Blood loss in pregnancy is always considered potentially serious and the cause, amount, type, and colour of the blood needs to be fully investigated by the midwife and may require a referral to specialist care.

Despite the conflicting accounts, what is certain in this case is that Ms A was bleeding and Ms B did not visit to find out the cause. In my opinion this was not prudent or sensible. By failing to visit or arrange a consultation with Ms A when Ms A informed her she was bleeding, Ms B did not provide midwifery services to Ms A with reasonable care and skill, and breached Right 4(1) of the Code.

Failure to provide adequate direction prior to and after the birth
In the early hours of the morning on 1 December 1999, when Ms A awoke in "total agony" with cramps and pain underneath her belly, she was initially unaware that she could be in labour. After first contacting her husband in the city, she telephoned Ms B, who sounded half asleep. This was understandable, as it was the middle of the night. Ms B believes this call was made at 2.30pm and Ms A believes it was closer to 1.45am. For reasons discussed later, I accept Ms B's version that the call was made about 2.30am.

There is conflicting evidence as to whether one or two calls were made and as to the content of these calls. Ms B believes there were two calls made: an initial call when she

suggested that Ms A go to the hospital directly and a further call when she reinforced the benefit of going to hospital, since the one way to save the baby was to keep it inside Ms A, and at the hospital medications would be administered for this purpose. Ms B said Ms A refused to go to hospital because she did not want any medical intervention and could not leave her other children unsupervised. This is not consistent with Ms A's version of events.

Ms A said there was only one call that night, during which she told Ms B she could not drive as she was in so much pain and asked Ms B to come. She did mention to Ms B that she had no one to look after her other two children who were asleep. Ms A said at interview that she would have gone to hospital if that was necessary but Ms B never mentioned going to the hospital or medications to stop her labour. Ms A had no aversion to going to hospital as she had intended having her baby in hospital. However, in Ms D's letter written on behalf of Ms A, it is stated that the LMC asked Ms A to drive to the hospital and that Ms A said she could not because she had two children she could not leave alone.

I am satisfied that Ms A would not have refused medical intervention, had it been suggested that she go to hospital.

Ms A described herself as being in total agony and unable to drive. Ms B must have known this was a probable spontaneous labour and therefore a medical emergency. Ms A needed Ms B in her professional capacity as her LMC midwife and to be present to assess, advise and assist her through this very traumatic and unexpected premature birth. Ms B could have called an ambulance to assist with transfer to hospital, if this was required. Ms B, as the health professional involved, was under a duty to provide services to Ms A with reasonable care and skill, in a manner consistent with Ms A's needs. It was entirely understandable that the suddenness and the unexpectedness of her miscarriage traumatised Ms A. The onus was on Ms B, as LMC, to be proactive in her approach to the situation. She failed to respond appropriately.

Ms B provided confusing and contradictory accounts about the situation she was confronted with when she arrived at Ms A's home. Ms B stated at interview that when she arrived she was confronted by a baby already born, which is consistent with Ms A's own account. However, in her notes she recorded that she arrived and found Ms A in obvious labour and feeling the urge to push, and that Ms A progressed to a rapid delivery of a live small male infant who was gasping.

Ms B's labour and delivery record notes that the baby was delivered by Ms A rapidly while Ms B was present, and incorrectly recorded the baby's weight as 250gms. The hospital notes record the baby's weight as 540gms.

In my opinion Ms A would know best when she gave birth and if anyone assisted. I am satisfied that Ms A had already given birth when Ms B arrived.

When Ms C arrived she was concerned and frustrated by the lack of direction that Ms B was providing to Ms A. I accept Ms A's and Ms C's version of events. There is no evidence of Ms B being proactive in her assistance or guidance to ensure that Ms A

delivered the placenta. It was Ms C who helped Ms A in the delivery of the placenta, even though she was only a support person.

In my opinion Ms B failed to show the direction and oversight expected of a responsible midwife in such circumstances. By failing to be more proactive and directive in her approach, Ms B did not provide midwifery services to Ms A with reasonable care and skill, and breached Right 4(1) of the Code.

Right 6(1)(a)

Failure to explain the prognosis for a baby born at 23 weeks
I am advised that current neonatal intensive care practice recognises 24 weeks as the cut-off point for viability. The survival rate for infants at this gestation is about 20%; the earlier the baby is born, the less the chance of survival. The baby was between 22-23 weeks and it was unlikely that he could have survived.

My midwife advisor stated that a premature birth is very traumatic to the mother, and the midwife needs to inform her of the likely outcomes for the baby. At a gestation of 22-23 weeks, it is probable that most babies will die. If a severely premature baby does survive, he or she will require a long period of intensive neonatal care, and may suffer long-term health difficulties.

Ms B did not explain the baby's condition or his likelihood of survival. Ms A was understandably confused, traumatised and upset and could not understand why more was not being done to try to save her baby, who was gasping for breath. She needed to be told the likely prognosis for the baby's continued survival. I accept that giving advice in such a situation is difficult, but a woman is totally dependent on her LMC for information. If Ms A had been given information about the likely prognosis, she would have been better able to prepare herself for the baby's death and to make an informed decision about how to spend their brief time together.

By failing to explain the baby's condition and the likely prognosis for a baby born at 23 weeks, Ms B breached Right 6(1)(a) of the Code.

Right 6(1)(b)

Failure to give Ms A the option to keep her baby at home
Ms A thought that Ms B was uncertain about how to respond to the baby's unexpected birth. Ms B wrapped the baby up to keep him warm and called an ambulance for the baby to be taken to hospital.

It appears that Ms B must have seen how small the baby was and realised that his chance of survival was very slim indeed. However, until the baby died, compassionate care should be given in the form of gentle handling and perhaps oxygenation.

My advisor considered that it was reasonable for Ms B to arrange for transfer to a hospital because, as discussed above, the issue of viability is very difficult to make at 22-23 weeks' gestation. It would probably not be considered normal practice for a midwife to make the

decision whether a baby should be left home to die with his family rather than transfer to hospital.

As noted by my advisor, keeping mother and baby together in such circumstances enables women to come to terms with their loss more readily. Separation can intensify grief, since a woman knows that her baby died without her support and love. Obviously it was a complication that no other adult was present in Ms A's house at the time, and her other children were sleeping. Nonetheless, it is inexplicable that Ms B did not offer to stay to look after the children in the short period of time between the ambulance departing for hospital and the expected arrival of Ms C.

As it turned out, Ms C arrived as the ambulance was pulling out of the driveway. If Ms B had looked after the children for this short period of time, Ms A could have travelled in the ambulance to hospital with her baby. The placenta could have been delivered in the ambulance or at hospital. However, Ms A was never given the option of accompanying her baby. Nor was Ms A given the option of keeping the baby at home to die in her arms.

Neither of these options was given to Ms A. The fact that her baby died alone without her has undoubtedly added to her grief. By failing to explain the available options, Ms B breached Right 6(1)(b) of the Code.

Rights 4(2) and 4(3)

Postnatal follow-up
My advisor noted that midwives should provide postnatal follow-up. Debrief is an essential part of the healing process for women and for midwives involved in unexpected pregnancy events, and is an essential part of professional practice. Arranging support and having good backup systems in place protects midwives and ultimately benefits women. There is no evidence that Ms B provided any postnatal care to Ms A.

Ms A experienced an unexpected and traumatic loss when she spontaneously gave birth to the baby on 1 December 1999. My advisor stated that in times of stress, such as in this instance, the midwife may be so distressed by the situation that she is not able to provide care, or to recognise the need to consider the emotional and physical needs of the woman experiencing a sudden loss.

On 6 December 1999 Ms A requested her notes. Ms B did not provide a copy of her records. This upset Ms A and undoubtedly compromised whatever relationship remained. Ms B assumed Ms A did not want any postnatal care from her and recorded this in her notes on 8 December 1999. Ms B recorded that Ms A was discharged from her care.

Ms B did not confirm with Ms A that she was discharged from her care, or refer Ms A to another health professional for postnatal care. Ms A said she did not realise that she would still get breast milk after the baby's birth and was unable to cope with the aftermath of the baby's death. These matters were the responsibility of the LMC as part of the postnatal follow-up care.

My advisor commented that when a woman indicates that she no longer wishes to receive care from her midwife, the midwife should arrange with the woman for her needs to be met

by another midwife. If another midwife is not available, the woman can be referred to another health practitioner such as a district nurse or general practitioner. Standard nine of the New Zealand College of Midwives *Handbook for Practice* requires that the midwife dissolving the partnership organises ongoing care from other health professionals.

In these circumstances, Ms B failed to comply with professional standards and breached Right 4(2) of the Code.

Grief counselling
My advisor noted that midwives should provide postnatal referral for grief counselling when there is an identified need. After the relationship between Ms B and Ms A broke down, Ms A was eventually referred to a social worker at the hospital for grief counselling, and to the hospital's Paediatric Outpatients Department for a debrief.

Standard 6 of the New Zealand College of Midwives *Handbook for Practice* states that the midwife has the responsibility to refer to the appropriate health professional when she has reached the limit of her expertise. In this instance the appropriate health professional was a grief counsellor or Ms A's general practitioner. Ms B did not provide any postnatal care to Ms A because she considered herself discharged from providing any such care. Ms B did not identify any need for grief counselling.

In these circumstances, Ms B failed to comply with professional standards and did not provide Ms A with midwifery services in a manner consistent with her needs. Accordingly, Ms B breached Rights 4(2) and 4(3) of the Code.

Right 4(2)

Failure to keep records of antenatal and delivery care
Ms A asked Ms B for her records after the baby's funeral. Ms B did not supply them to Ms A. Ms A was very upset by this and to date has still not received a copy of her records.

Ms B initially did not supply the records to my Office when requested to do so on 16 May 2000. However, at interview on 15 November 2000, Ms B provided my Investigation Officer with a copy of Ms A's antenatal record.

As discussed above, the notes contain information that conflicts with Ms A's account of events and, to some extent, with Ms B's own evidence at interview. It is a serious offence for a health professional to document events that have not occurred. Accurate documentation is a key aspect of the provision of good quality care. I am left in some doubt as to whether Ms B's notes are a true representation of the care she provided Ms A.

Ms B was required by Standard 4 of the New Zealand College of Midwives *Handbook for Practice* to "maintain purposeful, ongoing, updated records and make them available to the women and other relevant persons". In failing to do so, Ms B did not comply with professional standards (or Rule 6 of the Health Information Privacy Code) and breached Right 4(2) of the Code.

Opinion: No breach – Ms B

Right 4(1)

Delay in responding to Ms A's call on 1 December 1999
When Ms A telephoned Ms B on 1 December 1999 she needed professional help urgently as she was experiencing an unexpected and spontaneous labour. Ms A lived about a 15-minute drive from Ms B. In order to provide midwifery services to Ms A with reasonable care and skill, as required under Right 4(1) of the Code, Ms B should have responded to this call as quickly as possible.

There is conflicting evidence about the timing of Ms A's call to Ms B on 1 December 1999 although it is agreed that Ms B arrived at Ms A's home at around 3.00am.

Ms B's notes record that Ms A contacted her at 2.30am. Ms A initially thought she called Ms B at 2.45am, as recorded in her personal diary. However, at interview Ms A said she is now uncertain and believes Ms B took about one hour to arrive, in which case the call must have been made at about 1.45am, rather than 2.45am.

Ms A told her social worker at the hospital that she phoned Ms B about 2.00am. Telephone records, which could have clarified this issue, were not available.

Ms B's record of the call at 2.30am approximates Ms A's diary record that the call occurred at 2.45am. It follows that Ms B took between 15 to 30 minutes to arrive at Ms A's home. I do not consider this to be an unreasonable response time considering it was the early hours of the morning and Ms B had been asleep when she was called.

In these circumstances, I am satisfied that Ms B did not delay unduly in responding to Ms A's call and did not breach Right 4(1) of the Code in this respect.

Failing to send the placenta to the laboratory for analysis
When Ms A had delivered the placenta, Ms C asked Ms B if it would be possible to send the placenta to the laboratory for analysis. According to Ms C, Ms B reacted as if this was a strange suggestion. Ms C had personal experience of miscarriage and believed that the placenta can sometimes give clues as to why the miscarriage occurred.

I am unable to establish what happened to the placenta. Both Ms C and Ms A say Ms B took the placenta and put it into a plastic bag. Ms A does not know what happened to the placenta and believes Ms B disposed of it. At interview, Ms B said she took the placenta, put it into a plastic bag, and left it for Ms A to deal with. However, Ms B's notes contradict this and state that she disposed of the placenta at Ms A's request.

In light of the conflicting evidence on this issue, I am unable to take the matter any further.

Failure to provide information about funeral arrangements
Ms A claims that Ms B gave her no information or support in relation to legal requirements for her baby's funeral. My advisor commented that a midwife may not know the legal procedures for burial but can always seek advice from the bereavement team at the base hospital.

Ms B went to the hospital the morning after the baby's death and made funeral arrangements. This involved the funeral director, Mr H, who handled the required details from there on. Accordingly, there is no evidence that Ms B breached the Code in this respect.

Other Comments

I note Ms A's concern that Ms B initially dialled 911 for the ambulance and then asked Ms A what the emergency number was. Ms A informed her it was 111. Ms B has not provided me with her account of this issue. I have no reason to disbelieve Ms A. It is disturbing that a professional midwife, responding to a premature delivery in the middle of the night, does not know what telephone number to call for emergency assistance.

Actions

I recommend that Ms B take the following actions:

- Apologise to Ms A for breaching the Code. This apology is to be sent to my Office and will be forwarded to Ms A.
- Review her practice in light of this report.

Further actions

- This matter will be referred to the Director of Proceedings under section 45(f) of the Health and Disability Commissioner Act 1994 for the purpose of deciding whether any further action should be taken.
- A copy of this opinion will be sent to the Nursing Council of New Zealand and the National Director of the New Zealand College of Midwives.

- An anonymised copy of this opinion will be sent to the New Zealand College of Midwives and the Maternity Services Consumer Council, and placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

- An anonymised copy of this opinion will be sent to the ambulance service with the suggestion that they consider a protocol for the delivery of premature babies to hospital.

Addendum

The Director of Proceedings considered this matter and decided not to issue proceedings before the Nursing Council or the Human Rights Review Tribunal.