# Registered Midwife B

## A Report by the
## Deputy Health and Disability Commissioner

## (Case 21HDC00665)

Health and Disability Commissioner
*Te Toihau Hauora, Hauātanga*

## Contents

## Executive summary

1. This report relates to the midwifery care provided to Mrs A by RM B, and the tragic stillbirth of Mrs and Mr A's baby daughter, Baby A.

2. In 2020 Mrs A became pregnant. She planned to have a home birth, and the pregnancy progressed normally until 17 Month5[1] when her waters ruptured. Mrs A was then at 41 weeks' gestation.

3. Mr and Mrs A lived in a remote rural location at a property with no electricity, landline, cell phone coverage or internet. The circumstances surrounding Mrs A's living situation were relevant to this investigation and the management of her home birth and the care RM B provided to Mrs A.

### Findings

4. The circumstances in the period leading up to the still birth of Baby A have been extremely difficult to investigate, not least because of the very different accounts of the events provided by RM B and Mr and Mrs A, and the accounts of the information RM B provided to Mrs A. The clinical records have been of limited assistance, given the obvious inaccuracies within the documentation.

5. Notwithstanding the differing accounts, the information gathered over the course of the investigation has indicated that by the time Mrs A went into labour, it was no longer a normal pregnancy. Several concerning risk factors meant that it was unsafe for Mrs A to give birth at home in a remote locality with no communication channels and no ready access to specialist input. This high-risk birth should have been facilitated in a base hospital.

6. The Deputy Commissioner concluded that aspects of the care provided to Mrs A by RM B were deficient and did not meet the required standard, and RM B has been held responsible for some of the failings that occurred.

7. The Deputy Commissioner considered that RM B failed to provide Mrs A with the information that a reasonable person in her situation would expect to receive. Mrs A had concerns about medical intervention during her pregnancy and labour, and RM B should have addressed these in a balanced and evidence-based manner. The Deputy Commissioner found RM B in breach of Right 6(1) of the Code. As Mrs A was not in a position to make informed choices and give informed consent, RM B was also found to have breached Right 7(1) of the Code.

8. The Deputy Commissioner found that RM B failed to comply with the standards in the Referral Guidelines regarding consultation with another clinician, in breach of Right 4(2) of the Code. By failing to arrange an ultrasound scan, RM B failed to provide services to Mrs A with reasonable care and skill, in breach of Right 4(1) of the Code.

[1] Relevant months are referred to as Month1–Month6 to protect privacy.

9. The Deputy Commissioner considered that RM B should not have left Mrs A unattended, and by doing so failed to provide services to Mrs A with reasonable care and skill, in breach of Right 4(1) of the Code.

10. The Deputy Commissioner considered that following Baby A's unexpected death, RM B should have arranged appropriate investigations, obtained the necessary information, informed Mrs A of her options, and supported her. By failing to do so, RM B did not provide services with reasonable care and skill and breached Right 4(1) of the Code.

11. The Deputy Commissioner also criticised RM B's record-keeping and that RM B supplied a herbal tincture to Mrs A without having undertaken the required education on complementary and alternative therapies.

## Complaint and investigation

12. The Health and Disability Commissioner (HDC) received a complaint from Mrs A about the services provided by registered midwife (RM) B. The following issue was identified for investigation:

- *Whether RM B provided Mrs A with an appropriate standard of care in Month5 and Month6 2020.*

13. This report is the opinion of Rose Wall, Deputy Health and Disability Commissioner, and is made in accordance with the power delegated to her by the Commissioner.

14. The parties directly involved in the investigation were:

| | |
|---|---|
| Mrs A | Consumer |
| Mr A | Consumer's husband |
| RM B | Provider/midwife |

15. Other parties mentioned in this report:

| | |
|---|---|
| RM C | Provider/midwife |
| Dr D | Provider/hospital clinical director |
| RM E | Provider/midwife |

16. Further information was received from:

Ambulance service
Midwifery Council
Health New Zealand|Te Whatu Ora

17. Independent advice was obtained from RM Nicholette Emerson (Appendix A).

## Information gathered during investigation

### Introduction

18. This report relates to the midwifery care provided to Mrs A by RM B, and the tragic stillbirth of Mrs A and Mr A's baby daughter, Baby A.

19. Mr and Mrs A live in a relatively remote rural location around 15 minutes' drive from a nearby town, at a property with no electricity, landline, cellphone coverage, or internet. Cellphone coverage can be obtained only by driving for five minutes to the end of their road. The circumstances surrounding Mrs A's living situation are relevant to the management of her home birth and the care RM B provided to Mrs A.

20. RM B had been Mrs A's Lead Maternity Carer (LMC) during her first pregnancy three years earlier, but RM B did not attend the birth as she was attending another birth at that time. Mrs A's waters did not break prior to that labour. She had a home birth attended by two back-up midwives, but her baby was transferred to the public hospital and admitted to the NICU (Neonatal Intensive Care Unit) with meconium aspiration[2] and remained in hospital for 18 days. Mrs A decided that her baby should receive oral vitamin K, and baby's records confirm that this was administered after birth at the correct intervals.

21. In 2020 Mrs A was pregnant with her second child. Her estimated date of delivery (EDD) was 9 Month5 2020. Mrs A said that she was uncertain whether she wanted RM B to be her LMC during her second pregnancy, but RM B assured her that if she chose her to be the LMC for this pregnancy, she would not schedule any other births in the same month as Mrs A was due so that she would not miss the birth again. Mrs A decided that RM B would be her LMC for this pregnancy.

### Antenatal records

22. Mrs A told HDC that there are multiple inaccuracies in her antenatal records. She said that in the 'First and second trimester care summary' under the 'Number of visits in first trimester', RM B wrote '2', but there were no visits in the first trimester because at that stage Mrs A had not yet chosen a midwife. The first visit is recorded as being on 23 Month1 when Mrs A was 24+3 weeks' gestation.

23. Under the 'Number of visits in second trimester', RM B wrote '24'. Mrs A stated that there was one visit in the second trimester, not 24, and that in the 'Pregnancy summary Including third trimester care' under the section 'Number of visits in third trimester', RM B wrote '25' when actually there were 22 visits.

24. Mrs A told HDC that RM B did not ask her whether she wanted her baby to be administered vitamin K after the birth. However, RM B wrote in the notes on 24 Month1: 'Mrs A does not consent to vit K.' In the 'Guide for Care Plan Discussion' part of the midwifery notes under the section 'Immediate care of the baby/vitamin K', RM B wrote 'Declined'. Mrs A said that

[2] Difficulty breathing because meconium (the baby's first stool) has entered the trachea (windpipe).

this is incorrect, and if RM B had asked her, she would have told her that she consented to oral vitamin K as she had done with her first baby.

25. In contrast, RM B told HDC that vitamin K was discussed antenatally, and Mrs A declined vitamin K. RM B asserted that Mrs A had also declined vitamin K for her first baby. However, as noted in paragraph 20, her first baby's records show that he was given vitamin K.

**Rupture of membranes**

26. Mrs A planned to have a home birth, and the pregnancy progressed normally until 17 Month5. Mrs A was then at 41 weeks' gestation.

27. On 17 Month5 at 8.46am Mrs A texted RM B to say that her waters had broken, and she was going to her mother's house and would ring once she was there. When Mrs A telephoned RM B, she told RM B that initially her waters had been clear, but she now believed she had meconium present. RM B asked Mrs A to send a picture of her pad, which confirmed that there was meconium.

28. RM B told Mrs A to go to the birthing unit straight away to have a cardiotocography (CTG) (which measures the baby's heart rate). The CTG showed nothing abnormal.

29. RM B told HDC that she recommended to Mrs A that if meconium was in the waters, a consultation at the public hospital was warranted,[3] but Mrs A declined a consultation. Mrs A stated that RM B told her that this was the hospital's recommendation, and that if she went to hospital for a consultation, the result would be an induction of labour, and once she went to the hospital for a consultation, 'they would not let her out'.

30. RM B said that she explained to Mrs A that the recommendations are to augment labour,[4] to have continuous CTG monitoring during labour, and for intravenous antibiotics (IVAB) to be administered if the waters have broken and labour has not begun (premature rupture of membranes (PROM)). RM B said that Mrs A told her that she disagreed with continuous CTG monitoring and IVAB in labour.

31. Mrs A told HDC that she thought it was harmful to the baby for the mother to have antibiotics when pregnant, as she believed antibiotics harmed the baby's digestive system and killed off the good bacteria picked up by the baby when it passed through the birth canal. Mrs A said that RM B did not explain otherwise when she talked to her about this concern. Mrs A said that she did not know how much risk of infection there was, because RM B never explained how crucial IVAB are after the waters have been broken for a prolonged time, and instead RM B told her to take vitamin C and check her temperature four hourly day and night.

32. Mrs A said that after talking with RM B and a former friend who used to be a midwife, she declined hospital intervention. She said that she wanted to go home and wait for the labour

[3] See the Primary Maternity Services Notice pursuant to section 88 of the New Zealand Public Health and Disability Act 2000 — the Referral Guidelines.
[4] Stimulate the uterus to increase contractions after the onset of spontaneous labour.

to start naturally because her friend advised her that meconium is not usually a problem, and that induction of labour can be more dangerous than meconium. Mrs A said she found an article written from a natural birth perspective that said that with an induction of labour or a Caesarean delivery, the baby is much more likely to aspirate the meconium. In response to the provisional opinion, Mrs A said that RM B did not inform her that the information was incorrect.

33. RM B told Mrs A that she could not give birth at the birthing unit, because the unit had an exclusion policy if there was meconium in the waters due to the risks to the baby.

34. RM B advised Mr and Mrs A to move into the city to await the birth if they were declining to birth in the hospital. RM B said that she explained to Mr and Mrs A that her rationale was to avoid a long transfer if complications arose for the baby (noting that the nearby town is approximately 35km from the city and Mrs A's home is 26km from the city), and she told them that she had no way to know why the meconium had occurred or how the baby would cope during labour. RM B said that she repeated the potential for fetal distress and the delay in accessing appropriate services if they chose to give birth at home.

35. Mrs A said that she and her husband spent a long, stressful time calling motels and driving around trying to find a motel that was not fully booked. Eventually they found one, but it was noisy and unsuitable, so they checked out and decided to return home. RM B told Mrs A to meet her at the birthing unit that afternoon for another CTG before Mrs A went home.

36. At 4pm Mrs A returned to the birthing unit for a further CTG. RM B stated that the CTG and maternal observations were reassuring, and the baby's movements were good. She said that again she made Mrs A aware of her concerns about how the baby would cope in labour and stressed that she would need to listen to the baby's heart rate early and often if Mrs A went home. RM B said that she repeated her recommendation for hospital admission and CTG in labour, but again Mrs A declined.

37. Mrs A said that she chose not to go to hospital because she thought there was nothing to be concerned about, as there were no signs of distress from the CTGs. She said she thought that the labour would start naturally within the next few hours if she went home and relaxed. She said that in addition, RM B made her more afraid by saying that they would not let her out, which made her believe that she would be forced to do things that she did not want to do if she went to hospital.

38. Mrs A stated that after the CTGs, RM B did not give her much information about the risks except to tell her that there was a risk of cord compression with the waters being gone, but RM B said that by checking the baby's heart rate daily they would know if there was cord compression. Mrs A said she agreed that if there was any sign of distress or infection, she would go straight to hospital. RM B told Mrs A that she would know if she developed an infection because her temperature would increase, so she was to check her temperature every four hours day and night and take 10,000mg vitamin C daily spread out over the day.

*Meconium risks*

39. After the second CTG on 17 Month5, RM B wrote in Mrs A's notes: 'Mrs A aware of risks as had a baby in NBU [newborn unit] with [meconium] aspiration 3 years ago.' However, Mrs A said that this was an assumption made by RM B, as she (Mrs A) was aware only of the risk of meconium aspiration, not the risks of meconium generally.

40. Mrs A said that when she was pregnant with her first baby, she caught slapped cheek (parvovirus B19) a month before she was due to give birth and was very unwell for quite a while. She said that she had no idea that she had meconium with her first baby until after he was born, and prior to that she did not even know that meconium existed.

41. During his time in the NICU, her first baby developed a rash over his body, and a blood test showed that he had parvovirus. Mrs A said that she was told by several people that meconium aspiration is caused by distress, and she thought that her first baby had aspirated meconium because of the virus. She said that the only aspect of meconium about which she had any understanding was meconium aspiration, because that is what she had experienced with her first baby. RM B told HDC that after the first baby's birth, Mrs A visited her at her home, and they had a full debrief regarding the birth, the meconium aspiration, and his hospital stay. In response to the provisional opinion, Mrs A said that RM B's 'full debrief' was a very casual catch-up at her house, where Mrs A explained what had happened with her first baby.

42. RM B said that on 17 Month5 Mrs A indicated that she understood the seriousness of meconium being present. RM B stated: 'I believe Mrs A fully understood the risks of meconium exposure and risks of stillbirth.'

43. Mrs A told HDC that when her waters broke and there was meconium present, she was scared and worried that this baby would also aspirate meconium, especially as RM B told her that she would be induced if she went to hospital. Mrs A said that when she told RM B that she had read and heard that induction makes it more likely that the baby will aspirate meconium, RM B did not correct her understanding or alleviate her fears and worries.

44. Mrs A said:

> 'I just knew I didn't want our second baby to aspirate meconium and end up going through the very, very traumatic experience of NICU if it could be avoided by not being induced. Also, [RM B] was not at the birth or involved in any way with my postnatal care for our first baby so she shouldn't assume that I already knew, if that is what she did. In hindsight, I can see now that [RM B] didn't tell me more than half the information that I needed to know about meconium to make an accurately informed decision about whether I should go to hospital or not.'

45. Mrs A told HDC that after Baby A was stillborn, a hospital midwife told her that the presence of meconium is a sign of fetal stress or lack of oxygen, which was a shocking revelation to her. Mrs A said that it was not until five months later when she met with a hospital obstetrician and a midwife that she was told that induction does not increase the risks from meconium because when a baby with meconium is born, they do not stimulate the baby by

rubbing, and they check that the mouth is clear and clean the baby's lips before the baby takes its first breath. Mrs A said: 'I had no idea about this because [RM B] never told me this when I was trying to make decisions.'

**Home visits**

46. RM B did not consult with hospital clinicians regarding Mrs A's clinical picture. She said she consulted with colleagues at the birthing unit and her practice colleagues. RM B provided no evidence from the birthing unit that such a consultation took place, and she did not document in Mrs A's records that a consultation took place or the outcome of the consultation.

47. After Mrs A returned home, RM B visited her each day. Mrs A said she showed RM B her temperature chart at each visit, and RM B always said that it was 'all good'.

48. RM B stated that at each visit Mrs A continued to decline the extra clinical monitoring recommended, and she also declined obstetric consultation and augmentation, and all other recommendations. In contrast, Mrs A said that once she was home, RM B did not say anything further about the hospital recommendation for augmentation or try to alleviate her worries and fears about an induction. Mrs A said that RM B did not recommend any extra clinical monitoring.

49. Mrs A stated that RM B only said that if there was anything Mrs A needed apart from daily monitoring at home to let her know.

50. Mrs A stated:

> 'I did not say that I intended to decline any future CTG monitoring. I told RM B that I would tell her if I wanted to have any more CTG monitoring and she was happy with this arrangement.'

51. Mrs A said that RM B continued to make natural recommendations to cause labour to commence, including taking vitamin C instead of antibiotics, nipple stimulation, rubbing clary sage oil on her stomach, swinging her hips around and around, climbing steps for prolonged periods, dancing naked under a full moon, and acupuncture.

*Herbal tincture*

52. Mrs A stated that RM B bought a labour tincture and told her to take it. Mrs A said she saw that there was black and blue cohosh[5] in the tincture and she did not want to take it because she had decided in advance that she did not want to use those herbs, as she was concerned that taking them had contributed to her first baby's difficulties.

53. RM B told HDC that Mrs A requested the herbal tincture, so she offered to pick it up because of Mrs A's 'rural status and equity of access'. RM B said that she had a consultation with the medical herbalist regarding Mrs A's clinical presentation, and the labour tincture was

[5] A herb most commonly used for menopausal symptoms. As the research is not clear, black cohosh is not recommended for use during pregnancy or breastfeeding.

dispensed under the herbalist's recommendation. RM B stated: 'I did not prescribe or administer the tincture. Instructions were written by the herbalist regarding use and dosage.'

54. In response to the provisional opinion, Mrs A stated that she definitely did not request the labour tincture. She said that RM B talked to her about the labour tincture after her waters had broken and told her to get it when she was in town. Mrs A chose not to get it because she did not want to take it, and then RM B 'took it into her own hands' to buy it and told Mrs A to take it when she was there to supervise.

55. Mrs A told HDC that RM B was present when she first took the labour tincture. Mrs A said that the instructions RM B gave her for taking it were different from the instructions on the label, and after taking the first dose she followed the directions on the label. She said she still did not want to take the labour tincture, but she felt she had to because RM B had bought it for her.

*Consultation*

56. RM B stated that at a home visit on 24 Month5 she recommended to Mrs A that she have a consultation for postdates, and Mrs A declined. RM B said:

> 'Mrs A and Mr A continued to decline all of my previous recommendations, and continued to decline CTG monitoring, which I have consistently revisited at each contact.'

57. Mr A told HDC that he was not present during any of the visits after 17 Month5, and so the references in the clinical records to him declining recommendations are incorrect.

58. Mrs A said that on 24 Month5 she told RM B that she had read in her pregnancy book that studies show that after 42 weeks' gestation there is more chance of having a stillborn baby, but RM B told her that this was incorrect, and that 41 weeks' gestation was actually the dangerous time, and she had passed that point. Mrs A said that RM B told her briefly while walking to the car that at 42 weeks she had to offer her a consultation with an obstetrician but gave her no other explanation or encouragement. Mrs A said that as RM B had said that 41 weeks was the dangerous time, she did not see the point of a consultation at that time.

59. RM B documented that there were discussions regarding recommendations and choices on 17, 18, 20, 21, and 22 Month5. RM B stated that she told Mrs A that her choices were contrary to all known protocols. RM B said that she offered acupuncture, but Mrs A declined. RM B stated that she was concerned that if care was withdrawn, Mrs A might 'freebirth' unattended.

60. In contrast, Mrs A said that RM B did not make any clinical or hospital recommendations other than the obstetrician consultation mentioned on 24 Month5, and did not ask about CTG monitoring then or at other visits. Mrs A said that RM B was very insistent about acupuncture, but she declined acupuncture because it was contrary to her beliefs. Mrs A said that there was never any discussion of free birthing. She said that RM B's

recommendations were around acupuncture, nipple stimulation, circling hips, stair climbing, going for walks, and dancing naked under the full moon.

*Scan*

61. Mrs A said that on 30 Month5, after her waters had been broken for 14 days, one of her friends who is a nurse advised her to have an ultrasound scan (USS) to check on the baby. Mrs A said that she had never had a USS with either pregnancy because she had read about the damage a USS can do to babies and their development. However, she said that at that point she felt that she needed to have a USS, so on 30 Month5 she spoke with RM B about having a scan to check the placenta and cord, as she was uncomfortable continuing to wait for labour to begin without having some outside help to try to find out what was going on.

62. Mrs A stated that RM B said to her, 'What is a scan going to tell us that we don't already know?' and then told her that a USS was only going to show that there were not enough waters (amniotic fluid). Mrs A said that RM B told her that if she went to hospital to have a USS, the hospital clinicians would make recommendations, and she would end up in hospital and not be able to get out.

63. Mrs A said that RM B told her that a USS would show the blood flow to and from the placenta but would not show the cord, and RM B never told her that a USS would provide information about the placental function and the baby's wellbeing. Mrs A said that RM B told her that she (RM B) did not know whether a USS would damage the baby given that there were no waters present. In contrast, RM B told HDC that she encouraged Mrs A to have a USS and advised her that a USS would provide more information about the placental function and the baby's wellbeing. RM B said she told Mrs A that it was highly likely that oligohydramnios (lack of amniotic fluid) would be present due to the PROM. RM B told HDC that when it came to discussions about being postdates and regarding scanning, she was very clear that there needed to be an augmentation process facilitating the high-risk birth in a base hospital. In response, Mrs A told HDC that RM B did not say anything about the need for an augmentation process to facilitate the high-risk birth in a base hospital. Mrs A said that RM B just kept telling her that the labour would start and to keep following all her natural recommendations. Mrs A also denied that RM B told her that 'there are no protocols for this situation except immediate induction'.

64. RM B told HDC that she expressed concern at Mrs A's thinking that a USS would reassure her that all was well, as clinically this was a complex high-risk birth. RM B stated:

> 'I clearly recall saying to her "Why are we even talking about a scan — this will not provide enough reassurance? There are no protocols for this situation except immediate induction". A scan would have shown no liquor or little liquor, however, this was already known.'

65. On 30 Month5 RM B recorded: 'Mrs A has considered a scan to look at placenta function. At this point not wanting.' On 1 Month6 RM B recorded: 'Lots of discussion re scan, CTGs, acupuncture when this baby will come. Mrs A will tell me if she needs anything other than waiting and daily monitoring.'

66. Mrs A said that the 30 Month5 entry is misleading as RM B had discouraged her from having a USS by telling her that it would not tell them anything they did not already know. Mrs A stated that she had wanted to have a USS until RM B strongly discouraged her from doing so. Mrs A said that she asked about a USS again on 1 Month6, but RM B repeated the same information as the previous day and, because she had trusted RM B completely, she stopped asking about a USS after those two days.

67. RM B told HDC that it was clear that a USS would not change her recommendation for transfer to the public hospital and augmentation of labour. She stated:

> 'I clearly remember Mrs A showing frustration that I said this and [she was] agitated by my response that no matter what the scan outcome was, my recommendation would have remained in place.'

68. In response to the provisional opinion, Mrs A said that RM B never repeated the recommendation for a transfer after the day on which her waters broke. Mrs A stated that if she did show any frustration or agitation, then that was likely to have been because she was truly worried when she asked for the scan and very worried that the labour had not started even though RM B told her it would do so. Mrs A said that she was also very worried because she did not know what was the right thing to do this time in light of her past experience with her first baby.

**Birth**

69. Mrs A's labour began around midnight on 3 Month6. RM B arrived at Mr and Mrs A's house at 4.15am on 4 Month6. At 6.30am RM B called another midwife, RM C, and asked her to sit outside in the driveway to be available to assist as a second midwife if required. Mrs A said that she had agreed to the second midwife previously, given RM B's concerns about the meconium, but Mrs A did not want a stranger in the house while she was in labour because the whole house is only 36 square metres, so there is not much space or privacy.

70. RM B said that at 12.15pm she told Mrs A that her contractions had slowed down and asked her to get out of the pool and rest. Mrs A stated that at that time she was in a lot of pain with the contractions and was hardly able to move. Mrs A said:

> 'Before RM B left us when I was in established labour, I told her about the phase I thought I was in from reading my pregnancy book and she didn't listen to me or even care about how much intense pain I was in because she made me get out of the birth pool when I really felt like I needed to be in the pool to ease the pain. I was going backwards and forwards to our composting toilet which is in our big shed, by myself in complete agony … and RM B knew that I was going to the toilet because I told her every time after I came back from the toilet.'

71. RM B said that she asked to do a VE (vaginal examination) to check Mrs A's dilation, but Mrs A refused, saying that she would rather bounce on the Swiss ball. Mrs A stated that previously she had not had a VE while she was in labour, and RM B did not explain the purpose of the VE, but just asked whether she could do one. Mrs A said that RM B's

fingernails were dirty, and she thought that if she was not in proper labour and it stopped again, the dirty fingernails might cause infection.

72. RM B said that she attempted to utilise other midwifery observations to assess the progress of labour, such as the purple line[6] at the buttock cleft. She stated that with Mrs A standing, she looked for a purple line to assess dilatation but could not see one. RM B stated:

> 'This and the contraction pattern indicated to me that labour was not established, and the baby was not close to being born at this point. My impression was of a long latent phase.'

73. RM B told HDC that she tried to auscultate (listen to the heartbeat), but she could do so accurately only when Mrs A was lying down. RM B stated that she asked to use a Doppler (which uses sound waves to measure the baby's heart rate) to auscultate the baby so that she could assess the baby's wellbeing adequately and make clinical judgements on the wellness of the baby, but again Mrs A declined this. At 11.00am RM B recorded that they had discussed the need to use the Doppler but Mrs A 'prefers not'.

74. RM B said that once Mrs A was lying on the bed, she could hear the baby's heartbeat well with the fetoscope (a cone-shaped instrument pressed against the abdomen). At 11.18am RM B recorded that she had heard the baby, that the baby was LOL (left occipito lateral — baby lying on the mother's left side head down with the back facing the mother's side), and that the baby was well into the pelvis. The contractions were irregular, between 6 and 10 minutes apart, and 30 seconds long.

75. Mrs A said that during her pregnancy they had agreed as part of her birth plan that RM B would use the fetoscope for monitoring during labour so long as she could hear the baby with it, but if she needed to use the Doppler then Mrs A had consented to her doing so. The clinical records on 24 Month1 note: 'Mrs A wanting to avoid doppler antenatally & labour.' There is no record of Mrs A having agreed to the use of the Doppler if it was necessary.

76. Mrs A stated that during the daily visits before the birth, RM B never asked to use the Doppler for the checks and did not tell her that there were limitations with listening with a fetoscope as opposed to having a CTG.

*Midwives leave*

77. RM B told RM C that she did not believe that Mrs A's labour had established, and that RM C should leave, and RM B said that she would call her back once labour was established.

78. RM B told Mrs A that she was going to go to town to get coffee, have lunch, make some phone calls, and use the public toilet. RM B told HDC that there was no toilet at Mr and Mrs A's house. However, Mrs A said that this was not true, and RM B knew there was a composting toilet, but she never asked to use it.

[6] The 'purple line' is a line of temporary skin discolouration that can be seen in the anal cleft of some women as they progress in labour. The line gets longer as labour progresses.

79. RM B told Mrs A to try to lie down and rest between contractions. RM B then went outside to go to her car, stopping to inform Mr A what she was doing. She said she asked him to call her if the labour intensified, and then she left for town.

*Birth of Baby A*

80. After RM B left, Mr A came inside to be with Mrs A. Mrs A told HDC that she was still having contractions and was in so much pain that she was in tears. She said that she was beginning to feel the urge to start pushing and was feeling very worried and stressed. The contractions were so painful that she got back into the pool. After more contractions, she started to feel a very strong urge to push so she stood up and Mr A stepped into the pool and stood behind her to support her. She stated: 'I was petrified and didn't know what to do because there was no midwife with us.'

81. The baby started coming, and when Mr A saw that the baby's head was purple and the baby was still with no movement, he knew something was wrong. He said that he started praying loudly. Mrs A said:

> 'It was only three pushes before our baby's head came out to the neck and then it was one more push and Mr A caught our baby girl and at that moment [RM B] stepped onto our first step up to our front door.'

82. RM B said that she was not called back when labour became stronger or when Mrs A developed the urge to push. In response to the provisional opinion, Mrs A said that they could not call RM B because her husband could not leave her by herself to drive down the road to call because she was in so much pain and was starting to push. RM B stated that she returned to the house 1 hour and 20 minutes after she had left, to hear the sounds of active pushing. RM B told HDC:

> 'I am right there in the doorway moving towards Mrs A. Mrs A had three pushes within one contraction and with the last push, her baby's head was born. I was at Mrs A's side. Maternal pulse was visible at the carotid artery. With the next contraction, the baby's body was born. No cord present at the neck.'

83. In contrast, Mr A told HDC that once he was holding the baby, he heard the noise of the gate latch, then footsteps and RM B's voice. Mr A said that immediately after RM B unlatched the gate, he heard her ask: 'What's happening? Tell me what's going on.' Mr A said that as RM B walked up the steps into the house, he told her that the baby was born but there was no cord. RM B then rushed in and took over.

84. Mrs A also told HDC that RM B did not unlatch their house gate until just after Mr A was holding Baby A in his arms. Mrs A said that RM B definitely did not hear active pushes, as when she entered the house the baby had already been born. Mrs A said that RM B did not know how many pushes she had in one contraction, as she was not there and was not at her side. Mrs A stated that RM B did not see her pulse after the baby's head was born and did not take her pulse at any time after the baby was born.

85. RM B told HDC that the baby's umbilical cord was severed at the umbilicus. She stated that there was no blood on the baby, on Mrs A, or in the pool. However, this contradicts the information she provided to the ambulance officers (see below).

86. In contrast to RM B's account, Mrs A stated that although there was no blood on the baby, she (Mrs A) had blood on her legs and there was a lot of blood on the floor. When Mr A emptied the birth pool, both Mr and Mrs A also saw that there was a lot of blood in the water.

**Resuscitation**

87. Baby A was born pale and floppy with no muscle tone. RM B began resuscitation with Mr A assisting. After several minutes, RM B told Mr A to drive to the end of the road to call 111, which he did. Mrs A said that she still had the cord between her legs as the placenta had not been delivered, but she helped RM B with the resuscitation.

88. Mrs A said that Mr A returned and continued helping RM B while Mrs A waited for the placenta to be delivered. RM B injected Mrs A with oxytocin (a hormone that stimulates the uterine muscles to contract) and the placenta was then delivered.

*Ambulance*

89. The ambulance service stated that a 111 call was received at 2.03pm on 4 Month6 from Mr A, who requested an ambulance for Mrs A as she had given birth and the baby was purple and blue. Two ambulances were dispatched under lights and sirens and a message was sent to the fire service requesting assistance.

90. At 2.10pm a single crewed manager vehicle responded under lights and sirens, and at 2.17pm a helicopter was dispatched. RM B informed the attending ambulance personnel that Mrs A was at 41 weeks' gestation, had delivered her baby at home with her midwife present, and that the umbilical cord had been torn with significant blood loss noted. RM B informed the ambulance staff that she had commenced CPR (cardiopulmonary resuscitation) while the baby's father had called 111.

91. Mrs A told HDC that she was concerned about the inaccuracy of the information RM B provided to the ambulance crew, as she was at 43+4 weeks' gestation when Baby A was born, and RM B was not present at the birth. In addition, as noted above, RM B told HDC that she did not see any blood.

92. The attending personnel continued resuscitation, which included CPR, airway control, and ventilation. When the helicopter intensive care paramedic arrived, intraosseous (into the bone) access was gained, and cardiac drugs were administered.

93. However, based on the amount of time that the baby had been under resuscitation with no return of spontaneous circulation and no signs of life, resuscitation was stopped at 2.50pm and, sadly, it was concluded that Baby A was stillborn. Mrs A and Baby A were left in the care of RM B.

94. Mrs A told HDC that RM B said that her baby would be taken away from her if she transferred to hospital. Mrs A said she thought that there was no need to transfer when Baby A had already passed away and nothing could be done to help her. RM B did not take swabs or check the placenta and cord.

95. Mrs A said that she declined an autopsy because RM B failed to tell her about the different types of postmortem available for babies,[7] and so she thought the only option was a full autopsy, which she did not want.

**Histopathology report**

96. RM B did not ask Mr and Mrs A whether they would like the placenta and cord to be checked after the birth, so they were not aware that it was an option. RM B told HDC that in her mind, the clear cause of death was the cord rupture and hypovolaemic shock (blood loss).

97. Mr and Mrs A froze the placenta and umbilical cord. Mrs A said that RM B told her later that the cord was thin, and it was hard to tell whether there was enough Wharton's jelly[8] on it because it had ruptured inside Mrs A and it was flat rather than being full. Mrs A said that subsequently she researched articles about ruptured cords to try to learn what had happened and, in every case, the placenta and cord had been inspected closely. Mrs A said that after reading the articles, she asked RM B whether they could still get the placenta and cord checked after it had been frozen, and RM B replied that it was too late because it needed to be put in formaldehyde straightaway. Mrs A stated that RM B did not offer to find out any further information but told her that she should have thought of having the placenta and cord checked, and she apologised for not having done so.

98. In 2021 hospital staff arranged for Mr and Mrs A to take the placenta and cord for examination. The histopathology report states that there was umbilical vasculitis, funisitis and chorionic vasculitis (an inflammatory response by the fetus). Mild acute chorioamnionitis (intra-amniotic infection) was also reported.

99. The hospital clinical director, Dr D, explained the report to Mr and Mrs A. Dr D told them that the umbilical cord was inserted eccentrically, with a furcate cord insertion (branching prior to contacting the placental surface), which indicated that the cord may have had less protection than usual, and this may have increased the risk of growth problems. However, Dr D said that furcate cord insertion is not considered a major risk factor, and management in that situation is not universally agreed.

100. Dr D said that routinely they recommend offering serial growth scans in such cases, but furcate cord insertion is not an indication in the national Referral Guidelines for referral to a consultant. Dr D said that the cord was anatomically normal but there were signs of meconium, mild umbilical vasculitis-funisitis, and mild acute chorioamnionitis. Dr D told Mr and Mrs A that mild acute chorioamnionitis refers to an infection of the membranes covering the baby, with signs of a maternal inflammatory response, which is frequently

[7] There are three types of postmortem: an autopsy; a limited postmortem (the extent of which is decided by the mother); or an external postmortem (an examination of the outside of the baby's body).
[8] A gelatinous substance within the umbilical cord that insulates and protects the umbilical cord in the womb.

associated with rupture of membranes. Dr D said that the longer the membranes are ruptured, the higher the risk of infection, which is why it is recommended either to have the baby soon after rupturing the membranes or to have increased monitoring.

**Clinical records**

101. As discussed above, Mrs A has several concerns about her clinical records. She said that she asked RM B for her records, but RM B did not provide them all until HDC requested them. RM B wrote the birth notes as if she had been present for the whole birth, whereas Mr and Mrs A said that RM B did not arrive until after the cord had ruptured and the baby's body had been delivered.

102. RM B recorded that Mrs A's pulse was 70 beats per minute when the head was being born, but Mr and Mrs A said that RM B was not present at that time to take Mrs A's pulse. RM B recorded in the birth notes that Mr A was calmly supporting Mrs A as she gently pushed her baby's head out. However, Mr and Mrs A stated that if RM B had been present, she would have seen and heard that there was nothing calm about that time — only intense, stressful cries to God for help.

103. RM B does not agree that the notes are erroneous. She pointed out that she recorded that the notes were written retrospectively. She said that postnatally she debriefed extensively with Mr and Mrs A about times, how long Mrs A had pushed, and what Mrs A had experienced with her labour after RM B had left Mr and Mrs A's home. RM B stated that they worked backwards with this information to determine the details of the labour, which she then entered into the records. Although the records of the labour and birth are noted as having been written retrospectively, there is no indication that the notes were reconstructed from information obtained later. The records read as though RM B was present for the labour and birth.

**Further comment from Mrs A**

104. Mrs A said that after Baby A's death, RM B implied that the hospital staff could not have helped Baby A, and that being in hospital probably would not have prevented what happened. Mrs A said she now knows that this is a 'total lie', and she believes that Baby A could have been helped and would be alive today if Mrs A had had the right information to make the right decisions to get the help she needed.

105. Mrs A said that RM B told her not to talk to anyone about her birth experience with Baby A, apart from RM B and her backup midwife. Mrs A said that RM B also failed to tell her that there was free counselling available through a local charity, which Mrs A later found out about and arranged herself.

106. Mrs A stated that RM B never gave any explanation or information about the medical interventions recommended by the hospital and gave no reassurance and no positive reasons to have medical intervention. Mrs A said that RM B strongly discouraged her from getting the help she needed.

107. Mrs A stated that since these events she has had a third baby. During that pregnancy, her waters broke at 41+5 weeks' gestation with light meconium in the waters. Her LMC for that pregnancy, RM E, reassured her that she had never seen a baby aspirate meconium even when induced. Mrs A's baby was born in hospital without any intervention. Mrs A said that this experience reinforced to her the inadequacy of the information and the unsatisfactory support provided by RM B.

**Responses to provisional opinion**

108. Mrs A was provided with the 'information gathered' section of the provisional opinion. Her submissions have been incorporated into the report where appropriate. In addition, she submitted that RM B failed to recommend a post-dates scan; failed to tell her that the risk of infection would increase because prior to the day of Baby A's birth she had been in the pool when her labour started and then stopped again; and failed to find out whether a scan could damage the baby once the waters had broken.

109. RM B was provided with the provisional opinion. She made no further comments. She agreed to comply with the recommendations in the provisional opinion.

## Opinion: RM B

**Introduction**

110. At the outset I express my condolences to Mr and Mrs A for the tragic loss of Baby A. I acknowledge that the birth was traumatic, and that Mrs A has sought answers to her questions about what happened and whether Baby A's death could have been prevented.

111. The circumstances in the period leading up to the still birth of Baby A have been extremely difficult to investigate, not least on account of the multiple examples recorded throughout the report where RM B and Mr and Mrs A have given very different accounts of the events and of the information RM B provided to Mrs A. The evidence from the clinical records has been of limited assistance, given the obvious inaccuracies with the documentation.

112. Notwithstanding the differing accounts, the information gathered over the course of this investigation has led me to believe that by the time Mrs A went into labour, it was no longer a normal pregnancy. In my opinion, several concerning risk factors meant that it was unsafe for Mrs A to give birth at home in a remote locality with no ready access to specialist input, and this high-risk birth should have been facilitated in a base hospital.

113. I am cognisant of the advice of my inhouse clinical advisor, RM Nicholette Emerson:

> 'Retrospectively it is difficult to comment with certainty where the balance between professional recommendations, coercion and partnership resides. Mrs A had responded to strong recommendations from RM B regarding ascertaining her blood group and assessing fetal wellbeing when her waters broke originally, however Mrs A continued to determine her own care options by declining obstetric consultation, vaginal

examination, and auscultation with a doppler. RM B was concerned that if she withdrew her support that Mrs A may birth unattended.'

114. I acknowledge that RM B could not coerce Mrs A to have an obstetric consultation or go to hospital for monitoring and antibiotics after the rupture of her membranes at 41 weeks' gestation. The decision to birth at home as opposed to the hospital also rested with Mrs A, as did the nature and extent of monitoring by RM B after Mrs A's labour eventually began on 3 Month6. However, it was essential for RM B to provide Mrs A with the information she needed to make informed choices. It is apparent from Mrs A's subsequent evidence that either she did not receive this information, or, if she did, she did not understand RM B's advice and appreciate the significance of the choices she was making.

115. I do not accept that RM B set out to compromise either Mrs A's or her baby's wellbeing. However, as signalled in paragraph 112, I believe that Mrs A was placed in an unsafe situation during the labour and stillbirth of Baby A. My in-house clinical advisor has stated that for the most part RM B's care was of an appropriate standard and in keeping with accepted midwifery practice. However, RM Emerson has expressed concern about several key matters on which she has been unable to comment, most notably RM B's decision to leave Mrs A unattended. I have taken careful note of RM Emerson's advice, alongside all other information gathered over the course of this investigation, and I have concluded that aspects of the care RM B provided to Mrs A were deficient and did not meet the required standard, and I hold RM B responsible for some of the failings that occurred. These are set out below.

**Informed consent — breach**

116. The right to informed consent is set out in Right 7[9] of the Code of Health and Disability Services Consumers' Rights (the Code). Right 7(7)[10] provides that a person can choose to decline services. That includes treatment, referral to another health practitioner, or transfer of clinical responsibility for care. To allow informed decision-making, Right 6[11] of the Code requires that the person receive the information that a reasonable person in their circumstances would expect to receive. That includes an explanation of the options available and the risks, side effects, benefits, and costs of these options.

*Meconium*

117. Mrs A stated that RM B did not inform her about the risks of meconium. Mrs A said RM B assumed that she was aware of the risks because her first baby had had meconium aspiration. This is supported by RM B having recorded in Mrs A's notes: 'Mrs A aware of risks as had a baby in NBU [newborn unit] with [meconium] aspiration 3 years ago.' However,

[9] Right 7 states: 'Services may be provided to a consumer only if that consumer makes an informed choice and gives informed consent, except where any enactment, or the common law, or any other provision of this Code provides otherwise.'

[10] Right 7(7) states: 'Every consumer has the right to refuse services and to withdraw consent to services.'

[11] Right 6 states: 'Every consumer has the right to the information that a reasonable consumer, in that consumer's circumstances, would expect to receive, including — (a) an explanation of his or her condition; and (b) an explanation of the options available, including an assessment of the expected risks, side effects, benefits, and costs of each option …'

Mrs A said that she was aware of the risk of only meconium aspiration, not the risks of meconium generally, as the circumstances of her first baby's birth were quite different from those during her pregnancy with Baby A.

118. RM B told Mrs A that the recommendations following a PROM are to augment labour, administer IVAB, and use continuous CTG monitoring during the labour. Mrs A did not want continuous CTG monitoring and IVAB in labour because of her concerns that they might harm the baby.

119. There is no evidence that RM B advised Mrs A about the extent of the risk of infection once her membranes had ruptured. Mrs A said that RM B never explained that IVAB is crucial after the membranes have been ruptured for a prolonged time and instead told her to take vitamin C and check her temperature four hourly day and night.

120. After talking with RM B and a former friend who used to be a midwife, Mrs A declined hospital intervention. She wanted to wait for the labour to start naturally because her former friend had told her that meconium is not usually a problem, and that induction of labour can be more dangerous than meconium. Mrs A had read that the baby is much more likely to aspirate the meconium with an induction of labour or a Caesarean delivery.

121. Mrs A said that it was not until after Baby A was stillborn that she became aware that the presence of meconium is a sign of fetal stress or a lack of oxygen, and that induction does not increase the risk of meconium inhalation. Mrs A said: 'I had no idea about this because [RM B] never told me this when I was trying to make decisions.'

122. I consider it more likely than not that RM B presumed that Mrs A had wider knowledge of the risks of meconium than she actually had and, consequently, failed to explain Mrs A's condition to her adequately and inform her of the risks and options available to her. This would have included weighing Mrs A's concerns about IVAB with the risk of infection and providing Mrs A with evidence-based information about the interaction between induction and meconium aspiration.

*Consultation*

123. RM B told Mrs A that as she had meconium in the amniotic fluid, a consultation at the hospital was recommended. Mrs A said that she declined a consultation in part because RM B told her that if she went to hospital for a consultation, the result would be an induction of labour, and that once she went to the hospital for a consultation, 'they would not let her out'. RM B has not denied that she told Mrs A that.

124. Similarly, on 30 Month5 when discussing a scan, RM B told Mrs A that if she went to hospital for the scan, the hospital clinicians would make recommendations to Mrs A, and she would end up in hospital and not be able to get out. Again, RM B has not denied this.

125. Mrs A appears to have been influenced by this misinformation and concerned that she would be forced to have treatment that she did not want. In my view, RM B should have informed Mrs A that she could refuse services at any time and offered to support her while

she was at the hospital. Without that information, Mrs A was not in a position to make informed choices about her care.

*Vaginal examination*

126. On 4 Month6 at around 12.15pm, RM B thought that Mrs A's contractions had slowed, so she asked whether she could undertake a VE. She told HDC that this was to check Mrs A's dilation. Previously, Mrs A had not had a VE while she was in labour, and she said that RM B did not explain the purpose of the VE, but just asked whether she could do one. Mrs A refused a VE. RM B has provided no evidence that she discussed with Mrs A how the procedure would assist to assess the progress of Mrs A's labour.

127. In my view, RM B should have explained the purpose and significance of the VE to enable Mrs A to make an informed choice.

*Conclusion*

128. RM B failed to provide Mrs A with the information that a reasonable person in her situation would expect to receive. Mrs A had several anxieties about medical intervention during her pregnancy and labour, and RM B should have addressed these in a balanced and evidence-based manner. For the above reasons, I find that RM B breached Right 6(1) of the Code. It follows that Mrs A was not in a position to make informed choices and give informed consent, and I find that RM B also breached Right 7(1) of the Code.

**Clinical consultation — breach**

129. After Mrs A refused a consultation at the hospital, RM B did not consult with hospital clinicians regarding Mrs A's clinical picture. However, RM B said that she consulted with colleagues at the birthing unit and her practice colleagues.

130. The Referral Guidelines (2012) provide that if a woman refuses a consultation, the midwife should advise the woman of the recommended care, including the evidence for that care, and explain to the woman that the LMC is required to discuss the woman's case with at least one relevant clinician. The Referral Guidelines also require the LMC to share the outcomes of the discussion and any resulting advice with the woman and document in the care plan the process, the discussions, the recommendations given, the decisions made, and the woman's response. There is no evidence that RM B told Mrs A that she would discuss her case with colleagues, or that RM B informed Mrs A of the outcome of discussions with colleagues, and there is no documentation of this process in the records.

131. In my view, RM B failed to comply with the standards in the Referral Guidelines and, accordingly, breached Right 4(2)[12] of the Code.

**Scan — breach**

132. Mrs A said that on 30 Month5, after her waters had been broken for 14 days, she talked with RM B about having a USS to check the placenta and cord. Mrs A stated that RM B said

[12] Right 4(2) states: 'Every consumer has the right to have services provided that comply with legal, professional, ethical, and other relevant standards.'

to her, 'What is a scan going to tell us that we don't already know?' and then told her that a scan would show only that there was not enough amniotic fluid. Mrs A said that RM B told her that if she went to hospital to have a USS, she would end up in hospital and would not be able to get out.

133. Mrs A said that RM B told her that a USS would show the blood flow to and from the placenta but would not show the cord. Mrs A stated that RM B never told her that a USS would provide information about the placental function and the baby's wellbeing. Mrs A said that RM B told her that she (RM B) did not know whether a scan would damage the baby, given that there was no amniotic fluid present.

134. In contrast, RM B said that she encouraged Mrs A to have a scan and advised her that a scan would provide more information about the placental function and the baby's wellbeing. RM B agreed that she told Mrs A that it was highly likely that oligohydramnios would be present due to the PROM. RM B stated:

> 'I clearly recall saying to her "Why are we even talking about a scan — this will not provide enough reassurance? There are no protocols for this situation except immediate induction". A scan would have shown no liquor or little liquor, however, this was already known.'

135. On 30 Month5 RM B recorded: 'Mrs A has considered a scan to look at placenta function. At this point not wanting.' Mrs A said that this entry is misleading as RM B had discouraged her from having a USS by telling her that it would not tell them anything they did not already know. Mrs A said that she had wanted to have a USS until RM B strongly discouraged her from doing so. On 1 Month6 RM B recorded: 'Lots of discussion re scan, CTGs, acupuncture when this baby will come. Mrs A will tell me if she needs anything other than waiting and daily monitoring.' Mrs A said that when she asked again about a USS on that day, RM B repeated the same information as on the previous day. There is no record that RM B recommended a scan or explained why a scan would be clinically appropriate.

136. I accept that Mrs A asked about having a USS to check the placental function on both 30 Month5 and 1 Month6 and that both times RM B told her that a USS would not tell them anything they did not already know, and that a USS would show only that there was little or no amniotic fluid present. By telling Mrs A that a scan would not tell them anything they did not already know, RM B inferred that a scan was not clinically necessary. In the context of RM B knowing Mrs A's reluctance to have medical interventions and her concerns about being forced to have treatments if she went to hospital, I consider that effectively, RM B discouraged Mrs A from having a scan.

137. RM Emerson stated that if Mrs A requested a scan on 29 and 30 Month5 and RM B did not arrange a scan for her, this was a moderate departure from accepted midwifery practice. That was because of the increased risk factors of a prolonged pregnancy, prolonged ruptured membranes, and meconium exposure. I accept RM Emerson's advice.

138. This was a lost opportunity to arrange the support that Mrs A needed. I find that by failing to arrange a USS, RM B failed to provide services to Mrs A with reasonable care and skill and breached Right 4(1)[13] of the Code.

**Leaving Mrs A unattended — breach**

139. On 4 Month6 Mrs A was in labour attended by RM B, with RM C waiting outside to assist if required. At 12.15pm, Mrs A's contractions slowed down.

140. RM B asked to do a VE, but Mrs A refused and there was no purple line evident. RM B concluded that Mrs A was still in the latent phase of labour, so she told RM C to leave and then went to town and remained away for 1 hour and 20 minutes.

141. RM Emerson advised that due to the inability to assess the progression of labour through VE and the cessation of contractions, it would have been difficult to ascertain whether Mrs A was in latent or established labour. RM Emerson stated that as Mrs A was in labour at 43 weeks' gestation with a high-risk pregnancy and the labour had slowed, RM B should not have left the house after requesting that her backup midwife leave.

142. I accept this advice. RM B was aware that Mr and Mrs A had no way to contact her other than Mr A leaving Mrs A alone and driving to the end of the road to get cell phone coverage. In my view, it was both impractical and inappropriate to advise Mr A to call her if the labour intensified.

143. I consider that as RM B could not ascertain whether Mrs A was in latent or established labour, RM B should not have left Mrs A unattended. Given that RM C had been present, RM B should have arranged for RM C to remain while RM B went to town, to ensure that Mrs A was supported. For the above reasons, I consider that RM B failed to provide services to Mrs A with reasonable care and skill and, accordingly, breached Right 4(1) of the Code.

**Postmortem and postnatal placental examination — breach**

144. RM B did not ask Mr and Mrs A whether they wanted to get the placenta and cord checked after the birth, so they were not aware that this was an option. RM B also did not inform Mr and Mrs A of the options for a postmortem, and RM B concluded that the cause of death was the cord rupture and hypovolaemic shock.

145. Mr and Mrs A froze the placenta and umbilical cord. Subsequently, Mrs A asked RM B whether they could get the placenta and cord checked after it had been frozen. RM B replied that it was too late because it needed to be put in formaldehyde straightaway, and RM B did not offer to find out any further information. RM B told Mrs A that she (RM B) should have thought of having the placenta and cord checked and apologised for not having done so.

146. It was not until 2021 that Mrs A discovered that the information RM B had provided was incorrect and hospital staff arranged for Mr and Mrs A to take the placenta and cord for

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

examination. The examination showed signs of meconium, mild umbilical vasculitis-funisitis, and mild acute chorioamnionitis.

147. RM Emerson advised that consideration of the options for examination of the cord and placenta and the postmortem is important midwifery knowledge, although this is specialised knowledge and not required often. She stated that if RM B was unclear, further consideration and enquiry could have specified the options. RM Emerson advised that this was a moderate departure from accepted practice. I accept this advice.

148. It is not the role of a midwife to determine the cause of death. I consider that when faced with an unexpected death, RM B should have arranged appropriate investigations, obtained the necessary information, informed Mrs A of her options, and supported her. I consider that by failing to do so, RM B did not provide services with reasonable care and skill and breached Right 4(1) of the Code.

**Records — adverse comment**

149. RM B and Mr and Mrs A have given varying accounts of the events and of the information RM B provided to Mrs A. The evidence from the clinical records has been of limited assistance given the demonstrated inaccuracies — for example, that Mrs A had declined the administration of vitamin K, that her first baby was not administered vitamin K, the number of antenatal visits, and the events during the birth (as outlined in paragraphs 22–25).

150. RM B documented that on 17, 18, 20, 21, and 22 Month5 there were discussions regarding recommendations and choices. She stated that she told Mrs A that her choices were contrary to all known protocols and offered acupuncture, but Mrs A declined. RM B stated that she was concerned that if she withdrew care, Mrs A might 'freebirth' unattended.

151. In contrast, Mrs A said that RM B did not make any clinical or hospital recommendations other than for an obstetrician consultation on 24 Month5 and did not ask about CTG monitoring then or at other visits. Mrs A said that RM B was very insistent about acupuncture, but Mrs A declined because it was contrary to her beliefs. She said that there was never any discussion about 'free birthing'.

152. I am unable to make a finding as to whether RM B made recommendations at each of the visits.

153. Mr and Mrs A stated that RM B was not present when Baby A was born, and that when RM B returned, Mr A was holding Baby A in his arms. RM B stated that she returned immediately prior to the birth. She marked the notes as being retrospective, but in reality some of the events recorded did not occur when she was present. She reconstructed the events between the time she left and returned, but she recorded them as if she had been present throughout that time.

154. RM Emerson stated that the documentation appears to meet accepted midwifery practice. However, I am critical that RM B did not clarify that the notes were a reconstruction.

155. RM B was very slow to provide the information requested by this Office, and she did not provide Mrs A's full records until 7 November 2023. The delays caused by RM B have added to Mrs A's distress and inhibited the investigation by this Office. I remind RM B that Mrs A was entitled to her full records, and they should have been provided to her when she requested them.

**Herbal labour tincture — adverse comment**

156. Mrs A stated that RM B bought a labour tincture and told her to take it. RM B told HDC that Mrs A requested the herbal tincture, so RM B offered to pick it up because of Mrs A's 'rural status and equity of access'.

157. The New Zealand College of Midwives 'Consensus Statement on Complementary and Alternative Therapies' (2018) states:

> '• Midwives incorporating complementary and alternative therapies into their practice should have either undertaken a recognised education programme or have referred their clients to the appropriately qualified practitioners.
>
> • Each therapy has its own underpinning theory, and it is essential to understand the mechanism of action, indications, contraindications and precautions, side-effects and complications relating to each therapy or remedy used by, or advised on, within midwifery practice.'

158. RM B has not provided HDC with any evidence that she had undertaken a recognised education programme on complementary and alternative therapies. Her response to this issue was that she did not prescribe or administer the tincture, and that the instructions regarding its use and dosage were written by the herbalist. However, she also said that she had a consultation with the herbalist regarding Mrs A's clinical presentation, during which the herbalist recommended the tincture.

159. Mrs A said that she did not want to take the tincture because it contained herbs such as cohosh. She stated that RM B gave her instructions for taking it that were different from the instructions on the label. She said she felt she had to take it because RM B had bought it for her.

160. I accept that RM B did not prescribe the tincture. However, she supplied it to Mrs A, who took it in accordance with RM B's instructions. In my view, by having a consultation with the herbalist and advising Mrs A to take the tincture, RM B incorporated its use into her practice.

161. I am critical that RM B supplied the tincture without having undertaken the required education programme on complementary and alternative therapies.

## Changes made since events

162. RM B told HDC that she has made the following changes to her practice:

- She now consults with the multidisciplinary team if a woman declines to see them.
- She has engaged fully with the Midwifery Council's orders following her competence review.
- She has undertaken a year's supervision and has reflected on this case and what she would do differently.
- She has updated her GAP (Growth Assessment Protocol) knowledge and has completed the course.
- She undertakes her MSR (Midwifery Standards Review) and yearly educational requirements, including FSE (Fetal Scalp Electrode) courses.
- She has taken courses on boundaries and reflected on her boundaries in practice.
- She has completed a documentation workshop.
- She would involve the New Zealand College of Midwives (NZCOM) midwifery advisors and the NZCOM lawyer if presented with a similar case.
- She would consult with obstetric colleagues when women are declining recommendations in such a complex case.
- If presented with another neonatal loss or adverse outcome she would ask her colleagues to offer some postnatal care, as she feels that the distress and shock and grief that she felt as a midwife could lead to her not hearing women as they may need to be heard. She would also undertake counselling earlier.

## Recommendations

163. I acknowledge the actions taken by the Midwifery Council, and the changes RM B has made to her practice since this event.

164. RM B has provided a written apology to Mr and Mrs A for the breaches of the Code identified in this report. The apology will be forwarded to Mr and Mrs A.

165. I recommend that within three months of the date of this opinion, RM B undertake additional education on person-centred care and effective communication with health consumers and complete the HDC online modules for further learning: https://www.hdc.org.nz/education/online-learning/. Evidence of attendance at related training and completion of the online modules is to be provided to HDC.

166. I recommend that within three months of the date of this opinion, RM B undertake additional education on postnatal investigations following a stillbirth, including the

examination of the cord and placenta and the processes for a postmortem, and provide evidence to HDC on the content of the training and her attendance.

## Follow-up actions

167. A copy of the sections of this report that relate to RM B will be sent to the Midwifery Council of New Zealand.

168. A copy of this report with details identifying the parties removed, except the advisor on this case, will be sent to Health New Zealand|Te Whatu Ora, the New Zealand College of Midwives, the Perinatal and Maternal Mortality Review Committee, and the Midwifery Council of New Zealand. They will be encouraged to review the circumstances of this case and consider whether further change is called for to maintain safe consumer-centred maternity care and avoid such a situation arising in the future.

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

## Appendix A: In-house clinical advice to Commissioner

The following advice was obtained from RM Nicholette Emerson:

'**ADDENDUM: 20 March 2023 at Base of this original advice**

**CLINICAL ADVICE**

**MIDWIFERY CONSUMER:** [Mrs A]

**PROVIDER:** LMC [RM B]

**FILE NUMBER:** C21HDC00665

**DATE:** 19 November 2021

**1.** My name is Nicholette Emerson, and I am a Registered Midwife from Auckland. I have been asked to provide expert midwifery advice to you, the Health and Disability Commissioner on the above case. I am a Registered Midwife (2002). I am currently employed as a clinical educator for the Auckland University of Technology. In addition, I am a member of a Midwifery Council professional conduct committee. I completed a post graduate diploma in midwifery in July 2021. Previous roles have included DHB educator, Charge Midwife, DHB case loading midwife (diabetes team), core midwife on the High-Risk wards. I have also worked as a Lead Maternity Carer (LMC) prior to working for the DHB. Through my roles as LMC, case loading staff midwife and Charge Midwife for High Risk, I am familiar with the role of a LMC working in the community. The LMC midwife role incorporates the facilitation of secondary/tertiary services to deliver comprehensive care to women whose history or current circumstances require multidisciplinary care. I am a member of the New Zealand College of Midwives (NZCOM) and have been nominated as an expert advisor by NZCOM (2013). Thank you for the request that I provide clinical advice in relation to the complaint from [Mrs A] about the care provided by LMC [RM B]. In preparing the advice on this case, to the best of my knowledge I have no personal or professional conflict of interest. I agree to follow the Commissioner's Guidelines for Independent Advisors.

**2. I have reviewed the documentation supplied.**

Letter of complaint dated 23 March 2021

Further information from consumer dated 14 April 2021

Further information from consumer dated 25 April 2021

Further information referred from Midwifery Council dated 25 April 2021

Further information from consumer dated 18 May 2021

Further information from consumer dated 20 June 2021

Further information from consumer dated 28 August 2021

[RM B's] response dated 10 June 2021

Clinical records from [RM B] covering the period [Month5–Month6]

Copy of text messages between [Mrs A] and [RM B]

Clinical records from Ambulance Service for [4 Month6]

In addition, I have requested and received a copy of the placental pathology report (undated).

**Background: [**Mrs A] was under the care of [RM B] in [Mrs A's] second pregnancy. Estimated due date [9 Month5]. There is nil noted medical or surgical history. BMI was normal at 22.7. The pregnancy had progressed normally until [17 Month5] when at 41 weeks and 1 day gestation [Mrs A's] membranes ruptured (waters broke). There was meconium present in the waters. [Mrs A] declined to go to hospital but agreed to monitor the baby via CTG at the birthing unit. Initial plan following 2 reassuring CTGs was to await labour nearby in a motel, however [Mrs A] returned home. [Mrs A] monitored her temperature at home and was monitored by [RM B] daily from [17 Month5] till [3 Month6]. On [4 Month6] at 43 weeks and 4 days' gestation [Mrs A] birthed a stillborn baby girl at home. The cause of death was reported as hypovolemic shock following a cord rupture at the baby's umbilicus.

**Advice Request:**

I have been asked to advise on whether I consider the care provided to [Mrs A] by [RM B] was reasonable in the circumstances, and why. In particular I have been asked to comment on:

Whether all appropriate antenatal tests and assessments were offered and adequately recommended

Whether all appropriate referrals, consultations and escalation of care were made

Whether [Mrs A] and her baby were adequately monitored in the period from [17 Month5] to [4 Month6]

The concern regarding [RM B's] recommendation of the tincture used to encourage the onset of labour

[RM B's] management of [Mrs A's] labour and birth on [3 and 4 Month6]

The concern that [RM B] did not arrange a postnatal placental examination or inform [Mrs A] of the options for post-mortem investigations

The adequacy of documentation

Any other matters that warrant comment

[Mrs A] has submitted four documents of complaint. In the following advice I refer to the complaints in date order i.e., Complaint 1–23 March, Complaint 2–15 April, Complaint 3–25 April, Complaint 4–26 June.

**Whether all appropriate antenatal tests and assessments were offered and adequately recommended**

I have reviewed the four complaints submitted by [Mrs A], [RM B's] response to the complaints and the antenatal clinical notes. In forming an opinion on the above question, I have considered the following: At booking [24 Month1] (24 weeks + 3 days'

gestation), clinical documentation records discussion regarding routine blood tests and routine scanning. [Mrs A] was advised by [RM B] to have blood tests confirming her blood group. This advice is in keeping with accepted midwifery practice and section 88 (Ministry of Health, 2012) page 25, 4005.

An oral glucose test was offered and declined on 25 Month2 at 29 weeks' gestation. This advice is in keeping with accepted midwifery practice. Ongoing discussion regarding blood group antibodies is recorded in the clinical notes.

On [15 Month4] at 36 weeks and 2 days, documentation records [Mrs A] declining a Kleihauer test following birth but consents to cord bloods. Offering these tests is in keeping with accepted midwifery practice and demonstrates an ongoing dialogue regarding the importance of gaining information regarding antibodies. Clinical notes [31 Month4] record [Mrs A's] ambivalence regarding antibody testing however she did have the blood test and it was ascertained that her blood group required no further follow up. Although some issues are raised by [Mrs A] regarding her antenatal care, she states in complaint 1 (page 1) that she was reasonably satisfied with [RM B's] care and support up until [30 Month5].

On review of the antenatal notes, in my opinion the care was in keeping with accepted midwifery practice. The notes outline discussion between [RM B] and [Mrs A]. All expected aspects of antenatal care have been undertaken when consented by [Mrs A], and this is supported with documented discussion in the contemporaneous clinical notes. In my opinion the antenatal care provided by [RM B] until [17 Month5] is in keeping with accepted midwifery practice with no departures. Antenatal care from [17 Month5] until [4 Month6] is addressed in question 2 and 3 below.

**Whether all appropriate referrals, consultations and escalation of care were made**

On [17 Month5] at 41 weeks and 1 day [Mrs A] ruptured her membranes (waters broke with thick meconium present in the waters). The presence of thick meconium is indicative of possible fetal distress and if inhaled by the baby during labour there is an increased risk of morbidity/mortality. This is particularly concerning if the meconium is thick. [Mrs A] states in complaint 1 (page 2) that "*[RM B] strongly advised me that the recommendation was to go to hospital to have a consultation and that would result in an induction of labour*". This advice is in keeping with section 88 (Ministry of Health, 2012) page 27, 5018, recommending consultation when meconium liquor is present. [Mrs A] declined obstetric consultation, however consented to two CTGs at the birthing unit to assess fetal wellbeing. [Mrs A] did check into a nearby motel temporarily to await labour prior to going home. This action was advised by [RM B] as she thought it would be closer to the hospital if transfer during labour was required. In [Mrs A's] complaint 1 (page 2), [Mrs A] states, she declined further assessment and elected to go home and await labour. [RM B] advised that the birthing unit would no longer be an option as a place to birth (complaint 1, page 2). This advice is consistent with the birthing unit's birthing exclusion criteria page 2, ***Meconium-stained liquor (thick).***

In summary, accepted midwifery practice would include consultation with an obstetrician and the augmentation of labour, particularly in the context of a postdate pregnancy, now 41 weeks and 1 day gestation. In addition, the commencement of intravenous antibiotics after 18–24 hours (depending on protocol) of ruptured membranes and continuous CTG monitoring during labour would be recommended. This is in keeping with *section 88 (Ministry of Health, 2012)* ***Prelabour rupture of membranes*** *4027, page 26 — consult before 24 hours (Ministry of Health, 2012)* ***Prolonged pregnancy*** *4024, page 26 — consult (refer in a timely manner for planned induction at 42 weeks) (Ministry of Health, 2012)* ***Meconium Liquor — Moderate or thick*** *5018, page 27 — consultation*. The recommendations for compounding factors were declined by [Mrs A]. In her complaint response (complaint 1, page 2) [Mrs A] discusses the code of rights stating that *You must be able to make your own decisions about treatment and be free to change your mind.* [Mrs A] states she took advice from a friend who stated that "*meconium is not usually a problem and induction of labour is worse"*. The risks of meconium aspiration and transfer time from home are documented in contemporaneous notes as being discussed. Further advice given to [Mrs A] when she elected to go home included showers only (no baths), inserting nothing into [Mrs A's] vagina, monitoring of maternal temperature 4 hourly, taking Vitamin C, and monitoring of baby movements. In my opinion all appropriate referrals, consultations and escalations of care were offered up until [17 Month5] with no departures from accepted Midwifery practice.

**Whether [Mrs A] and her baby were adequately monitored in the period from [17 Month5 to 4 Month6]**

When membranes ruptured (waters broke) on [17 Month5] and meconium was present, [Mrs A] was strongly advised to go to [the birthing unit] for a CTG. [Mrs A] was informed by [RM B] that an Induction of labour was recommended, and [Mrs A] would not be able to birth at the birthing unit. [Mrs A] declined hospital intervention. [Mrs A] undertook her own research from a natural birth perspective. [RM B] suggested checking into a motel. [Mrs A] checked out of the motel and had a 2nd CTG that afternoon before returning home to await labour. The care in the following weeks has been based on [Mrs A] declining recommendations. Whilst staying at home in the context of a postdate pregnancy, ruptured membranes, and the presence of thick meconium would be considered high risk and contrary to accepted midwifery care. [RM B's] options for care were limited by the circumstances. [Mrs A] had elected to go home and await labour. In the circumstances [RM B] advised 4 hourly temperatures at home. [Mrs A] was conscientious with this, along with the monitoring of fetal movements. [RM B] visited [Mrs A] every day at home for the next 15 days to check maternal pulse, assess maternal temperature recordings from the preceding 24 hours and to check on fetal heart rate, position, and movements. Sanitary pads were assessed for meconium and odour (odour may be indicative of infection). Visits to [Mrs A] required one and a half hours' travel each day for [RM B]. Contemporaneous notes document discussion regarding recommendations and choices on 17, 18, 20, 21, and 22 [Month5]. In her complaint response [RM B] states that she outlined that [Mrs A's] choices were contrary to all known protocols. Acupuncture was offered and declined. [RM B] states in her

complaint response that she did not want to coerce [Mrs A] however she was concerned that if care was withdrawn [Mrs A] may "freebirth" unattended.

I have considered the following. New Zealand College of Midwives (NZCOM) Code of ethics (2014) state: Midwives accept the right of each woman to control her pregnancy and birthing experience; Midwives uphold each woman's right to free, informed choice and consent throughout her childbirth experience; Midwives accept that the woman is responsible for decisions that affect herself, her baby and her family/whānau; NZCOM Handbook for practice (2018) **Standard 2:** The Midwife upholds each woman's right to free and informed choice and consent throughout the childbirth experience. Respects the informed decisions made by the woman, even when these decisions are contrary to her own beliefs. Respects the woman's right to decline treatments or procedures. Attends when requested by the woman in situations when no other health professional is available.

According to complaint 1 (page 3) contractions started on [22 Month5]. [RM B] arrived at 5.00am on [23 Month5]. The contractions stopped at 6.45am. [24 Month5] contemporaneous notes record discussion regarding consultation for a postdate pregnancy. [RM B] states that she continued to offer to monitor with CTG at each visit. [Mrs A] continued to decline. [25 Month5] [Mrs A] declines assessment in hospital. Supporting documentation can be found in contemporaneous clinical notes and in [Mrs A's] complaint response (Complaint 1, page2). [26 Month5] [Mrs A] declines acupuncture. [27 Month5] Discussion regarding cord compression with reduced liquor. [29 Month5] hospital discussed, declined. Acupuncture offered, declined, [midwife] reassures [Mrs A] regarding her support in hospital, documented in both clinical notes and in response. [30 Month5] [Mrs A] states that she is completely against ultrasounds in complaint 1, pg 4. Clinical notes document that [Mrs A] is considering a scan but at this point not wanting one. *Lots of discussion re scan and CTG's. [Mrs A] to tell me if wanting anything other than waiting for baby to come.* [RM B] states she wanted to have consent to keep providing care without coercing.

**Ultrasound Scan** There is a differing version of events regarding an ultrasound scan. It is agreed that an ultrasound scan was discussed between [Mrs A] and [RM B] on the [29 and 30 Month5] at 43 weeks' gestation. [Mrs A] states that she requested an ultrasound scan as she was concerned about her postdates pregnancy. She states (Complaint 1, page 5) that [RM B] said, *"what is a scan going to tell you that you don't already know".* [Mrs A] states that [RM B] actively discouraged her from having a scan and inaccurately wrote in the clinical notes stating "at *this point not wanting it*". [RM B's] complaint response, June 2021 (23.1) states that she does not accept that she discouraged [Mrs A] from having a scan. [RM B] states there was a long discussion about the pros and cons and the subject was revisited the following day and [Mrs A] stated that she was at peace following praying with a friend who was also a midwife.

If it is accepted that [Mrs A] requested a scan on [29 and 30 Month5] and [RM B] did not arrange a scan for her; in the context of a prolonged pregnancy, prolonged ruptured membranes, and meconium exposure, in my opinion this is a severe departure from

accepted midwifery practice. If it is accepted that [RM B] did not discourage a scan and [Mrs A] was against ultrasound scans, ambivalent about having an ultrasound scan and discussed this on [29 and 30 Month5], praying regarding this and finding peace; then in my opinion there is no departure from accepted midwifery practice in not coercing [Mrs A] to have an ultrasound scan.

**The concern regarding [RM B's] recommendation of the tincture used to encourage the onset of labour**

[RM B] bought [Mrs A] a labour tincture on [24 Month5]. [Mrs A] took the tincture over the following days and is concerned that this may have contributed to her baby's eventual death. New Zealand College of Midwives (NZCOM) consensus statement on Complementary and alternative therapies states the following (last update 2018):

- *Midwives incorporating complementary and alternative therapies into their practice should have either undertaken a recognized education programme or have referred their clients to the appropriately qualified practitioners 1, 3.*
- *Each therapy has its own underpinning theory, and it is essential to understand the mechanism of action, indications, contraindications and precautions, side-effects and complications relating to each therapy or remedy used by, or advised on, within midwifery practice*

I cannot comment on whether [RM B] was qualified to supply the tincture. I am not qualified to comment on the labour tincture supplied to [Mrs A].

**[RM B's] management of [Mrs A's] labour and birth on [3 and 4 Month6]**

Labour commenced on [3 Month6]. [RM B] arrived at 4.15am [4 Month6] and called her second midwife at 6.30am. The second midwife remained on standby at the top of the driveway at [Mrs A's] request. At 9.15am contemporaneous clinical notes record [RM B's] request to auscultate the fetal heart rate with a doppler instead of a fetoscope as she was unable to hear clearly. [Mrs A] is documented as declining. 11.00am the clinical notes and (Complaint 1, page 6) record that [RM B] has requested to undertake a vaginal examination to assess labour progress. [Mrs A] has declined the examination. 11.18 placental sounds auscultated with a fetoscope. 12.15pm Contractions had slowed. Second midwife left at [RM B's] request. 12.15pm [RM B] left to go to town 15 mins away. This was to make some phone calls, eat and use toilet as no toilet, internet, phone signal at property. 1.50pm baby birthing as [RM B] returns and coming up back steps. No signs of life. 2.05pm Mr A to call ambulance and back up (ambulance record 2.03pm) 2.10 adrenaline given and CPR continues. 2.50 resuscitation stopped with agreement by ambulance staff. In [Mrs A's] complaints, she states that if she had not been left alone in labour that fetal distress may have been identified through auscultation and her baby may have lived.

A) If it is accepted that [Mrs A] was now in labour at 43 weeks' gestation with a high-risk pregnancy and the labour had slowed, then [RM B] should not have left the house after requesting that her back up midwife leave. Membranes had ruptured two weeks

prior with thick meconium present and the pregnancy had continued beyond the recommended 42 weeks. If it is accepted that a change in fetal heart could be identified with a fetoscope despite requesting to use a doppler for accuracy, and subsequently transfer could have been arranged, and [Mrs A] would have agreed, then in my opinion there is a severe departure from accepted midwifery practice to have left [Mrs A] unattended in a high-risk situation.

B) if it is accepted that [Mrs A] was now in labour at 43 weeks' gestation with a high-risk pregnancy and [RM B] considered this to be the latent phase of labour, the labour had slowed, then [RM B] took a calculated risk to leave prior to reassessing latent labour progress on her return from town. [RM B] had phone calls to make, there was no internet or phone service, no toilet and [RM B] needed to eat and drink. [Mrs A] had declined consultation and induction of labour for her postdates pregnancy, had declined a vaginal examination, and had declined doppler assessment of fetal heart in labour. If it is accepted that [Mrs A] would later have accepted a vaginal examination and auscultation with a doppler in labour, then in my opinion to leave her unattended was a moderate departure from accepted midwifery practice.

It is impossible to ascertain retrospectively whether staying with [Mrs A] would have changed the outcome. To do so assumes that previously declined requests for vaginal assessment and doppler auscultation would have been accepted. The remote nature and lack of alternative in an emergency have been carefully considered (no obstetrician, no theatre) when forming an opinion. [Mrs A] states in her complaint response that birth is not a linear process and the backup midwife who had been in the driveway for the previous six hours should have remained until [RM B] returned.

**The concern that [RM B] did not arrange a postnatal placental examination or inform [Mrs A] of the options for post-mortem investigations**

[Mrs A's] concern that [RM B] did not arrange a postnatal placental examination or inform [Mrs A] of the options for post-mortem investigations has been acknowledged by [RM B]. The apology is acknowledged in [Mrs A's] complaint 1 (page 8). Whilst consideration of the options is important midwifery knowledge, it is also specialised and not required often. However, if [RM B] was unclear, further consideration and enquiry could have specified the options. Acknowledgement and an educative approach may be the most appropriate action in my opinion for this moderate departure from accepted practice. In this case the cause of death appeared to be the cord rupture and subsequent hypovolemic shock, and this may have influenced the decision not to investigate further.

**The adequacy of documentation**

[Mrs A] raises some concerns regarding the accuracy of times entered and incorrect details. I am unable to resolve these concerns however the documentation in my opinion appears to meet accepted midwifery practice with no departures.

**Any other matters that warrant comment**

This case is complex and has a tragic outcome for all concerned. Retrospectively it is difficult to comment with certainty where the balance between professional recommendations, coercion and partnership resides. [Mrs A] had responded to strong recommendations from [RM B] regarding ascertaining her blood group and assessing fetal wellbeing when her waters broke originally, however [Mrs A] continued to determine her own care options by declining obstetric consultation, vaginal examination, and auscultation with a doppler. [RM B] was concerned that if she withdrew her support that [Mrs A] may birth unattended. I hope that this report has addressed some of [Mrs A's] unanswered questions and I extend my heartfelt sympathy to her, Mr A, and [Mrs A's] first baby for the loss of their precious baby daughter.

Nicky Emerson BHSc — Midwifery

Ministry of Health. (2012). *Maternity referral guidelines.* https://www.health.govt.nz/system/files/documents/publications/referral-glines-jan12.pdf

**ADDENDUM: 20 March 2023** I have considered my advice 21 November 2021 and on review have amended my advice on questions 3 (ultrasound scan) and questions 5. My updated advice is written below.

**Ultrasound scan — Question 3** There is a differing version of events regarding an ultrasound scan. It is agreed that an ultrasound scan was discussed between [Mrs A] and [RM B] on [29 and 30 Month5] at 43 weeks' gestation. [Mrs A] states that she requested an ultrasound scan as she was concerned about her postdates pregnancy. She states (Complaint 1, page 5) that [RM B] said, *"what is a scan going to tell you that you don't already know".* [Mrs A] states that [RM B] actively discouraged her from having a scan and inaccurately wrote in the clinical notes stating "*at this point not wanting it*". [RM B's] complaint response, June 2021 (23.1) states that she does not accept that she discouraged [Mrs A] from having a scan. [RM B] states there was a long discussion about the pros and cons and the subject was revisited the following day and [Mrs A] stated that she was at peace following praying with a friend who was also a midwife.

If it is accepted that [Mrs A] requested a scan on [29 and 30 Month5] and [RM B] did not arrange a scan for her; in the context of a prolonged pregnancy, prolonged ruptured membranes, and meconium exposure, in my opinion this is a moderate departure from accepted midwifery practice.

If it is accepted that [RM B] did not discourage a scan and [Mrs A] was against ultrasound scans, ambivalent about having an ultrasound scan and discussed this on [29 and 30 Month5], praying regarding this and finding peace; then in my opinion there is no departure from accepted midwifery practice in not coercing [Mrs A] to have an ultrasound scan.

**Question 5: [RM B's] management of [Mrs A's] labour and birth on [3 and 4 Month6]**

Labour commenced on [3 Month6]. [RM B] arrived at 4.15am [4 Month6] and called her second midwife at 6.30am. The second midwife remained on standby at the top of the driveway at [Mrs A's] request. At 9.15am contemporaneous clinical notes record [RM B's] request to auscultate the fetal heart rate with a doppler instead of a fetoscope as she was unable to hear clearly. [Mrs A] is documented as declining. 11.00am the clinical notes and (Complaint 1, page 6) record that [RM B] has requested to undertake a vaginal examination to assess labour progress. [Mrs A] has declined the examination. 11.18 placental sounds auscultated with a fetoscope 12.15pm Contractions had slowed. Second midwife left at [RM B's] request. 12.15pm [RM B] left to go to town 15 mins away. This was to make some phone calls, eat and use toilet as no toilet, internet, and phone signal at property. 1.50pm baby birthing as [RM B] returns and coming up back steps. No signs of life. 2.05pm Mr A to call ambulance and back up (ambulance record 2.03pm) 2.10 adrenaline given and CPR continues 2.50 resuscitation stopped with agreement by ambulance staff. In [Mrs A's] complaints, she states that if she had not been left alone in labour that fetal distress may have been identified through auscultation and her baby may have lived.

A) If it is accepted that [Mrs A] was now in labour at 43 weeks' gestation with a high-risk pregnancy and the labour had slowed, then [RM B] should not have left the house after requesting that her back up midwife leave. Membranes had ruptured two weeks prior with thick meconium present and the pregnancy had continued beyond the recommended 42 weeks. If it is accepted that a change in fetal heart could be identified with a fetoscope despite requesting to use a doppler for accuracy, and subsequently transfer could have been arranged, and [Mrs A] would have agreed, then in my opinion there is a moderate departure from accepted midwifery practice to have left [Mrs A] unattended in a high-risk situation.

B) If it is accepted that [Mrs A] was now in labour at 43 weeks' gestation with a high-risk pregnancy and [RM B] considered this to be the latent phase of labour, the labour had slowed, then [RM B] took a calculated risk to leave prior to reassessing latent labour progress on her return from town. [RM B] had phone calls to make, there was no internet or phone service, no toilet and [RM B] needed to eat and drink. [Mrs A] had declined consultation and induction of labour for her postdates pregnancy, had declined a vaginal examination, and had declined doppler assessment of fetal heart in labour. If it is accepted that [Mrs A] would later have accepted a vaginal examination and auscultation with a doppler in labour, then in my opinion to leave her unattended was a moderate departure from accepted midwifery practice.

It is impossible to ascertain retrospectively whether staying with [Mrs A] would have changed the outcome. To do so assumes that previously declined requests for vaginal assessment and doppler auscultation would have been accepted. The remote nature and lack of alternative in an emergency have been carefully considered (no obstetrician, no theatre) when forming an opinion. [Mrs A] states in her complaint response that birth is not a linear process and the backup midwife who had been in the driveway for the previous six hours should have remained until [RM B] returned. Due to the inability

to assess the progression of labour through vaginal examination and the cessation of contractions, it would have been difficult to ascertain whether [Mrs A] was in latent or established labour.

Nicholette Emerson, BHSc, PG Dip-Midwifery
**Midwifery Advisor** Health and Disability Commissioner'