Registered Midwife, RM A

A Report by the
Deputy Health and Disability Commissioner

(Cases 21HDC01864, 21HDC02085, 21HDC02086, 21HDC02087, 21HDC02089, 21HDC02090, 21HDC02091, 21HDC02092)

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

Contents

Executive summary

1. RM A was registered as a midwife from 2005 until 2021. At the time of the events, RM A was a self-employed LMC midwife, and she had an agreement with Health New Zealand|Te Whatu Ora that allowed her access to its maternity facilities and birthing units in the region.

2. In 2021, following the stillbirth of a baby, Te Whatu Ora wrote to the Midwifery Council with concerns about the care that RM A had provided to the mother of the stillborn baby. Te Whatu Ora advised the Midwifery Council that it had 'ongoing concerns' about RM A's competence, and concerns for the women in her care. At the same time, Te Whatu Ora suspended RM A's access to its maternity facilities and birthing units.

3. Te Whatu Ora wrote to the Midwifery Council again and provided details of the concerns it had about the care that RM A provided to six other consumers between 2017 and 2021.

Findings

4. The Deputy Commissioner found that RM A breached Right 6(1)(b), Right 4(1), and Right 4(2) of the Code when she provided services to five of the eight consumers (consisting of seven women and one baby).

5. The Deputy Commissioner found that RM A breached Right 6(1)(b) of the Code in her care of one of the consumers, for failing to provide the appropriate information that a consumer could reasonably have expected to receive, which in that case related to recommendations under the Referral Guidelines and a recommendation for serial growth scans.

6. The Deputy Commissioner also found that RM A breached Right 4(1) of the Code in her care of three consumers, for failing to recognise a condition that necessitated consultation with, or referral to, another medical practitioner, failing to perform palpation and maternal baseline observations, failing to monitor both maternal and fetal wellbeing, failing to perform ongoing observations at critical stages of labour, and failing to respond with timely and appropriate intervention when there were indications of difficulty.

7. The Deputy Commissioner found that RM A breached Right 4(2) of the Code in the care she provided to the five consumers, for failing to keep adequate and accurate records.

8. In addition, the Deputy Commissioner made adverse comment about the care provided by RM A to one of the consumers because RM A did not perform and document maternal baseline observations prior to the consumer's admission to hospital. The Deputy Commissioner made other comment in relation to the care RM A provided to one consumer and her baby.

Recommendations

9. The Deputy Commissioner recommended that RM A provide written apologies to six of the eight consumers and their whānau for the deficiencies in care outlined in this report. The Deputy Commissioner also recommended that should RM A decide to return to midwifery

practice, she undertake a full return-to-practice programme to update her midwifery knowledge, skills, and competencies to practise, as recommended by the Midwifery Council.

Complaint and investigation

10. Ms U, the senior manager of a public hospital's midwifery services, complained to the Midwifery Council about the midwifery care provided by registered midwife (RM) A to multiple consumers at the public hospital between 2017 and 2021 (inclusive). The Midwifery Council referred the complaint to the Health and Disability Commissioner (HDC).

11. The following issues were identified for investigation:

- *Whether RM A provided multiple consumers with an appropriate standard of care from 2017 to 2021 (inclusive).*
- *Whether RM A provided Ms B with an appropriate standard of care in 2017.*
- *Whether RM A provided Ms C with an appropriate standard of care in 2019.*
- *Whether RM A provided Ms D with an appropriate standard of care in 2019.*
- *Whether RM A provided Ms E with an appropriate standard of care in 2019.*
- *Whether RM A provided Ms F with an appropriate standard of care in 2020.*
- *Whether RM A provided Baby F with an appropriate standard of care in 2020.*
- *Whether RM A provided Ms G with an appropriate standard of care in 2021.*
- *Whether RM A provided Ms H with an appropriate standard of care in 2021.*

12. 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.

13. The parties directly involved in the investigation were:

RM A	Registered midwife/provider
Ms B	Consumer
Ms C	Consumer
Ms D	Consumer
Ms E	Consumer
Ms F	Consumer
Baby F	Consumer
Ms G	Consumer
Ms H	Consumer

Further information was received from:

Health NZ|Te Whatu Ora	Group provider
Primary birthing facility	Group provider
Oranga Tamariki|Ministry for Children	

14. The following persons are also referred to in the report:

RM I	Registered midwife/provider
RM J	Registered midwife/provider
RM K	Charge midwife
Ms L	Student midwife
RM M	Charge midwife
Dr N	Obstetrician and gynaecologist
RM O	Registered midwife/provider
RM P	Registered midwife/provider
Dr Q	Obstetrician and gynaecologist
Ms R	Social worker
RM S	Registered midwife/provider
RM T	Registered midwife/provider

15. In-house clinical advice was obtained from Midwifery Advisor RM Nicholette Emerson (Appendix A).

How matter arose

16. At the time of the events, RM A was a self-employed lead maternity carer[1] (LMC) midwife. RM A had an agreement with Health NZ that allowed her access to its maternity facilities and birthing units in the region (the Access Agreement).

17. Access Agreements outline the obligations of LMCs when accessing facilities to provide care to women (antenatally, during labour and birth, and postnatally).

18. The Access Agreement states:

> 'Primary maternity services will be provided in a clinically safe manner. This means that primary maternity care provided by the practitioner or the facilities must be based on the application of the best available knowledge derived from research and clinical expertise that incorporates the skills and standards of the relevant profession …

[1] An LMC is responsible for the care throughout a pregnancy, labour, and birth, and also care for the mother and baby until the baby is six weeks old.

> Both parties will take into account the Guidelines for Consultation with Obstetric and Related Specialist Medical Services that identify clinical reasons for consultation with a specialist and that are published by the Ministry of Health from time to time, when providing primary maternity services ...
>
> All clinical policies and procedures of the facilities will form the basis of primary maternity care provided in the facilities, and must be available to the practitioner.'

19. In 2021, following the stillbirth of Ms H's baby (discussed later in this report), Health NZ wrote to the Midwifery Council about the care that had been provided to Ms H. Health NZ advised the Midwifery Council that it had 'ongoing concerns' about RM A's competence, and concerns for the women in her care. At the same time, Health NZ suspended RM A's access to its maternity facilities and birthing units.

20. In the letter, Health NZ advised the Midwifery Council that there had been previous situations where there had been a lack of comprehensive assessment by RM A, even when there were abnormalities present, and a lack of documentation accompanying such situations. Health NZ said that 'these generally happen[ed] in community units or in women's homes', and that eventually it resulted in the women being transferred to the public hospital.

21. Health NZ wrote to the Midwifery Council again providing a timeline of the concerns it had for clients of RM A, with details of care provided to six further consumers between 2017 and 2021. Health NZ told HDC:

> 'We started to develop a heightened sense of awareness about [RM A] at [the public hospital] and in our community units by the staff. We started to see her less and less at [the public hospital] and note that she was using community units and homebirth. This led to us then going back through all cases to determine if any other cases had been raised and hence the timeline we sent to the [Midwifery Council].'

22. On 19 March 2021, the Midwifery Council resolved to undertake a stage two[2] competence review of RM A's practice under section 36[3] of the Health Practitioners Competence Assurance Act 2003. The Midwifery Council completed a Competence Review Report (the Midwifery Council's Report) on 21 March 2021.

23. Following the Midwifery Council's Report, RM A retired as a midwife, and her practising certificate expired in 2021.

24. The circumstances of this investigation are a salient reminder of the importance of health professionals 'speaking up' when they observe an emerging pattern of poor care or issues of clinical concern. Ms U's actions in this respect should be commended. As a result of the

[2] A stage two review focuses on competence in general.

[3] Section 36(1) of the Health Practitioners Competence Assurance Act 2003 states: 'Promptly after receiving a notice of the kind described in subsection (2), an authority must make inquiries into, and may review, the competence of a health practitioner who is registered with the authority and who holds a current practising certificate.'

Midwifery Council referring Ms U's complaint to the HDC there has been an opportunity for the HDC to examine the standard of care RM A provided to eight consumers.

Opinion: RM A — breach

Introduction

25. The investigation focused on the care provided by RM A to eight consumers (seven mothers and one baby). To determine whether the care provided by RM A was reasonable, I considered the advice of my in-house midwifery advisor, RM Nicholette Emerson.

26. I have undertaken a thorough assessment of the information gathered, and I consider that RM A breached Right 6(1)(b), Right 4(1), and Right 4(2) of the Code of Health and Disability Services Consumers' Rights (the Code) when she provided services to five of the eight consumers. The care provided to each consumer, and the reasons for my decision, are set out below.

27. At the outset, it should be noted that aspects of the investigation were made more challenging on account of RM A's poor standard of documentation. At times, this made the retrospective review of the standard of maternity care RM A provided to the eight consumers difficult.

Responses to provisional opinion

28. Each of the consumers was given an opportunity to respond to the 'information gathered' sections of the provisional opinion that relate to the care provided to them. The consumers' comments have been incorporated into this opinion where relevant and appropriate.

29. RM A was given an opportunity to respond to the provisional opinion. RM A said:

> 'I have no intention of ever returning to midwifery. I have spent much time reflecting on this and it has again only served to impact my mental health with a return of stress and anxiety. I realise this is not as great an impact as a stillbirth would be.'

Care provided to Ms B — breach

Introduction

30. In 2017, RM A provided Ms B with back-up LMC care during labour.

31. Health NZ raised concerns that RM A left the room while Ms B was giving birth, and that there was a delay in removing Ms B from the birthing pool following the birth of the baby, when Ms B was experiencing increasing blood loss.

Antenatal care

32. RM I was Ms B's LMC midwife. RM I documented in the clinical records that she had discussed with Ms B the 'place of birth options', and that she had explained to Ms B the difference between a primary and tertiary setting.

33. Primary maternity facilities are run and staffed by midwives and are designed for well women who have no complications during pregnancy. Tertiary maternity facilities are designed for women with complex maternity needs that require specialist multidisciplinary care.

34. RM I documented in the clinical records that she was 'happy to go' where Ms B was most comfortable.

35. Following discussion of birthing locations and with Ms B's agreement, RM I booked Ms B to birth at a primary maternity facility (birthing unit). The facility does not have an emergency department (ED) and the nearest emergency medical care is in a main centre.

36. Ms B had an uncomplicated pregnancy.

Labour and birth

37. At approximately 39 weeks' gestation, Ms B went into spontaneous labour and was admitted to the birthing unit at 2.25am. RM A arrived at 2.38am to provide back-up LMC care to Ms B during labour, as RM I was not available.

38. At 2.45am, RM A noted in the clinical records that Ms B was 'coping well with strong contractions'. At 3.08am, Ms B entered the birthing pool, and at 3.32am it was documented that she was pushing with contractions.

39. At 4.17am, RM A noted that Ms B was 'feeling like she [wasn't] getting anywhere'. At 4.23am, RM A performed a vaginal examination and found that the baby's head was at zero[4] fetal station.[5]

40. At 4.46am, Ms B was noted to be 'exhausted', and an hour later, at 5.46am, Ms B was noted to have said: 'Can't do this anymore.' At 5.57am, RM A encouraged Ms B to change positions in the birthing pool to help with progress in labour.

41. At 6.21am, while Ms B was in the birthing pool, RM A performed another vaginal examination to see if the baby's head had descended any further. RM A noted that the fetal station was at +1,[6] and that the fetal heart rate was 132[7] beats per minute (bpm).

[4] The baby's head is aligned with the ischial spines.
[5] Describes how far down the baby's head has descended into the pelvis and is measured on a scale from -5 to +5.
[6] Positive numbers are used when a baby has descended beyond the ischial spines. During birth, a baby is at the +4 to +5 fetal station.
[7] A normal fetal heart rate is between 110–160bpm.

42. At 6.42am, RM A left the room to provide an update to staff. Ms B remained in the birthing pool. While RM A was providing staff with an update, Ms B's husband activated the call bell for assistance. RM A responded to the call and, when she returned to the room, the baby's head had been born. RM A documented retrospectively in the clinical records: 'I was in office to update staff before handover when [Ms B's husband] rang bell. Head was out when I got in room. I rang again for [the core midwife].'

43. RM A said that she was aware of Health NZ's recommendation to refer a primiparous[8] woman for medical consultation after two hours of active pushing. She stated that it had taken two hours for the fetal station to progress from -1 to +1, and she wanted to update the staff to see if they were happy with Ms B's progress. RM A said:

> 'Since it had taken two hours to progress two centimetres in descent and [Ms B] was a [primiparous woman], I thought there was time to briefly leave the room. If I had thought that the birth was imminent, I would, of course, have rung the bell and not left the room to get a second midwife. During the two hours between vaginal exams, I had tried to encourage [Ms B] to change positions to see if it helped with progress. She finally changed from a sitting position to a kneeling position after the second [vaginal examination]. This is possibly why she progressed so rapidly.'

44. The baby was born at 6.44am, two minutes after RM A had left the room, in a healthy condition.

45. The next entry in the clinical records was at 7.33am, approximately 45 minutes after the birth of the baby, when RM A noted that Ms B was 'feeling faint'. RM A activated the call bell (not documented), and core midwife RM J responded to the call. RM J documented in the clinical records:

> 'Called to assist [at] 0733hrs. LMC said [Ms B] feeling unwell — still in the bath with baby. [Ms B] very pale. Water in bath heavily bloodstained. I said we need to get her out straight away. LMC clamped and cut cord and baby given to father to hold. We attempted to get [Ms B] up and out of the bath and she fainted. She came to fairly quickly. Asked the partner to ring the emergency bell and asked the LMC to pull the plug. We attempted to get [Ms B] out again. This time she collapsed back in the water and went right out of it — a deep faint. I pulled her up into a sitting position and by this stage plenty of help had arrived. We managed to get her onto the side of the bath and into the wheelchair. From here we lifted her onto the bed. Assisted LMC to put up fluids and start syntocinon.[9] Catheterised [Ms B]. Continued to do [blood pressure] readings on [Ms B]. Helped prepare for transfer to [the public hospital].'

[8] Giving birth for the first time.

[9] A synthetic form of oxytocin, used to prevent and treat postpartum uterine haemorrhage.

46. Subsequently, it was discovered that the umbilical cord had avulsed,[10] making delivery of the placenta difficult. As a result, Ms B had a retained placenta and postpartum haemorrhage[11] (PPH) due to the retained placenta.

47. RM A did not record the avulsion of the umbilical cord, the retention of the placenta, or the PPH in the clinical notes.

48. RM A said that after the birth of a baby, and if all is normal, it is her usual process to leave the umbilical cord attached until after the birth of the placenta. RM A said that in Ms B's case, she clamped and cut the cord before the birth of the placenta because she recognised the need to get Ms B out of the birthing pool promptly. There is no record of this in RM A's clinical notes.

49. RM A said that it was challenging to get Ms B out of the birthing pool because Ms B 'was reluctant to move'. RM A stated that Ms B had progressed to kneeling and holding on to the bar of the ladder when she started to feel faint. RM A said that she activated the call bell for assistance and noticed that the water in the birthing pool had turned dark red. RM A stated:

> 'Antenatally, I usually talk to women planning a water birth and explain that, if at any time I ask them to get out of the pool urgently, they need to move immediately. Since I was the [back-up] midwife, I had never had this conversation with [Ms B].'

50. At 7.43am, oxytocin[12] was administered and Ms B was noted to be 'feeling better'. An ambulance was called for Ms B to be transferred to the public hospital. However, no ambulances were available at that time, and there was a delay of approximately one hour before the ambulance arrived.

51. At 8.35am, RM A documented in the clinical records that Ms B was being prepared for transfer to the public hospital, but the reason for the transfer (the manual removal of the placenta) is not documented in the clinical records.

Admission to public hospital

52. At 9.58am, Ms B arrived at the public hospital by ambulance. Her PPH was estimated to be approximately 1,200ml.

53. Shortly after Ms B's arrival at the public hospital, the retained placenta was removed in the operating theatre under general anaesthetic.

54. Ms B was discharged three days later.

Review of events

55. Charge Midwife (CM) RM K at the birthing unit completed an incident report, which states:

[10] When the umbilical cord ruptures, or tears from its insertion site on the placenta. Cord avulsion makes delivery of the placenta difficult, possibly requiring manual extraction of the placenta.
[11] Blood loss from the genital tract, exceeding 500ml within 24 hours of delivery.
[12] Used to prevent and treat postpartum uterine haemorrhage.

> 'As this was [RM A's] first birth at [the birthing unit] I have spoken to her about the importance of getting the mother out of the pool in future soon after the baby is born so that if she is bleeding it is easy to identify where this is coming from [eg,] perineum or uterine. It is also a safety measure if the [woman] does bleed in the pool and collapse [as] it is very difficult to get her out without a lot of help and usually there may only be a core midwife, hospital aide and LMC to assist.
>
> I will also speak to [RM A] about her documentation as this could be improved as was a bit scant in places especially as there was a wait [until the ambulance arrived].
>
> [Ms U] is also going to speak to [RM A] and ask her to attend the Waterbirth Education Session here [in 2017].'

56. Subsequently, Health NZ told the Midwifery Council:

> 'At incident review of this case it was noted that rather than ring the bell when woman was clearly advancing in second stage in the birth pool LMC left the room to ask for a second midwife and baby's head was already born on return.
>
> The woman remained in the pool following the birth for 45 minutes with no sign of the placenta and increasing blood loss into the birth pool. Only when the woman felt faint that [RM A] rang for assistance.
>
> The staff reported that they had to initiate all management for both removal from the pool and active management to both determine condition of the woman, stabilise her and to actively manage third stage to try to assist the woman [to] birth the placenta. Our concerns included assessment post-birth.'

57. Ms B told HDC that she was concerned to discover that she had a retained placenta, and that RM A did not get her out of the birthing pool quickly.

Changes made since events

58. RM A said that, as recommended, she attended a water birth workshop. RM A stated:

> 'Since this birth I have worked on my authoritative "get moving NOW" voice. I have also been far more aware of watching the blood loss in the pool and do not hesitate to get women out quickly if I have concerns.'

59. RM A said that following the review of the events, the concerns were resolved. She stated that she received no further communication from Health NZ about the events, and considered the matter closed.

My opinion

60. To determine whether the care provided by RM A was reasonable, I considered the advice of my in-house midwifery advisor, RM Emerson.

61. RM Emerson advised that it was reasonable for RM A to leave the room to update the staff. RM Emerson advised:

> 'There is a fine balance between predicting the course of labour accurately and preparing colleagues for upcoming events … It is however reasonable to consider whether ringing the bell for assistance might have been wiser than leaving the room.'

62. RM Emerson advised that, in the circumstances, RM A's rationale for leaving the room (to update the staff on Ms B's progress in labour) was in keeping with accepted midwifery practice, and that this was not a departure from the accepted standard of care.

63. RM Emerson did, however, have concerns about RM A's documentation.

64. There are no clinical notes from the time when the baby was born (at 6.44am) until Ms B was noted to be 'feeling faint' (at 7.33am). The clinical notes do not record the avulsion of the umbilical cord, the retention of the placenta, or the PPH. The reason for Ms B's transfer to the public hospital is also not documented in the clinical records.

65. RM Emerson noted that retrospectively it is difficult to assess when the bleeding commenced and whether help was summoned immediately.

66. RM Emerson advised:

> 'The standard of documentation does not meet accepted midwifery standards with gaps not accounted for and the absence of a retrospective note from RM A outlining events.'

67. RM Emerson advised that the standard of documentation represents a moderate departure from the accepted standard of care.

68. I accept RM Emerson's advice. Performance criteria 2.16 of the Midwifery Council's Competencies for Entry to the Register of Midwives (2007) states:

> 'The midwife provides accurate and timely written progress notes and relevant documented evidence of all decisions made and midwifery care offered and provided.'

69. I consider that RM A's documentation in relation to the care provided to Ms B did not meet the standard of documentation required by the Midwifery Council. Accordingly, I find that RM A breached Right 4(2) of the Code.

70. I acknowledge the significant time that has elapsed since these events (more than six years). I also acknowledge that following the events, RM A engaged in the review, she complied with the recommendation made by Health NZ (to attend a water birth workshop), and she believed that the incident had been closed. Accordingly, apart from RM A's poor documentation, I have no other concerns in relation to the care she provided to Ms B.

Care provided to Ms E — breach

Introduction

71. In 2018, Ms E registered with RM A as her LMC midwife.

72. Health NZ raised concern that RM A delayed using clinical assessment skills (palpation and vaginal examination) to measure Ms E's progress in labour.

Antenatal care

73. RM A had a total of 13 antenatal visits with Ms E.

74. Two weeks before the estimated due date, RM A met with Ms E in the presence of Ms L, a student midwife. Ms L documented in the clinical records:

> '[Ms E] looking well and feeling well, reports feeling that baby has moved "down" more as is feeling more pressure. Today we have discussed the labour and birth process and time after birth with [Ms E] from the Maternity Services Consumer Council pamphlets.'

75. The entry made by Ms L in the clinical records was not counter-signed by RM A.

76. RM A said that when she discussed the labour and birth process with Ms E, she reviewed all the topics set out in the Maternity Services Consumer Council pamphlet, and vaginal examinations was one of the topics discussed.

77. Two days prior to the estimated due date, RM A discussed with Ms E her birth plan and preferences. RM A documented in the clinical records under 'Woman's choices for labour, birth, and postnatal stay' — 'Discussed'. RM A documented that Ms E's preference was to have a water birth at a primary birthing facility, but there is no detail in the clinical record as to what RM A discussed with Ms E in relation to her labour, birth, and postnatal stay.

78. The clinical records list other matters that were discussed (options and choices for pain relief, the birth position, clamping and cutting of the cord, the third stage of labour and the placenta, Ms E's support people, Vitamin K, and Ms E's chosen method of infant feeding), but there is limited detail of the discussions and the outcome of the decisions in relation to these matters.

Labour

79. At 11.00pm that evening, Ms E went into spontaneous labour.

80. At 6.00am the following day, the first stage of labour[13] was established, and at 6.50am Ms E was admitted to the birthing unit.

[13] When the neck of the cervix opens to 10cm dilated.

81. There is no record in the clinical notes as to what RM A had discussed with Ms E, or what assessments RM A had undertaken, in the approximately eight hours prior to Ms E's admission to the birthing unit.

82. RM A arrived at the birthing unit at 7.40am, and Ms L arrived shortly afterwards at 7.58am. There is no record of any palpation or vaginal examination performed by RM A on admission.

83. It was recorded that Ms E entered the birthing pool at 8.25am. At 8.37am, Ms L documented in the clinical records that Ms E was coping well through the contractions. RM A did not counter-sign this entry, or any other entries made by Ms L in the clinical records.

84. Ms E's labour appeared to progress normally. At 9.12am, RM A documented that Ms E was 'breathing well through long contractions'. At 9.49am, Ms L documented that the contractions continued to be 'quite intense', and at 10.24am, RM A recorded that nitrous oxide[14] was commenced.

85. At 1.06pm, Ms L documented in the clinical records that Ms E was starting to feel very exhausted and that she asked if there was anything that could be done. Ms L discussed with Ms E the option of performing a vaginal examination to assess progress in labour.

86. At 1.15pm, Ms E exited the birthing pool so that a vaginal examination could be performed by Ms L. This was the first vaginal examination to be performed since Ms E's admission to the birthing unit. On examination, Ms L's findings were that Ms E was possibly fully dilated[15] and fully effaced,[16] that the fetal station was at zero, and that the baby was in the ROA[17] position.

87. Following the vaginal examination, Ms E did not wish to get back into the birthing pool, and she was encouraged to mobilise.

88. At 5.05pm, RM A performed another vaginal examination to assess progress in labour. RM A documented in the clinical records: 'Can feel a bit of anterior lip which is likely why not feeling head come down. Head at 0 to +1 [station]. Suture line feels a bit asynclitic.[18]'

89. At 5.19pm, RM A updated the core midwife on the vaginal examination findings.

90. At 5.31pm, RM A discussed with Ms E the option of transferring to the public hospital, but Ms E decided 'to wait and give it more time for now'.

91. At 6.45pm, RM A performed another vaginal examination. RM A documented in the clinical records:

[14] Provides pain relief during labour.
[15] The second stage of labour begins when the cervix is fully dilated (open) and the baby's had moves down out of the uterus and into the vagina, or birth canal.
[16] The thinning and shortening of the cervix.
[17] Right Occiput Anterior.
[18] When the baby's head is tilted or leaning to the side toward a shoulder.

> 'Head still [feels asynclitic] with suture line more on left. Slightly less cervix but still anterior lip. About same [descent]. [Ms E] wanting to transfer to [the public hospital].'

92. At 6.57pm, RM A called the obstetrics registrar, and it was agreed that Ms E should be transferred to the public hospital. The core midwife called an ambulance, and Ms E was prepared for transfer. Ms E was discharged from the birthing unit at 7.30pm.

Admission to hospital

93. Ms E arrived at the hospital at 7.58pm, and at 9.50pm, the core staff took over care of Ms E from RM A.

94. The baby was born at 6.42am, and Ms E was discharged the following day.

Correspondence from the birthing facility following events

95. Following the events, RM M, Charge Midwife at the birthing facility, sent an email to Ms U raising concerns about the care provided to Ms E by RM A. RM M's email stated:

> 'I met with [RM A] on [date] to discuss concerns regarding the labour care she provided to her client at [the facility]. The concerns outlined were not using clinical assessment skills (palpation or vaginal examination) to measure progress, for five hours following admission.
>
> No harm occurred as the woman transferred later in the day and had a … good outcome the following day.
>
> [RM A] expressed her skepticism for the value of vaginal examination to measure progress but accepted that a [vaginal examination] to establish a baseline and confirm presentation may be useful in a primary setting, and that it is expected of our profession to share this information with women to inform their decision-making.'

96. In its letter to the Midwifery Council on 8 February 2021, Health NZ said that since her discussion with RM M, RM A had not used the unit's facilities.

RM A's response

97. In response to the concerns raised by RM M, RM A told the Midwifery Council (and provided the information to HDC):

> 'I normally do a palpation when I first listen to a baby's heart, so I know where to listen. I do not always document this palpation. I will do so in the future.
>
> I do not do vaginal exams as a routine part of my initial assessment … I have found that a vaginal exam does not tell us how much longer labour will be and can be uncomfortable, invasive, or even [traumatising] to the woman … With a [vaginal examination], the woman usually finds out she is not as far along as she hoped, which can be very disappointing and lead to a slowing of the labour. A [vaginal examination] can be helpful if the woman's behaviour does not match what appears to be happening

> and when labour starts to deviate from normal. A [vaginal examination] is also helpful when at a decision point in the labour and more information is needed.'

98. RM A said that 'often' she finds that a vaginal examination does not add important information to the decision-making process, and she referred to the National Institute for Health and Care Excellence guideline[19] (the NICE guideline) on Intrapartum Care,[20] which states: 'When conducting a vaginal examination: be sure that the examination is necessary and will add important information to the decision-making process.'

99. However, RM A said that she did not hesitate to recommend a vaginal examination if she believed it was appropriate. She stated: '[I]t appeared that the main reason [RM M] stressed the importance of a vaginal examination was to protect the reputation of a primary unit such as [the birthing unit].'

100. RM A denies that she 'avoided' the facility and said that she has not used the facility because she has had no other clients requesting it as their place of birth.

My opinion

Documentation

101. No palpation or vaginal examination was performed by RM A on Ms E's admission to the birthing unit. The first vaginal examination was performed by Ms L at 1.15pm, more than six hours following Ms E's admission to the birthing unit.

102. RM A said that vaginal examinations are not a routine part of her initial assessment, but she does not hesitate to recommend a vaginal examination if she believes it is appropriate. RM A referred to the NICE guideline, which states that a vaginal examination should be done if necessary, and if it will add important information to the decision-making process.

103. RM A said that usually she performs palpation when she first listens to the baby's heartbeat but does not always document this.

104. RM Emerson advised that throughout Ms E's labour at the birthing unit, RM A's monitoring of the fetal heart was in keeping with accepted midwifery practice. However, RM Emerson noted that there is a lack of clinical documentation in relation to the decision-making, and retrospectively it is not possible to determine whether RM A had discussed palpation and vaginal examination with Ms E, and whether Ms E had consented to the decision not to have a vaginal examination or palpation on admission. RM Emerson advised:

> 'On consideration, there appears to be a wide range of views regarding a midwifery perspective regarding an admission vaginal examination in a normally progressing labour. Whilst the range of opinion may not be resolved here, the underpinning partnership between the midwife with the woman/birthing person/whānau is founded on an expectation that an action/inaction is discussed and informed consent is sought. Clinical documentation regarding the birth plan on [dates] outline birth plan discussion,

[19] A British guideline.
[20] Published on 29 September 2023.

> stating that the birth plan is completed on [date]. Vaginal examinations are not documented as discussed.'

105. RM Emerson is also concerned that there is no documentation of any discussions or assessments of the lead-up to Ms E's admission to the birthing unit. In addition, RM A did not counter-sign any of the entries made by Ms L, who was a student midwife. RM Emerson considers that RM A's documentation represents a moderate departure from accepted practice.

106. I accept RM Emerson's advice. Competency One of the Midwifery Council's Competencies for Entry to the Register of Midwives (2007) states that the midwife works in partnership with the woman throughout the maternity experience, and the criteria includes formulating and documenting the care plan in partnership with the woman/wahine. Standard Five of the New Zealand College of Midwives (NZCOM) Standards of Practice states that midwifery care is planned with the woman. The Standard Five criteria[21] includes:

> 'The midwife provides information from her knowledge and experience … The midwife facilitates and records outcomes of conversations related to the decision-making process.'

107. Standard Two of the NZCOM's Standards of Practice also requires the midwife to document decisions and midwifery actions.

108. I acknowledge that RM A may have discussed palpation and vaginal examination with Ms E at the antenatal consultation (when the Maternity Services Consumer Council pamphlet was discussed). However, I am critical that there is no documentation to show that agreement was reached between RM A and Ms E in relation to palpation and vaginal examination. In my view, it is not sufficient to document only the issues discussed without outlining the details of the discussion.

109. I am also critical that RM A did not document her assessments or discussions with Ms E prior to Ms E's admission to the birthing unit. In addition, I am critical that RM A did not counter-sign any of the entries made in the clinical records by a student midwife.

110. In my view, RM A failed to comply with professional standards to document Ms E's care comprehensively. Accordingly, I find that RM A breached Right 4(2) of the Code.

[21] From the *New Zealand College of Midwives Handbook for Practice*.

Care provided to Ms C — breach

Introduction

111. In 2018, Ms C registered with RM A as her LMC midwife.

112. During the last two months of her pregnancy, Ms C was experiencing excessive thirst and had difficulty eating. Sadly, Ms C's baby was stillborn at term at 40+3 weeks' gestation. Following the birth of the baby, Ms C became severely unwell with multi-organ failure. Ms C required treatment by the intensive care unit (ICU), and subsequently was diagnosed with HELLP syndrome[22] (a variant of severe pre-eclampsia[23]), acute kidney failure, and PPH.

Antenatal care

113. This was Ms C's first pregnancy. Ms C intended to have a water birth at a primary birthing facility.

114. At the booking visit, Ms C weighed 43.80kg, and she had a body mass index[24] (BMI) of 18.71.[25] Ms C's blood pressure was normal throughout her pregnancy.

115. On 9 Month1,[26] Ms C met with RM A for an antenatal assessment. RM A documented in the clinical records: 'Has had lots of [heartburn]. Unable to eat very big meals as gets heartburn. Suggest eating small frequent meals — grazing throughout the day.'

116. Ms C's blood tests taken on 4 Month1 were normal, and RM A documented that this was discussed during the appointment.

117. At the next appointment on 28 Month1, RM A noted that Ms C looked 'well' and that her heartburn had improved.

118. At her appointment on 25 Month2, RM A noted that Ms C looked 'well', but that Ms C still had some discomfort in her lower abdomen. At this stage, Ms C weighed 58.60kg and, up to this point, Ms C was recorded as having gained weight at her appointments in Months 1 and 2.

119. On 3 Month3, Ms C saw RM A and a student midwife, and it was recorded that Ms C weighed 57.10kg, meaning that Ms C had lost 1.5kg in the eight days since her last appointment with RM A. The student midwife documented in the clinical records:

> '[Ms C] is experiencing a lot of heartburn, and is feeling very thirsty a lot of the time. She is trying to eat, but feeling as though she can't eat that much. [Ms C's] mum is here now, and she's making lots of yummy food, but [Ms C] isn't able to stomach much of it

[22] Elements include haemolysis, elevated liver enzymes, and low platelet count.
[23] A potentially dangerous pregnancy complication characterised by high blood pressure.
[24] A tool that uses height and weight to calculate body size.
[25] A normal BMI range is 18.5–24.9.
[26] Relevant months are referred to as Months 1–3 to protect Ms C's privacy.

> at the moment. [Ms C] is sleeping well, and drinking lots of fluids … [Ms C] is sleeping upright when the heartburn is bad.'

120. Ms C continued to lose weight, and by her appointment with RM A on 9 Month3, Ms C weighed 55.60kg. Ms C's blood pressure was recorded as normal.[27] RM A documented in the clinical records:

> 'Still really thirsty and no energy. Has lost 1.5kg since last week. Scared to eat in case she vomits. Drinks so much fluid, no room for food. Encouraged to sleep/nap when able and eat as well as possible.'

121. RM A told HDC that she has cared for many women who had experienced a decreased appetite towards the end of their pregnancy, and that this was due to there being less room in the stomach for food. RM A said that she has also seen some pregnant women lose weight in the week before labour. RM A stated:

> '[Ms C's husband] thought she wasn't eating as much as she was drinking so many fluids so I do remember discussing it. He was trying to restrict her drinking so she would eat more. I remember saying that she should still drink to her thirst, but to consider food with a high water content such as soup. I never considered a GP referral. After this case, I did refer several women to the OB clinic with even borderline results.'

Labour

10 Month3

122. At 8.37pm on 10 Month3, RM A assessed Ms C at her home for early labour. RM A located a fetal heartbeat using a Doppler[28] and noted that the fetal heart rate was normal.[29] RM A documented in the clinical records:

> 'Lost some of mucus plug last night. Contractions started about 11 this morning. Were 10 minutes apart at noon … Had a nap … and then they were 5 minutes apart, but not as intense. Getting lots of back pain. Was shivering with the cold when I arrived at the home so I suggested turning the heat on so [Ms C] can relax better. Can talk through contractions. Now, the contractions are irregular and about 4–7 minutes apart and lasting about 40 seconds. Discussed when to call — when they are about 3 minutes apart and lasting for over a minute and have been for at least an hour. I will go home and await your call.'

123. RM A said that she would have performed palpation to determine where to listen to the fetal heartbeat, but this has not been documented in the clinical records.

124. No maternal baseline observations (temperature, pulse, respirations, and blood pressure) were done by RM A at the assessment on 10 Month3. RM A said that she did not assess Ms

[27] 112/74mmHg. Normal blood pressure is between 110–130/70–80mmHg.
[28] An electronic fetal heart-rate monitor.
[29] 148bpm. A normal fetal heart rate is between 110–160bpm.

C's blood pressure, as this had been normal the previous day (9 Month3). RM A stated that she regrets not measuring Ms C's blood pressure at the assessment on 10 Month3 but said that she was aware that Ms C's blood pressure was always normal.

11 Month3

125. The following morning, at approximately 5.00am, Ms C called RM A to advise that she had had a spontaneous rupture of membranes at 2.20am, and that her contractions were stronger and more frequent. RM A documented in the clinical records: 'After listening to contractions and discussions for about 15 minutes, decided to go to [the birthing unit].'

126. The clinical records contain no details of what assessments were done by RM A, or what discussions took place, prior to the decision for Ms C to be admitted to the birthing unit. It is also unclear whether the assessment was done in person, or whether it was done verbally by telephone.

Admission to birthing unit

127. Ms C was admitted to the birthing unit at 7.00am, and RM A arrived at 7.03am.

128. RM A and two hospital midwives attempted to find a fetal heartbeat with a Doppler and a CTG[30] but were unable to find a fetal heartbeat.

129. At 7.59am, the ambulance left the birthing unit to transfer Ms C to the public hospital, accompanied by RM A.

130. At 11.20am on 11 Month3, RM A documented retrospectively in the clinical records:

> '[Ms C] called at 0501 this morning to say contractions stronger and more frequent. Water broke at 0220 clear fluid (straw colour) and had some blood on pad. After listening to contractions and discussions for about 15 minutes, decided to go to [the primary birthing facility]. Around 7am, I couldn't hear the baby's heartbeat so called for another midwife. Several Dopplers were tried and the CTG. Called [the public hospital obstetrics registrar] at 0730. Arrived at [the hospital] at 0830. Bedside scan showed no fetal heartbeat.'

Admission to hospital

131. At 8.16am, Ms C was admitted to the public hospital. On arrival, no fetal heartbeat could be located. Sadly, Ms C's baby was delivered stillborn.

132. Following the delivery of the baby, Ms C became severely unwell and developed multi-organ failure. Ms C required ICU treatment and subsequently was diagnosed with HELLP syndrome (a variant of severe pre-eclampsia), acute kidney failure, and PPH.

133. Ms C's condition improved, and she was discharged.

[30] Cardiotocograph (a device used to monitor the fetal heart rate and uterine contractions).

Health NZ

134. Health NZ raised concern that no records were shared with Health NZ in relation to any assessments or observations that may or may not have been done by RM A until the point of admission to the birthing unit, when no fetal heartbeat could be heard and Ms C was transferred to hospital.

RM A's response

135. In response to the concerns raised by Health NZ, RM A said that she is unsure whether Health NZ was implying that she had 'missed anything antenatally which could have flagged pre-eclampsia'. RM A stated:

> 'The only thing that was different was an unusual thirst for the two weeks prior to labour and a return of [Ms C's] nausea and vomiting. No one ever asked me to share any notes recorded prior to arriving at [the primary birthing facility] …'

136. RM A told the Midwifery Council:

> 'This was a truly terrifying situation to see a labouring woman's health go downhill so rapidly. She was fully [cognisant] when we were at [the birthing unit] and after we transferred to [the public hospital] she became less and less aware of her surroundings. Some of this could have been the grief, but grief would not explain her getting more and more jaundiced [as] the day progressed.'

Changes made since events

137. RM A said that following the events she changed her practice, and she now always includes a blood pressure assessment as part of the initial labour assessment, 'unless the woman is about to push her baby out'. RM A stated:

> 'This reflection [to include a blood pressure assessment as part of the initial labour assessment] was on my own as I never had anyone inquire about it. Since this birth I have probably tripled the requisitions I do for liver and kidney function tests but have only had one case of pre-eclampsia since.'

My opinion

Care provided — breach

<u>GP referral</u>

138. In the weeks leading up to her labour, Ms C experienced an increased thirst and a decreased appetite. From 25 Month2 to 3 Month3, Ms C had lost 1.5kg, and from 3 Month3 to 9 Month3, she had lost a further 1.5kg.

139. RM Emerson advised that given Ms C's ongoing thirst, difficulty eating, and weight loss, it would have been prudent at least to have suggested a visit to a general practitioner (GP) for assessment on 9 Month3. RM Emerson advised:

> 'Further follow up on 9 [Month3] following extended period of excessive thirst, inability to eat and weight loss would be in keeping with accepted midwifery practice, [and] not to have referred to at least the GP on the 3 or 9 [Month3] represents a moderate departure from accepted midwifery practice.'

140. I accept RM Emerson's advice. In my opinion, RM A should have referred Ms C to her GP or a specialist for further assessment on 3 Month3 or 9 Month3.

141. I note also that performance criteria 2.3 of the Midwifery Council's Competencies for Entry to the Register of Midwives states:

> 'The midwife assesses the health and well-being of the woman/wāhine and her baby/tamaiti throughout pregnancy, recognising any condition which necessitates consultation with, or referral to, another midwife, medical practitioner or other health professional.'

142. Given Ms C's difficulty eating and excessive thirst over a prolonged period, in addition to her weight loss, in my view a GP referral or a referral to a specialist was warranted. I am concerned that RM A failed to recognise this.

Palpation and maternal baseline observations

143. On 9 Month3, the day prior to Ms C going into labour, RM A recorded Ms C's blood pressure, which was normal.

144. On 10 Month3, Ms C was assessed by RM A for early labour. RM A said that she would have performed palpation to determine where to listen to the fetal heartbeat, but she did not document this in the clinical records.

145. No maternal baseline observations (temperature, pulse, respirations, and blood pressure) were recorded by RM A. RM A acknowledged that she did not take blood pressure but did not comment on whether any other maternal baseline observations were performed, only noting that she had seen Ms C the previous day.

146. I leave open the possibility that palpation was performed by RM A but not documented, but I do not accept that RM A performed maternal baseline observations. In the absence of any clinical notes providing these observations and evidence from RM A of having completed these observations on this date, I consider it more likely than not that RM A did not undertake these observations.

147. RM Emerson advised that the failure to perform palpation and maternal baseline observations at the assessment on 10 Month3 is a moderate departure from accepted midwifery practice.

148. I accept RM Emerson's advice. I am critical that RM A did not measure Ms C's blood pressure on 10 Month3 and did not perform any other maternal baseline observations when Ms C went into early labour. This was inappropriate care. In addition, if RM A performed palpation, she should have documented this.

Conclusion

149. For the following reasons, I consider that RM A failed to provide services to Ms C with reasonable care and skill, and therefore breached Right 4(1) of the Code:

- RM A failed to refer Ms C to her GP for further assessment on 3 Month3 or by 9 Month3; and
- RM A failed to perform maternal baseline observations when Ms C went into early labour on 10 Month3.

Documentation — adverse comment

150. On 11 Month3, Ms C called RM A to advise that she had had a spontaneous rupture of membranes at 2.20am, and that her contractions were stronger and more frequent. RM A documented in the clinical records: 'After listening to contractions and discussions for about 15 minutes, decided to go to [the birthing unit].'

151. The clinical records contain no details of what assessments were done by RM A, or what she had discussed with Ms C on 11 Month3, prior to the decision for Ms C to be admitted to the primary birthing facility. It is also unclear whether RM A's assessment of Ms C on 11 Month3, prior to the admission to the birthing unit, was done in person, or whether it was done verbally over a telephone call.

152. Standard Five of the NZCOM's Standard of Practice includes: 'The midwife facilitates and records outcomes of conversations related to the decision-making process.'

153. Standard Two of the NZCOM's Standard of Practice also requires the midwife to document decisions and midwifery actions.

154. While RM A briefly documented that she had had a discussion with Ms C before her admission to the birthing unit, I am concerned that RM A did not document her discussions with Ms C in any detail, or any assessments she undertook at this time.

Care provided to Ms D — breach

Introduction

155. In 2019, Ms D registered with RM A as her LMC midwife.

156. A breech presentation was identified during labour, and Ms D required immediate transfer to the operating theatre for delivery of the baby. Health NZ raised several concerns about the care RM A provided, including that serial growth scans were not arranged, and that the breech was not diagnosed until Ms D presented in labour.

Antenatal care

157. Ms D was pregnant with her third baby. RM A noted in the clinical records that the birth of Ms D's second baby had been complicated by shoulder dystocia.[31]

158. At the booking visit, Ms D weighed 116kg, and she had a BMI of 40.86.[32]

159. RM A documented that there were no risk factors present in relation to Ms D's third pregnancy.

Anatomy scans

160. Ms D had an anatomy scan, but due to Ms D's body habitus, there was difficulty obtaining a clear view, and the scan was unable to be completed. The radiologist's report states:

> 'Conclusion: Incomplete anatomy scan. Visualisation of the fetal heart, profile and upper limbs were limited by maternal habitus. These views will be completed at a subsequent scan next week.'

161. Ms D had a follow-up anatomy scan, but the scan was still unable to be completed due to limited views. The radiologist's report states:

> 'Conclusion: Incomplete anatomy scan. Visualisation of the fetal heart remains limited by maternal habitus. A [follow-up] scan has been arranged for three [weeks'] time …'

162. Ms D had a further follow-up anatomy scan. The view remained limited, but the anatomy scan was able to be completed in conjunction with the earlier scans. The radiologist's report states:

> 'Fetal anatomy: Cardiac views remain slightly suboptimal, as a consequence of fetal position and maternal body habitus. Views obtained appear normal … Conclusion: … In combination with [two previous examinations], fetal anatomy review is complete. No abnormality has been demonstrated.'

Growth scans

163. No serial growth scans were done during Ms D's pregnancy.

164. RM A met with Ms D for another antenatal follow-up appointment. RM A documented in the clinical records: 'Discussed doing a scan. [Ms D] has declined. Knows she is going to have a big baby. Last one was over 5kgs.'

165. RM A told the Midwifery Council that she recommended a referral for a scan at both 31 weeks' and 37 weeks' gestation, but Ms D declined the referral due to the costs involved. RM A said:

[31] When one or both the baby's shoulders get stuck during vaginal delivery.
[32] A BMI of 25 or more is above the normal BMI range.

> '[Ms D] said she already knew the baby would be big. If I had suspected a breech baby, I would have arranged to take her to [the public hospital] for a bedside scan to confirm position. I had been sure I felt the baby was head down antenatally.'

166. RM A told HDC:

> 'I had discussed growth scans with [Ms D] and [her partner] due to the size of the baby and the difficulty palpating due to excess adipose tissue.[33] Every time I mentioned it, [Ms D] would say she knew the baby would be large so there was no sense confirming it.'

167. There is no detail in the clinical records of what RM A discussed with Ms D in relation to the recommendation for growth scans, or the reasons for this recommendation.

168. HDC has made several attempts to contact Ms D to obtain her recollection of the discussion with RM A in relation to the recommendation for growth scans, but these attempts have been unsuccessful.

Referral to obstetrician

169. RM A told HDC that she discussed with Ms D a referral for consultation with an obstetrician, but Ms D declined the referral. RM A said:

> 'I had mentioned the recommendation for an [obstetric] consult. [Ms D] wanted as little to do with the hospital system as possible and wouldn't accept a referral.'

170. There is nothing in the clinical records to indicate that RM A discussed referring Ms D for a consultation with an obstetrician, or a transfer of care, or what RM A discussed with Ms D about the reasons for a referral.

171. As noted above, HDC made several attempts to contact Ms D to obtain her recollection of the discussions with RM A, but these attempts were unsuccessful.

Place of birth

172. RM A recorded that she had discussed with Ms D her 'choices for labour, birth and postnatal stay', but there is no detail in the clinical records of what RM A discussed with Ms D in relation to this.

173. Ms D's plan was to birth at a primary birthing facility (birthing unit). RM A noted that Ms D was 'not too keen' on a waterbirth, and that if Ms D was to birth at the public hospital, she would 'likely go home after'.

174. Initially, Ms D was booked to birth at the birthing unit but due to Oranga Tamariki involvement and Ms D's elevated BMI, she was precluded from birthing at the birthing unit.

[33] Body fat.

175. RM A told the Midwifery Council:

> 'Even though [Ms D] and [her partner] requested to birth at [the birthing unit], I was aware of her history and not comfortable with a primary unit due to her body mass index (BMI) and history of shoulder dystocia. I was looking for any excuse to change to the hospital. At 36 weeks, due to Oranga Tamariki involvement, a social worker recommended birthing at [the public hospital]. I latched on to that excuse and said that was where we would go. I am not usually this deceitful about the place of birth with the birthing family, but there was no way I wanted to attend her birthing at a primary unit.'

Labour and diagnosis of breech presentation

176. Ms D went into spontaneous labour at around 9am and was admitted to the public hospital at 10am. Another midwife provided Ms D with labour care until RM A's arrival.

177. RM A arrived at 10.22am but no palpation or maternal baseline observations were performed by RM A on admission. RM A told the Midwifery Council:

> 'When I walked into the room at 1022, the core midwife immediately said to me that because [Ms D] had a history of shoulder dystocia she needed an intravenous line inserted, handing me the equipment to do so. I inserted the line, took bloods and sent them to the lab … I agree I should have done my own initial assessment and not relied on the core midwife's assessment, however, things were happening very quickly.'

178. At 12.03pm, Ms D had a spontaneous rupture of membranes.

179. At 1.31pm, the emergency bell was activated, but it is unclear from the clinical records why this occurred, as there is no note from RM A and only an entry from another staff member outlining what occurred after the bell had been activated.

180. An obstetric consultant and registrar Dr N responded to the emergency bell, and Dr N performed a vaginal examination. This was the first vaginal examination since Ms D's admission to hospital. There is no record of any other vaginal examinations or palpations done by RM A during Ms D's admission.

181. On vaginal examination, Dr N diagnosed a footling breech presentation[34] and noticed meconium.[35] A breech presentation at the second stage of labour is considered an obstetric emergency. A decision was made for Ms D to be transferred to the operating theatre for spinal anaesthesia and to trial a vaginal breech delivery, but she was also consented for a possible Caesarean section.[36]

182. Ms D was transferred to the operating theatre at 1.40pm. The baby's foot was delivered, and it was decided to abandon the spinal anaesthetic. At 1.49pm, the baby's legs and buttocks were delivered. At 1.52pm, the baby was rotated but there was difficulty delivering

[34] One or both feet are pointing downward and will enter into the birth canal ahead of the baby's bottom.
[35] The first bowel motion passed by a baby.
[36] A surgical incision into the abdominal and uterine wall to achieve delivery of the baby.

the baby's right arm. An episiotomy[37] was performed, and at 1.57pm, the baby was 'completely delivered'. The delivery was described in the clinical records as 'vaginal breech delivery (difficult)'.

183. The baby was admitted to the neonatal intensive care unit (NICU) and noted to have 'dec[r]eased movement' of her right arm with bruising evident over her shoulder. Subsequently, she was diagnosed with an upper arm fracture related to the difficult delivery. The plan was for non-operative management of the fracture. The baby was otherwise in good condition.

184. Following the birth, Ms D recovered well and was discharged four days earlier than her baby.

Review of events

185. The Charge Midwife Manager at the public hospital completed an incident report for the undiagnosed breech presentation that was identified only on presentation of the foot, and for the difficult breech extraction. The lack of baseline observations at admission and the absence of growth scans antenatally were noted in the report.

RM A's response

186. In response to the concerns raised by Health NZ, RM A told the Midwifery Council:

> 'I was fully aware of [Ms D's] history. I agree I should have done my own initial assessment and not relied on the core midwife's assessment, however, things were happening very quickly. In spite of what [Ms U] says, none of these issues was ever discussed with me following the birth or at any other time.'

My opinion

Information and care provided

Recommendation for transfer of care and consultation

187. At the booking visit with RM A, Ms D's BMI was over 40 (40.86). Ms D had a known history of complications with shoulder dystocia in relation to her previous pregnancy.

188. Manatū Hauora|the Ministry of Health published *Guidelines for Consultation with Obstetric and Related Medical Services (Referral Guidelines)* in 2012, which were revised and published by Health NZ in March 2023. The *Referral Guidelines* provide health practitioners with a list of conditions and criteria about referring pregnant, birthing, and postnatal women and babies for consultations with other clinicians, transferring clinical responsibility for care to specialists, and transferring care in emergencies.

189. The *Referral Guidelines* in place at the time of the events recommended a transfer of clinical responsibility for women with a BMI of over 40. The *Referral Guidelines* also stated that a woman with a previous maternity history of shoulder dystocia should be referred for consultation with an obstetrician.

[37] An incision made between the vaginal opening and the anus to make more space for the baby to be born.

190. The *Referral Guidelines* stated that if a woman declined a referral, consultation, or transfer of clinical responsibility, the LMC could be left operating outside their experience or scope of practice, and/or might feel that they could not provide the level of care the woman needed for her safety and the safety of her baby.

191. The *Referral Guidelines* stated that in the event that a woman declined a referral, consultation, or transfer of clinical responsibility, the LMC should advise the woman of the recommended care, including the evidence for that care, explain to the woman the LMC's need to consider discussing her case with at least one other healthcare provider,[38] 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 and decisions made, and the woman's response.

192. The *Referral Guidelines* stated that if after this process, resolution satisfactory to the LMC and the woman has not been reached, and the LMC decides to continue care, she should continue making recommendations to the woman for safe maternity care, including further attempts at referral, engage other practitioners as appropriate for professional support, and continue to document all discussions and decisions.

193. RM A said that she 'mentioned the recommendation' to Ms D for a consultation with an obstetrician, but this was declined by Ms D. Nothing in the clinical records indicates that RM A discussed referring Ms D for a consultation with an obstetrician, or a transfer of care, or what RM A discussed with Ms D about the reasons for a referral.

194. In the absence of contemporaneous documentation of any such discussion and confirmed documented declining of a referral by Ms D, and the limited evidence provided by RM A of what she recalled was discussed, I consider it more likely than not that while there may have been a brief discussion, it was limited and did not cover the reasons for referral and that it was needed for Ms D's raised BMI and because of her previous baby's shoulder dystocia.

195. RM Emerson advised that the former DHBs did not always accept a referral based on BMI, and she noted that the current 2023 guidelines now suggest consultation for a BMI over 40, instead of a transfer of care, which is likely to reflect the increasing number of birthing people with an increased BMI. However, RM Emerson said that the change reflected since 2012 and the practice of each district does not mitigate the need for an LMC to discuss the guideline recommendations with the woman/birthing person at that time.

196. RM Emerson advised that if it is accepted that referral for Ms D's raised BMI and previous shoulder dystocia were not discussed with Ms D, this represents a moderate departure from accepted practice.

197. I accept RM Emerson's advice. As Ms D's BMI was over 40, at the time of events the *Referral Guidelines* clearly recommended that clinical responsibility be transferred to secondary care services. In addition, Ms D's maternity history of shoulder dystocia warranted a referral for

[38] Another midwife, GPO or GP, an appropriate specialist, or an experienced colleague/mentor.

a consultation with an obstetrician, as set out in the *Referral Guidelines*. I am critical that RM A did not discuss these matters with Ms D.

198. As RM A decided to continue care, in accordance with the *Referral Guidelines* she should have continued to make recommendations to Ms D for safe maternity care, including further attempts at referral. As set out in the *Referral Guidelines*, RM A should also have engaged other practitioners as appropriate for professional support, and she should have continued to document all discussions and decisions.

199. There is also no evidence to suggest that RM A made any further attempts at a referral, or that she had any further discussions with Ms D about the need for a referral, after the initial referral had been declined.

200. In my view, RM A did not provide Ms D with the information to which she was entitled under the *Referral Guidelines*. I consider that this was information that a reasonable consumer in Ms D's circumstances could expect to receive.

Recommendation for growth scans

201. Ms D required three anatomy scans to complete the fetal anatomy review, given the difficulty in obtaining clear fetal views on these scans.

202. RM A recommended that a growth scan be done, but this was declined by Ms D. RM A documented this in the clinical records, but there is no detail of what RM A discussed with Ms D in relation to this recommendation, or her reasons for recommending a growth scan. There is no record of any discussion about serial growth scans, nor were any undertaken.

203. RM A said that she also recommended a referral for a scan earlier at 31 weeks' gestation, but Ms D declined due to the costs involved. RM A said that she discussed growth scans with Ms D and her partner due to the size of the baby and difficulty palpating, but every time it was mentioned, Ms D said she knew that the baby would be large so there was no sense confirming it.

204. The New Zealand Maternal Fetal Medicine Network Guidelines for the Management of Suspected Small for Gestational Age Singleton Pregnancies and Infants after 34 weeks' Gestation 2014 (the SGA Guidelines) state:

> 'The BMI at which fundal height measurement is unreliable is difficult to prescribe as it depends on distribution of maternal fat and also height. A plan for growth scans is recommended with a BMI of >35.'

205. Similarly, the Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG) Best Practice Statement Management of Obesity in Pregnancy[39] (RANZCOG Guidelines) state:

[39] First endorsed by RANZCOG in March 2013.

> 'Pregnant women with obesity should be offered additional serial ultrasounds for fetal growth. The timing and frequency of serial scans should be based on the full clinical picture.'

206. RM Emerson noted that serial growth scans were not undertaken despite difficulty obtaining clear fetal views due to maternal habitus on three anatomy scans, and these have not been documented as having been offered. She noted that a growth scan was declined by Ms D but that there is no documented discussion regarding why the scan was recommended. RM Emerson advised that if it is accepted that serial growth scans were not discussed, this represents a moderate departure from accepted practice.

207. I accept RM Emerson's advice. While I acknowledge that there is one recording of RM A having recommended a growth scan and this being declined by Ms D, there is nothing in the clinical records to indicate that RM A offered or discussed serial growth scans. Based on the evidence before me, I find it more likely than not that serial growth scans were not discussed with Ms D.

208. In my view, RM A should have offered serial growth scans and provided Ms D with a detailed explanation of why they were recommended, especially given that there had been difficulty obtaining clear fetal views due to maternal habitus during the three anatomy scans. In my opinion, this was information that a reasonable consumer in Ms D's circumstances could expect to receive.

Palpation and maternal baseline observations

209. Ms D was admitted to the public hospital in labour. No palpation or maternal baseline observations were performed by RM A on admission, and RM A acknowledged that she should have done so.

210. RM Emerson advised that the failure to undertake palpation and maternal baseline observations on admission was a moderate departure from the accepted standard of care.

211. I accept RM Emerson's advice. While I cannot determine whether palpation on admission could have diagnosed the breech presentation earlier, I am critical that no palpation or maternal baseline observations were done by RM A on admission. This was not appropriate care.

Conclusion

212. RM Emerson advised:

> 'Accepting that diagnosis of a breech presentation can occur in labour, reasonable steps were not taken by [RM A] to mitigate this possibility. Reasonable steps would have included recommendation for obstetric consultation … based on previous shoulder dystocia and elevated BMI. In addition, a recommendation for serial growth scans in the later stages of pregnancy. Palpation on admission to [the public hospital] in labour could possibly have diagnosed the breech presentation. It is impossible to determine retrospectively if the breech presentation would have been diagnosed prior to labour with Obstetric consultation, serial scans and palpation on admission in labour, however,

all these actions would be in keeping with accepted midwifery practice for the reasons outlined above.'

213. In conclusion, I find that RM A breached Right 6(1)(b) of the Code for failing to provide Ms D with the information she was entitled to receive under the *Referral Guidelines* (in relation to a transfer of care due to an elevated BMI and a consultation due to previous shoulder dystocia) and failing to offer serial growth scans to Ms D with an explanation and reasons for recommending them.

214. I also find that RM A breached Right 4(1) of the Code for failing to perform palpation and maternal baseline observations on admission. In addition, RM A should have at least considered engaging other practitioners for professional support.

Documentation

215. RM A said that she discussed with Ms D a referral for a consultation with an obstetrician, but this was declined by Ms D. RM A did not document the discussion, or her reasons for recommending a referral.

216. The clinical records show that at 37 weeks' gestation, RM A recommended a growth scan to Ms D, and that Ms D declined the scan. However, there is no record of what was discussed. RM A said that she had also recommended a referral for a scan earlier, at 31 weeks' gestation but that Ms D declined due to the costs involved. This was not documented. However, I leave open the possibility that RM A did recommend a scan at this time.

217. Standard Five of the NZCOM's Standard of Practice states: 'The midwife facilitates and records outcomes of conversations related to the decision-making process.'

218. Standard Two of the NZCOM's Standard of Practice also requires the midwife to document decisions and midwifery actions.

219. I am critical that RM A did not document her recommendation for a referral to an obstetrician, or her discussion with Ms D in relation to the referral. In addition, I am critical that RM A did not document any recommendation or discussion of a referral for a growth scan at 31 weeks' gestation, and I am critical of the lack of detailed documentation about exactly what was discussed regarding the scan at 37 weeks' gestation.

220. In my view, RM A's documentation in her care of Ms D did not meet professional midwifery standards and, accordingly, I find that RM A breached Right 4(2) of the Code.

Care provided to Ms G — adverse comment

Introduction

221. In 2020, Ms G registered with RM O as her LMC midwife. RM A provided Ms G with back-up LMC care during labour.

222. In the morning of Day 3,[40] Ms G went into early labour. Ms G's labour was progressing very slowly, and RM A remained with her for a prolonged period during this time. Health NZ raised concern that when Ms G was admitted to the public hospital at 2.30pm on Day 4, RM A appeared tired. Health NZ questioned whether RM A was able to provide Ms G with safe care, given how tired she appeared.

Labour

223. Ms G planned on giving birth at her home. On the evening of Day 1, Ms G started to have mild contractions, which continued throughout the following day.

Day 3

224. RM A said that in the 'late morning' on Day 3, she received a telephone call from RM O advising that Ms G was in early labour and that she (RM O) would be visiting Ms G shortly.

225. RM A said that at 12.45pm, she received another telephone call from RM O advising that she was unwell and unable to visit Ms G. RM A was the back-up LMC and agreed that Ms G could call her when needed.

226. At 3.13pm, Ms G's husband called RM A to advise that they required her support. RM A arrived at Mr and Ms G's home at 4.15pm.

227. At 4.51pm on Day 3, RM A documented in the clinical records:

> 'At [Mr and Ms G's] place. Started mild contractions the evening of [Day 1]. They got stronger and more regular during the night last night. Had called [RM O] earlier today to come out, but things had slowed down.
>
> Feeling tired and frustrated that things aren't progressing as quickly as had hoped. Using hot towels on back with some counter pressure.'

228. Ms G's labour progressed slowly. At 6.28pm, RM A left Mr and Ms G's home to have dinner. At 9.10pm, RM A documented in the clinical records: 'Back at the home. Discussed what to do next. Decided to fill the pool. Getting in the water would either speed things up or slow things down and [Ms G] could rest.'

229. Ms G's labour continued to progress slowly, and RM A said that at 10.15pm, RM A and Mr and Ms G decided that they would rest. RM A said that because of the distance to her home, she decided to sleep in Mr and Ms G's spare bed so that she could be available. RM A stated:

[40] Relevant dates are referred to as Days 1–5 to protect Ms G's privacy.

> 'We had discussed the possibility of going to the hospital for medication for pain and sleeping, but they declined. Since they seemed to want my support, I agreed to stay in their spare bedroom. I really expected labour to either kick into gear or [Ms G] to decide she was too tired to cope and to go to the hospital. We all dozed off and on all night.'

Day 4

230. The following morning, at 6.49am, RM A documented that she and Mr and Ms G got up 'after snoozing off and on during the night'. Ms G's contractions were noted to be 'a bit irregular with most being about 8 minutes apart', but 'more intense'.

231. At 8.17am, the contractions were noted to be 'quite variable in frequency'. RM A documented that after discussion, it was decided that she would go home to rest. She discussed with Mr and Ms G what they needed to do if the birth happened 'really fast' and advised that they could call her at any time if they had questions, or if they wanted her to return to their home.

232. RM A said that at 12.49pm, Mr G called her advising that Ms G was 'exhausted' and that she wanted to go to the hospital. RM A stated:

> 'I called the ACMM[41] at [1.02pm] and was told they were very busy and would not be able to do an epidural handover and that it may be hours before we could consult with a doctor. I called [Mr G] back and explained this to him. After talking to [Ms G], they decided they still wanted to head to the hospital.'

233. At 2.30pm, due to the delay in labour, Ms G was admitted to the public hospital.

234. At 2.40pm, RM A documented in the clinical records:

> '[Ms G] arrived [at the public hospital] after labouring at home since evening of [Day 3] for planned home birth. Transferred in as exhausted [and] wanting epidural.'

235. On admission, RM A performed a vaginal examination and palpation, but it is unclear whether she performed maternal baseline observations because this is not documented in the clinical records. RM A documented that Ms G was 4cm dilated and that the baby was at fetal station -2.

236. RM A noted that at 3.01pm she saw the obstetrics registrar, who asked her to perform an artificial rupture of membranes (ARM). RM A performed the ARM and noticed meconium-stained liquor. Ms G was given morphine to assist with 'intense contractions', and at 5.32pm, she was reviewed by the obstetrics registrar. Another vaginal examination was performed and options for an epidural and oxytocin were discussed.

237. Oxytocin was commenced at 7.19pm, and at 7.45pm RM A handed over care of Ms G to the core midwife for epidural care.

[41] Associate Charge Midwife Manager.

238. RM A said:

> 'My expectation going to the hospital was to hand over for epidural care since I wasn't epidural certified. Due to staffing issues, it took much longer to get a staff member to do labour cares than anticipated.'

Day 5

239. At 4.37am on Day 5, the baby was born in good condition.

Health NZ

240. Health NZ raised concern that RM A had been with Ms G for a prolonged period. Health NZ questioned whether RM A was able to provide safe care to Ms G, given how tired she appeared. Health NZ told the Midwifery Council:

> 'The afternoon ACMM confirmed with [RM A] that she was still feeling safe to practi[s]e … as she was concerned that she had been with the woman for 36 [hours] and perhaps she should have called in a back-up. [RM A] was reluctant to call a back-up. She stated she was happy to continue as she had been able to snooze on and off at the woman's house.
>
> About [8.00pm] approximately, there was a complete epidural handover so that she could go home. The ACMM felt uncomfortable with her being with the woman any longer given how tired she appeared. She also did not offer an epidural buddy as actually wanted [RM A] to go home and rest otherwise she may have stayed on and was too tired.'

RM A's response

241. RM A denies that she had been with Mr and Ms G for 36 hours. RM A told the Midwifery Council:

> 'I had just woken up when [Mr G] called at [12.49pm on Day 4], and I was feeling rested. I had discussed that I was transferring to the hospital just after [1.00pm] with the [back-up midwife]. [The back-up midwife] and I thought it made more sense for me to meet [Mr and Ms G] at the hospital since they knew me and I knew what had been happening. I may have looked tired to the ACMM, but I felt rested and well able to care for [Ms G].'

My opinion

242. RM Emerson noted that no baseline maternal observations are recorded, and that the handover to the core midwife occurred with 'sparse handover information documented'. RM Emerson advised that it is not possible to assess retrospectively what the circumstances around the handover were, and that, due to insufficient information, she is unable to determine whether the care provided by RM A was appropriate.

243. Having considered the matter, I am unable to determine whether RM A's ability to provide safe care to Ms G was reduced because of fatigue. I accept that RM A was able to get some rest during the evening of Day 3, when she stayed at Ms G's home overnight. In the

circumstances, I am not critical of the care provided by RM A to Ms G prior to her admission to hospital.

244. However, I am critical that RM A did not perform and document maternal baseline observations on Ms G's admission to hospital. The responsibility for performing maternal baseline observations rests with RM A as the back-up LMC, and I would have expected these assessments to have been completed and documented prior to the care of Ms G being handed over to the core midwife at 7.45pm.

245. In addition, I am concerned about the lack of professionalism shown by RM A when she elected to stay at Ms G's home overnight. In my view, in the circumstances, it would have been preferable for RM A to return to her own home.

Care provided to Ms F and Baby F — other comment

Introduction

246. Ms F gave birth to a baby in a healthy condition. RM A had stepped in to assist with the birth as both Ms F's LMC and back-up LMC were not available. Health NZ raised concern about RM A's lack of handover to the staff caring for Ms F and her baby following the birth, and, in particular, that RM A did not provide all relevant information that affected the provision of care to Ms F and her baby.

Initial LMC

247. Initially, Ms F received LMC care from RM P.

248. At 3.20pm on 4 Month1,[42] Ms F self-presented to a community maternity unit with back pain and lower abdominal pain. She had been 'cramping' since the afternoon on 3 Month1 and had not felt the baby move for three days. RM P was contacted by staff, and at 4.30pm, care of Ms F was handed over to RM P.

249. Following a discussion with the obstetrics registrar, the decision was made for Ms F to be transferred to the public hospital by ambulance for review of the pain.

250. At 5.30pm, an intravenous (IV) line was inserted to provide Ms F with fluids and antibiotics. The ambulance arrived at 5.40pm and Ms F was transferred to hospital.

Admission to hospital

4 Month1

251. At around 7pm, the ambulance arrived at the public hospital. At 7.15pm on 4 Month1, Ms F was reported to be 'crying and demanding' that the IV line be removed. Following a discussion with the obstetrics and gynaecology registrar, Dr Q, it was agreed that the IV line

[42] Relevant months are referred to as Months 1–4 to protect Ms F's privacy.

could be removed if Ms F insisted, but that she be provided with an explanation of the reasons why the IV line was needed.

252. At 7.20pm, the IV line was removed, after which Ms F was reported to be calm.

253. At 7.32pm, Dr Q reviewed Ms F and documented in the clinical records that there had been 'previous Oranga Tamariki[43] input', and that Ms F had 'complex social and behavioural issues'. Dr Q made an entry in the clinical records to 'see [Oranga Tamariki]'. Dr Q's plan for Ms F included 'social work input'.

254. A referral for social work was completed at 9.45pm.

5 Month1

255. At 9.45am on 5 Month1, Ms F was assessed by social worker Ms R. Ms R noted that the staff had concerns because Ms F wanted to self-discharge and 'did not appear to grasp the seriousness of her condition'. Ms R documented in the clinical records:

> 'When I spoke with [Ms F] she was concerned about having to stay in hospital and miss [a family birthday] party. She did not feel there was anything wrong with her anymore. Staff wanted her to stay another night, and to be seen by a consultant but she was not willing … [Ms F] decided to leave regardless of medical advice as she did not wish to wait any longer but said she would come back after the party.'

256. The clinical notes show that Ms F returned to hospital at 3.30pm. She was taken to have a scan and was reviewed by the registrar before she self-discharged at approximately 10pm.

Report of concern and Oranga Tamariki referral

257. Ms R noted that she was concerned about Ms F's 'lack of insight into her condition and the impact her decisions could have on the baby and herself'. On 21 Month1, Ms R telephoned RM P, who advised that she had not seen Ms F since her admission to hospital. RM P said that Ms F had 'cancelled and not turned up to her appointments', and that she was unable to get in touch with her.

258. On the same day, Ms R completed a report of concern (ROC) for Ms F. Ms R reported that she had concerns about Ms F's 'lack of support and ability to safely parent', and that she was unable to contact Ms F or assess further as Ms F was in another town. Oranga Tamariki said that Ms R also raised concerns about Ms F's antenatal care and drug use.

259. On 22 Month1, Ms R discussed her concerns again with RM P, who advised that she had concerns about Ms F 'and her ability to parent a child safely'.

260. Ms R also followed up with Ms F on this day and documented in the clinical records:

> '[Ms F] said she is working with a social worker at … (though could not give detail on what this was) and does not have [Oranga Tamariki] involvement. I discussed my

[43] Ministry for Children.

> concerns briefly about the lack of support she appears to have … I will follow up with [social services] to ascertain what supports she is currently receiving.'

261. On 23 Month1, Ms R discussed Ms F with another social worker at the hospital, who agreed to follow up with Ms F and Oranga Tamariki.

262. On 27 Month1, Ms F contacted Ms R and advised that she had been given the number of another LMC. Ms R documented in the clinical records: 'I let [Ms F] know that I had made a referral to [Oranga Tamariki] as I was concerned about her and baby which she appeared understanding of.'

Booking with new LMC

263. On 13 Month2, Ms F had a booking visit with her new LMC, RM S, and a care plan was completed. The additional notes in the care plan state that she was to birth at the public hospital and 'home for postnatal', 'for [third] trimester scans (smoking and no palpations)', and 'needle phobic'.

264. RM A said that, at this point, RM T (another midwife at her practice) was Ms F's back-up LMC.

Hui a-whānau

265. On 21 Month3, Ms F, her partner, and their whānau attended a hui a-whānau at Oranga Tamariki. Oranga Tamariki provided HDC with a copy of the hui minutes.

266. Oranga Tamariki had several concerns, which were shared with Ms F and discussed during the hui. Oranga Tamariki said that due to these concerns, it was agreed that a robust safety plan was needed when the baby was born.

267. The hui notes state that Ms F wanted to stay with her mother for a couple of days after the birth of the baby but that this was dependent on the birth, and then Ms F, her partner, and their baby would move to Ms F's partner's mother's home, where they had set up a spare room for the baby.

268. The hui minutes state:

> 'There still needs to be a robust plan put in place for the safety of the unborn pēpi. Whānau will monitor baby safety when in the homes. Regular contact with external providers and midwife to monitor and check on baby. Family Start will engage and provide parenting course.'

Maternity booking form

269. On 21 Month3, Ms F was booked for birth and labour at the public hospital. The maternity booking form was completed by RM S and noted Oranga Tamariki's involvement. The maternity booking form states:

'Do you have any child or family agencies working with your family? Yes

If yes, who are they? Oranga Tamariki, Social work'

Final antenatal appointment

270. On 28 Month3, Ms F had her last antenatal appointment with RM S. RM S documented in the clinical records: '[Oranga Tamariki] meeting last week reported to have gone well. They will update me if any plans are made.'

271. RM A said that this was the only note of Oranga Tamariki involvement contained in RM S's MIS[44] notes.

Labour and birth

2 Month4

272. On 2 Month4, Ms F started to experience irregular tightenings, with increased intensity in the evening. RM S reviewed Ms F at the public hospital at 11.50pm. On vaginal examination, RM S noted that the baby's head was at fetal station -1.

273. At 11.50pm, RM S documented in the clinical records that she was unable to get hold of the back-up LMC. RM S also documented that there was '[Oranga Tamariki] involvement'. The clinical records contain no details of Oranga Tamariki's plan following the birth of the baby.

3 Month4

274. At 12.32am on 3 Month4, RM S's plan was for Ms F to be discharged home, and for the back-up midwife to assess Ms F at her home, prior to Ms F returning to the hospital.

275. At 2.30am on 3 Month4, Ms F returned to the hospital in active labour.

276. RM A said that at that time, she was providing labour cares to another woman at the public hospital. RM A stated that, as the back-up LMC (RM T) was unable to be contacted and her client had birthed, she agreed to assist with labour cares for Ms F once she 'wrapped up' with her client. The hospital midwifery staff provided Ms F with labour cares until RM A's arrival to assist at 3.28am.

277. There were no complications during labour, and Baby F was born at 4.58am.

278. RM A said that the Acting Charge Midwife Manager was kind enough to assign a core midwife to help her with the postnatal cares and paperwork. Following Baby F's birth, RM A handed over care of Ms F and Baby F to the hospital staff. There is no documentation as to what was handed over or when this occurred, although RM A's last entry is made at 7.50am, and staff midwife documentation continued at 7.53am.

[44] Management Information System.

279. After Ms F was transferred to the maternity ward, the clinical notes for the morning shift record Ms F's progress, and that a meeting on the ward with Oranga Tamariki had been arranged for the following day.

Oranga Tamariki's safety plan

280. On the morning of 4 Month4, Ms F and her partner met with Oranga Tamariki and a social worker.

281. Oranga Tamariki told HDC:

> 'On [4 Month4] it is recorded that a safety plan was organised where [Ms F] and baby were to be discharged from hospital and into the care of [Ms F's mother] who would provide 24/7 supervision.'

Review of events

282. Following the events, Health NZ completed an incident report. The incident report states:

> 'Handover by back-up LMC. Back-up LMC did not provide all relevant information (none) regarding significant [Oranga Tamariki] and social work concerns which affected the providing of care to mum and her baby. Only when curious about the [Oranga Tamariki] flag on [electronic whiteboard] did it become clear that there was a lot of information not provided — particularly regarding the need for a sitter during the postnatal stay. This was subsequently difficult to arrange at such short notice … Back-up LMC handed over no [information] at all regarding [Oranga Tamariki] and appeared to not know anything about it.'

RM A's response

283. RM A told the Midwifery Council that she was unaware of Oranga Tamariki's safety plan when care of Ms F was handed over. RM A said:

> 'When I handed over to the postnatal midwife, I did not know anything about needing a sitter during the postnatal stay and from the MIS and hospital notes, it would appear that [RM S] did not know either. The only documentation was that [Ms F] would go home postnatally.'

284. RM A also said that the birth care plan is not in the MIS notes and so she did not have access to it, and the only note of Oranga Tamariki involvement in the MIS notes was the record on 28 Month3.

285. RM A told HDC:

> 'I did have time to read the MIS notes while attending my own labouring woman. I was also aware of [Ms F's] history from discussions at our weekly midwifery practice meetings that [RM S] occasionally attended.'

My opinion

286. Oranga Tamariki's involvement in Ms F's pregnancy was noted in the maternity booking form completed by RM S dated 21 Month3.

287. On 28 Month3, RM S documented in the clinical records that Oranga Tamariki would provide her with an update if any plans were made for Ms F and Baby F, but there was no further mention of Oranga Tamariki in the clinical notes. On 2 Month4, when RM S assessed Ms F in early labour, Oranga Tamariki's involvement was documented in the hospital clinical records, but no details of Oranga Tamariki's plan are included.

288. I am unable to determine with certainty when Oranga Tamariki's plan for a postnatal sitter was made. It appears that Oranga Tamariki's safety plan was put in place the day after Baby F's birth.

289. RM Emerson noted that there did not appear to be a formal handover in the clinical notes, although staff midwife documentation followed RM A's previous documentation. RM Emerson advised:

> 'If it is accepted that [RM A] was not the intended back up and stepped in an hour and a half prior to [Ms F] birthing, then there is a moderate departure in accepted practice [in not] documenting a thorough [handover] to the staff.'

290. I accept RM Emerson's advice. I am concerned that RM A did not document her handover. However, I acknowledge that there were other health professionals involved in Ms F's care and that RM A had limited information about Oranga Tamariki's involvement when care of Ms F was handed over.

291. In addition, while I acknowledge Health NZ's concerns, the need for a sitter was not documented anywhere in the clinical records that RM A had access to at the time. I am therefore not critical that RM A did not document this information in her own clinical records.

292. In the circumstances I accept that RM A's management of Ms F and her baby postnatally was significantly hampered by her late involvement in their care. I acknowledge that RM A was not the intended back-up LMC for Ms F, and that RM A provided assistance with Ms F's labour at short notice because the back-up LMC was unavailable. In my view, these are mitigating factors, and therefore I am not critical of the care provided by RM A and I consider that she did not breach the Code in relation to her handover.

Care provided to Ms H — breach

Introduction

293. In 2020, Ms H registered with RM O as her LMC midwife. RM A provided Ms H with back-up LMC care during labour.

294. Health NZ raised concern about RM A's monitoring of the fetal heartbeat during labour, and that RM A did not act promptly when she was having difficulty hearing the fetal heartbeat. Sadly, Ms H's baby was stillborn at term.

Labour

295. Ms H planned on having a water birth at her home.

296. Ms H was 40+2 weeks' gestation when she went into early labour. At 1.23pm, Ms H sent a text message to RM A advising that she was in early labour. RM A went to see Ms H after completing a postnatal visit for another client.

297. RM A documented that on arrival at 2.55pm, she performed maternal baseline observations. RM A also performed palpation and listened to the fetal heartbeat. RM A documented in the clinical records:

> 'Was tricky to hear baby's [heartbeat] as heard [mum's] at 94–112, but did finally hear it around 140.[45] Did feel and see a movement in process too. Heard best centrally above pubic bone.'

298. RM A noted that Ms H was coping well. RM A left Ms H's home and advised that Ms H should call her when the contractions continued for longer than a minute, for at least an hour.

299. RM A documented that she returned to Ms H's home at 6.03pm as the contractions were consistently longer than a minute for over an hour.

300. On her arrival at Ms H's home, RM A documented that the fetal heartbeat was 'still difficult to hear but eventually got it'.

301. RM A documented in the clinical records that the fetal heart rate was 138bpm at 6.06pm, 144bpm at 6.56pm, and 115bpm at 7.07pm (which were all normal). No maternal heart rate was documented at any of these times.

302. At 7.09pm, Ms H entered the birthing pool. At 7.49pm, RM A documented in the clinical records: 'Tried to hear baby's [heartbeat] between a few contraction[s]. Heard it momentarily a couple of times but not long enough to get a read out.'

303. At approximately 8.30pm, RM A contacted RM T, another back-up LMC, for assistance. RM A sent RM T a text message that said:

> '[Ms H] said she is feeling a bit of pressure. I'm stressed as the heartbeat is really hard to get. I'm probably just tired and they have techno music playing which [is] probably increasing my heart rate. Could you please come over …'

[45] A normal fetal heartbeat is between 110–160bpm.

304. RM A said that usually she would wait until 'effective pushing is established' to call a second midwife for a birth but, because she was tired, she called RM T early as she 'sought support and another pair of eyes'.

305. At 8.37pm, RM A documented that the fetal heart rate was 120bpm (normal). No maternal heart rate was documented.

306. RM T arrived at Ms H's home at 9.13pm.

307. There are inconsistencies between RM T's recollection of the events and RM A's documentation about the fetal heartbeat.

308. RM A documented that RM T was able to hear the fetal heartbeat. At 9.32pm, RM A documented in the clinical records: '[RM T] tried listening to [heartbeat]. Heard faintly at about 120 with [Ms H] standing.'

309. RM T has a different recollection of the events and said that she never heard the fetal heartbeat. RM T stated:

> 'I asked [RM A] when she thought she last heard the fetal heartbeat, she said she wasn't sure. I look[ed] through the notes and could only see 3–4 times [within] the last few hours that [RM A] had check[ed] for the fetal heartbeat and the last couple that had been documented she was not 100 percent as she commented to me. I picked up the doppler and went over to [Ms H] and asked her if I could please try to listen to [the] baby's heartbeat. She said yes. I tried but it was different as [Ms H] was in the pool and working hard. I then explained after the next contraction if she could get out of the pool to try, please. She said she would try. I then spoke to [RM A] and said when was the last time she felt confident about getting the heartbeat. She did not have time to answer as [Ms H's husband] then asked what was happening should we be concerned. I explained that [RM A] had been finding it difficult to pick up the fetal heartbeat and I would really like [Ms H] to get out of the pool for me to try again. [Ms H] got out of the pool after the next contraction and lay down on the couch. I was still not able to locate a fetal heartbeat. [Ms H] then needed to stand up due to the pain of the contraction. The conversation was had about doing a vaginal exam to see if we could stimulate [the] baby or work out a position in case we were not listening in the correct location. [RM A] declined the vaginal exam and asked me to complete it [as] she said she is not very good at working out position. I looked at her and said I am a new grad midwife so am no good at working out if the baby is posterior or anterior yet however, I performed the vaginal exam with [Ms H's] consent and was easily able to locate the baby's head and [Ms H] was 9cm dilated. I once again tried to hear a fetal heartbeat for where we should hear it know[ing] where the baby's head is located and unfortunately, I could still not hear a fetal heartbeat. [Ms H] then had to stand for another contraction, I then looked up at her and said I am so sorry I cannot get a fetal heartbeat and we need to go to [the hospital] as soon as possible.'

310. At 9.52pm, RM A documented in the clinical records that Ms H was 'out of the pool due to not being able to hear [fetal] heartbeat'. A vaginal examination and palpation were

performed. RM A documented that the baby's head was at fetal station -1 and that Ms H's cervix was 8cm dilated.

311. As no fetal heartbeat could be heard, Ms H was transferred to hospital.

Admission to hospital

312. Ms H was admitted to the public hospital at 10.14pm.

313. On admission, no fetal heartbeat could be seen or heard. The ACMM documented in the clinical records that RM A had reported difficulty hearing the fetal heartbeat throughout the day, and following assessment by the ACMM, a registrar, and an obstetrics consultant, it was confirmed that no fetal heartbeat was present, and condolences were given. The ACMM documented that she suggested that RM A and RM T head home, as care was now with tertiary services.

314. Sadly, the baby was stillborn.

Postmortem report

315. The postmortem report concluded that the baby had died 'in association with placental pathology'. The postmortem report found that the placenta had 'mild acute chorioamnionitis[46] with a fetal inflammatory response' and 'severe (high grade) chronic villitis of unknown aetiology[47]'.

Health NZ

316. Health NZ told the Midwifery Council:

> '[T]here seemed to be a lack of realisation from [RM A] about the severity of struggling to hear the [fetal heart rate] "all day" and no reflection of the need in such a situation to conduct a full assessment to feel confident about hearing the fetal heart rate and then to act earlier if there were concerns.'

Concerns raised by Ms H

317. Ms H provided HDC with further information about her concerns with RM A's care. Ms H said that it was important to note that what happened to her baby was a combination of 'a major issue with the placenta' (which meant that the baby did not get the oxygen she required during labour), as well as RM A's practice.

318. Ms H said that prior to her labour, RM A had been busy with other births, and that RM A was 'very tired'. Ms H believes that RM A should have called someone else to attend to her labour and birth.

[46] An infection of the amniotic fluid and tissue that surround the fetus during pregnancy.
[47] Inflammation of the structures that cover the surface of the placenta that ensure the baby receives sufficient nutrients and gases from the mother.

319. Ms H said that RM A incorrectly attributed her difficulty finding a consistent heartbeat to the position of the baby. Ms H stated:

> 'This meant that action was not taken early enough (going to the hospital), and faint or inconsistent heartbeats were accepted by [RM A] as normal for many hours during the labour. [RM A] also did not check the heartbeat as regularly as she should have (especially given the inconsistent results she was getting), with up to an hour in between checks at times. We were subsequently told by our hospital obstetrician that we should have come to the hospital as soon as there were any concerns regarding heart rates.'

320. Ms H said that RM A advised her that she had called the back-up midwife (RM T) earlier than usual because she was tired and wanted support. Ms H stated:

> 'The backup midwife was a new grad and when she arrived, [RM A] asked her to do an internal examination. We subsequently were told that this was unacceptable for an experienced midwife to ask a new midwife to do this and that [RM A] should have been taking the lead.'

321. Ms H also raised concerns about RM A's documentation. Ms H said:

> 'Following [the baby's] death, we spent time looking over [RM A's] notes and found several errors, including noting down heart rates at times where it was not assessed. This was extremely frustrating and distressing to me, particularly [given my profession], as correct note taking is vital and there should not be errors regarding basic facts such as times and heart rate results.'

RM A's response

322. RM A told the Midwifery Council that she listened to the fetal heart rate at least every 30 minutes but that she documented it only when she 'clearly heard and could count the baby's heartbeat'. RM A said:

> 'The [District Heath Board] guidelines on Fetal Heart Monitoring suggest listening every 15–30 minutes in active labour. During [Ms H's] labour I realise that, despite listening in at least every 30 minutes I only documented when I clearly heard and could count the baby's heartbeat. [Ms H's] contractions were coming so fast and furiously that it was difficult to locate the precise spot to hear the baby's heartbeat clearly in the time available. I omitted to document every time I could not clearly do so and even though I listened to the fetal heart frequently, comparing it with [Ms H's] pulse if it was unclear, I did not record those attempts. That is a fault in my record keeping which I will never allow to happen again.'

323. RM A also said:

> 'Throughout [Ms H's] labour, including immediately prior to transfer, I was always hearing either maternal and/or baby's heartbeat … It is true that I struggled to hear clearly, but always did, in fact, hear a good and regular heartbeat, which I documented.

> There was no "concern" because I always did hear the heartbeat, it was just not easy to locate it. I was therefore stunned when there was no heartbeat on the scan at the public hospital and was subsequently in profound shock.'

324. In response to the provisional opinion, Ms H said:

> '… I struggle to understand [RM A's] comments of not having any concerns about finding a heartbeat, even prior to transferring to the hospital. This doesn't make sense because the reason I got out of the pool and the reason we went to the hospital was because they couldn't find a heartbeat. Our experience matches more with [RM T's] report …'

Policies and guidelines

Fetal heart monitoring

325. Health NZ's guidelines on fetal heart monitoring[48] (Fetal Heart Guidelines) state that during the first stage of labour, the fetal heart rate should be monitored using intermittent auscultation every 15 to 30 minutes. The Fetal Heart Guidelines state that the monitoring should commence toward the end of a contraction and last for 30 to 60 seconds afterwards.

326. The Fetal Heart Guidelines state that a normal fetal heart rate is between 110–160bpm.

327. The Fetal Heart Guidelines state that both intermittent auscultation and continuous electronic fetal monitoring require careful documentation, and that the timing and duration is to be documented, as well as the equipment used to listen to the fetal heart.

328. The Fetal Heart Guidelines state that fetal monitoring training is mandatory for all health professionals undertaking any aspect of electronic fetal monitoring, and is a strong recommendation for all self-employed LMCs, with no charge to attend.

My opinion

Fetal monitoring

329. The RANZCOG Clinical Guideline on Intrapartum Fetal Surveillance[49] (the Fetal Surveillance Guideline) states that it is recommended that intermittent auscultation be undertaken and documented every 15–30 minutes in the active phase of the first stage of labour.

330. Health NZ's Fetal Heart Guidelines are consistent with RANZCOG's Fetal Surveillance Guideline, and also state that the fetal heartbeat should be monitored every 15–30 minutes. Under the Access Agreement, all Health NZ's clinical policies and procedures formed the basis of primary maternity care provided in the facilities. While the birth did not take place in Health NZ's facility, as an LMC who regularly worked in Health NZ's facilities, RM A would have been aware of Health NZ's Fetal Heart Guidelines, and she would have been required to follow these guidelines in Health NZ's facility.

[48] Issued in October 2020.
[49] Fourth Edition 2019.

331. Between 6.06pm and 9.32pm (the last time when the fetal heartbeat was documented as being heard), RM A documented the fetal heart rate on five occasions,[50] and it was documented as a normal rate. No maternal heart rate was documented by RM A after 2.55pm. In addition, there are inconsistencies between RM A's documentation and RM T's recollection of the events for the final recording at 9.32pm.

332. RM A documented that the fetal heartbeat was heard 'faintly' by RM T at 9.32pm, and that the fetal heart rate was normal. RM T denied this and said that she never heard the fetal heartbeat. It is evident that an attempt to hear the fetal heartbeat occurred at this time but given that RM T used a Doppler and RM A did not listen herself, I am inclined to accept RM T's recollection of events that the fetal heartbeat was not heard at 9.32pm.

333. There are also inconsistencies between RM A's and Ms H's recollection of the events. RM A said that she listened to the fetal heartbeat at least every 30 minutes but that she documented it only when she could hear it clearly and was able to 'count the baby's heartbeat'. On the other hand, Ms H said that RM A did not listen to the fetal heartbeat as regularly as she should have, with up to an hour in between checks at times.

334. I note that in the five documented recordings of fetal heart rate, apart from the 11 minutes between the 6.56pm and 7.07pm recording, the other recordings do represent gaps of 50 minutes to 1.5 hours, which appears more consistent with Ms H's recollection. While RM A said that she documented only when she could hear the fetal heart rate clearly, I note that RM A did document on one occasion (at 7.49pm) that she tried to hear the fetal heart rate and, while she heard it momentarily, she could not hear it for long enough to determine the rate.

335. Having considered RM A's documentation and the differing statements presented by RM A and Ms H, and for the reasons outlined above, including the additional feedback Ms H has offered in response to the provisional opinion, I consider that it is more likely than not that RM A listened to the fetal heartbeat on only five[51] occasions (and recorded the fetal heart rate on four of these) between 6.06pm and 8.37pm, as set out in her clinical records.

336. RM Emerson advised:

> 'If it is accepted that the fetal heart was not heard a minimum of every 30 minutes in the first stage of labour and the notes do not adequately represent the difficulty or do not document a differentiated maternal heart rate and additional confirmation and support was not sought in a timely manner, this represents a moderate to severe departure from accepted midwifery practice in both midwifery care and documentation.'

[50] At 6.06pm, 6.56pm, 7.07pm, 8.37pm, and 9.32pm.
[51] Including at 7.49pm.

337. I accept RM Emerson's advice. I am critical that RM A failed to monitor the fetal heartbeat every 15 to 30 minutes. This was contrary to RANZCOG's Fetal Surveillance Guideline, and contrary to accepted practice.

338. RM A should have monitored the fetal heartbeat at least every 30 minutes. I find it concerning that RM A left Ms H unassessed for extended periods of time, with almost an hour of no fetal surveillance at certain points. Given the concerns RM A had around hearing the fetal heartbeat clearly, I would have expected her to monitor Ms H more closely, and to listen to the fetal heartbeat more frequently.

339. In addition, given the difficulty RM A had with hearing the fetal heartbeat, I am critical that she did not seek support earlier. The Midwifery Council Competencies for Practice clause 2.6 states:

> 'The midwife identifies factors in the woman/wāhine or her baby/tamaiti during labour and birth which indicate the necessity for consultation with, or referral to, another midwife or a specialist medical practitioner.'

340. In my view, RM A should have sought support from another midwife or specialist medical practitioner at 7.49pm. By that time, RM A had already been having difficulty hearing the fetal heartbeat and could no longer be reassured that she was hearing it clearly.

341. In addition, I am critical that RM A did not record a maternal heartbeat at all after 2.55pm. It is important to differentiate between a maternal and fetal heartbeat, especially in circumstances where the practitioner is finding it difficult to hear the fetal heartbeat. RM A's documentation does not adequately represent the difficulty she was having with hearing the fetal heartbeat clearly. In addition, RM A did not record the assessments accurately as she documented that a fetal heartbeat was heard by RM T at 9.32pm, when that was not the case. However, I acknowledge that this error could have occurred because of a misunderstanding or miscommunication with RM T.

342. Maternal and fetal monitoring require careful documentation. The importance of diligently and accurately documenting maternal and fetal wellbeing cannot be overstated.

343. Standard Two of the NZCOM's Standard of Practice states:

> 'The midwife provides accurate and timely written progress notes and relevant documented evidence of all decisions made and midwifery care offered and provided.'

Conclusion

344. By failing to monitor the fetal heart rate adequately, including documented differentiation of this from the maternal heart rate, and failing to escalate her concerns about fetal heart rate in a timely manner, I find that RM A failed to provide services to Ms H with reasonable care and skill, in breach of Right 4(1) of the Code.

345. In addition, I find that RM A's documentation was poor and does not meet the standard required by the Midwifery Council, in breach of Right 4(2) of the Code.

Summary

346. RM Emerson advised that from her review of the information gathered, there are emerging themes in the care provided by RM A, which include:

> '• Documentation that does not meet the accepted midwifery standard.
>
> • There is a lack of record of consultation with and handover to secondary care.
>
> • There is a lack of documented discussion both by text or phone and a sparsity of documentation regarding assessment.
>
> • There is a sparsity of history review and consideration at the onset of care episodes.
>
> • Lack of baseline observations to determine fetal and maternal wellbeing at critical stages of labour, a lack of palpation, and evaluation of history at the commencement of labour.'

347. I accept RM Emerson's advice. The numerous failures by RM A represent a pattern of poor care and, overall, the care provided by RM A was not in keeping with the standard reasonably expected of a midwife. In summary, I have found that RM A:

- Breached Right 6(1)(b)[52] of the Code for failing to provide the appropriate information that could reasonably have been expected to be received.
- Breached Right 4(1)[53] of the Code for:
  - — Failing to recognise a condition that necessitated consultation with, or referral to, another medical practitioner;
  - — Failing to perform palpation and maternal baseline observations;
  - — Failing to monitor both maternal and fetal wellbeing and failing to perform ongoing observations at critical stages of labour; and
  - — Failing to respond with timely and appropriate intervention when there were indications of difficulty.
- Breached Right 4(2)[54] of the Code for failing to keep adequate and accurate records.

[52] In relation to the care provided to Ms D.
[53] In relation to the care provided to Ms C, Ms D, and Ms H.
[54] In relation to the care provided to Ms B, Ms E, Ms D, and Ms H.

Recommendations

348. As RM A is no longer practising as a midwife, I recommend that RM A:

a) Provide written apologies to Ms B, Ms C, Ms D, Ms E, Ms G, Ms H, and their whānau for the deficiencies in care outlined in this report. The apologies are to be sent to HDC, for forwarding to each of the women and their whānau, within three weeks of the date of this report.

b) Should she decide to return to midwifery practice, undertake a full return-to-practice programme to update her midwifery knowledge, skills, and competencies to practise, as recommended by the Midwifery Council.

Follow-up actions

349. A copy of this report will be provided to Health NZ|Te Whatu Ora.

350. A copy of this report with details identifying the parties removed, except the advisor on this case, will be sent to the Midwifery Council, and it will be advised of RM A's name.

351. A copy of this report with details identifying the parties removed, except the advisor on this case, will be sent to Te Kāreti o Nga Kaiwhakawhanau Ki Aotearoa|New Zealand College of Midwives and 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 Midwifery Advisor RM Nicholette Emerson:

'**DATE: 2 October 2023**

1. Thank you for the request that I provide clinical advice in relation to the complaint forwarded from the Midwifery Council, originally from [Ms U] (Director of Midwifery) to the Midwifery Council. 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 on file: Documents provided.

- Clinical notes both DHB and midwifery notes for all seven cases
- Response from [RM A]

Background: Complaint was referred by [the DHB] to the Midwifery Council, who then referred it to HDC. Concerns were raised about [RM A's] care of 7 women (from 2017 to 2021).

Advice Request: I have been asked to review the care of the seven cases and provide midwifery comment.

[Ms B] [2017]

[Ms B] booked during her second pregnancy with LMC midwife [RM I]. [Ms B] had a history of a previous spontaneous miscarriage which resulted in a significant bleed followed by a dilation and curettage (D&C). [Ms B's] BMI was raised at 38. According to midwifery documentation, [Ms B] declined referral for her raised BMI. Diet and exercise are documented as being discussed and BMI risks addressed. [Ms B] had a normal diabetes result (GTT) at 31 weeks' gestation. A marginal placental umbilical cord insertion was noted on scan. RM I recommended scans to assess growth and placental function based on the marginal cord insertion. A normal scan at 37+4 concluded normal fetal growth and amniotic fluid index (AFI). As a result of the scan findings, dopplers were not thought to be necessary.

A referral at 25 weeks' gestation stating that [Ms B] had requested to birth at [the birthing unit] is found in RM I's clinical notes, however without a supporting obstetric letter, this is documented as declined. It is unclear if this issue of suitability to birth at [the birthing unit] was resolved. This leaves a question of whether [Ms B] was suitable to birth at [the birthing unit] based on her previous significant bleeding and her current raised BMI.

A BMI of 38 is classed as Obese and there is an association of increased risk of postpartum haemorrhage (PPH). [Regional] Women's Health Guidelines (2020) state that Obesity is a predisposing factor for PPH.

Labour commenced [at approximately 39 weeks'gestation] and [RM A] attended as back up for [RM I] who was not available. The first entry into the clinical notes from [RM A] is at 2.38am. Baseline observations had been taken by the staff midwife; however, an abdominal palpation had not been documented. The staff midwives were updated and advised of full cervical dilation at 4.29am. The labour notes continue to document progress and [RM A] left the room at 6.42am to again update the midwifery staff. At this point the bell was rung by [Ms B's] partner and the baby's head had been born when [RM A] re-entered the room.

The [DHB] Incident review is critical stating — *Instead of ringing the bell when [Ms B] was clearly advancing in 2nd stage in the birth pool, [RM A] left the room to ask for a 2nd midwife and baby's head was already born on her return.*

In consideration of the above, application of retrospection highlights the view that [RM A] should not have left the room. Practice reality is challenging. Had [RM A] left the room to update the staff without incident, she may not have been criticised. There is a fine balance between predicting the course of labour accurately and preparing colleagues for upcoming events. A culture of retrospective criticism can create siloed care and hesitation to consult and seek support. It is however reasonable to consider whether ringing the bell for assistance might have been wiser than leaving the room. In response, [RM A] states *After documenting the exam, I wanted to update the staff and see if they were happy with the progress. Since it had taken two hours to progress two centimetres in descent and [Ms B] was a primip, I thought there was time to briefly leave the room. If I had thought that the birth was imminent, I would, of course, have rung the bell and not left the room to get a second midwife.*

[RM A] shares a rationale that would be in keeping with accepted midwifery practice and on this basis does **not depart** from accepted practice.

Post partum Haemorrhage

There appears to be no clinical notes between the birth of the baby 6.42 and 7.33am when the documentation records "feeling faint".

RM rang bell and Core MW responded to find water in pool dark red. [Ms B] pale and losing consciousness — eyes rolling back in head and sinking into pool. Core MW rang emergency bell.

It is stated by Health NZ that the staff midwives took over care, removing [Ms B] from the pool, taking observations, administering a uterotonic and asking for the assistance of an anaesthetist to gain IV access to [Ms B]. The clinical notes do not

record ongoing bleeding or the avulsion (shearing off) of the umbilical cord. Notes at 8.35am state "*preparing for transfer to [hospital]. 2nd [luer] in situ in right hand, catheter in situ draining urine*."

The notes do not state that the transfer is for the removal of a retained placenta and PPH.

There is no further clinical documentation until the arrival via ambulance to [the hospital] at 9.58am.

[RM A] states *My usual process after a birth, if all is normal, is to leave the cord attached until after the birth of the placenta. Because I recognised that I needed [Ms B] out of the pool, I had already clamped and cut the cord and made some progress towards getting her out but it was difficult because, just as during second stage while [Ms B] was pushing, she was reluctant to move. She had progressed to kneeling and holding on to bar of the ladder when she started to feel faint. I rang the bell for help, and noticed that the water in the pool was now dark red.*

Since this birth I have worked on my authoritative "get moving NOW" voice. I have also been far more aware of watching the blood loss in the pool and do not hesitate to get women out quickly if I have concerns. At Incident Review, it was recommended that I attend a water birth workshop, which I did [in] 2017. This labour happened over three years ago, and these concerns were resolved according to the Incident Review's recommendation. I have received no other communication since and considered the matter closed.

Retrospectively it is difficult to assess when the bleeding commenced and whether help was summoned immediately. Whilst the LMC generally will lead the obstetric emergency, it is accepted that there is a multi-disciplinary team approach in an obstetric emergency.

Remaining concerns are regarding the eligibility of [Ms B] to birth at [the birthing unit] given her risk factors of a previous significant bleed and her BMI. The standard of documentation does not meet accepted midwifery standards with gaps not accounted for and the absence of a retrospective note from [RM A] outlining events.

A) If it is accepted that this event occurred in 2017, was dealt with within the DHB and [RM A] engaged in the review, followed recommendations, and believed the incident to be closed then there is **no further departure** from accepted practice.

B) If it is accepted that [Ms B] should not have birthed at [the birthing unit] because of her risks for PPH and BMI, then this, along with the standard of

documentation represents a **moderate departure** [55] from accepted Midwifery practice[56].

[Ms E] 2019

Concerns raised by Health NZ regarding the midwifery care provided by [RM A] are that clinical skills of palpation and vaginal examination were not used for the 5 hours following [Ms E's] admission to [the birthing unit].

Following review of [RM A's] clinical notes

- [Ms E] was admitted in labour to [the birthing unit] at 6.50am
- [RM A] is documented as arriving at 7.40am
- Third year midwifery student [Ms L] is documented as arriving at 7.58am
- The labour appeared to be progressing normally however no maternal baseline observations were taken on admission. No palpation or vaginal examination was undertaken on admission.
- The monitoring of the fetal heart is in keeping with accepted midwifery practice throughout the time at [the birthing unit].
- At 1.06pm [Ms E] was beginning to feel exhausted, a vaginal examination was offered and undertaken to assess progress.

On consideration of the above

In her complaint response [RM A] states that she often undertakes an admission palpation, but this is not always documented. Her complaint response discusses the reasons why she does not perform an admission vaginal examination. The reasons include a negative personal experience, an article (link submitted) and the NICE guidelines. [RM A's] response suggests that an admission vaginal examination was advocated in this context retrospectively to protect the reputation of the birthing facility.

On consideration, there appears to be a wide range of views regarding a midwifery perspective regarding an admission vaginal examination in a normally progressing labour. Whilst the range of opinion may not be resolved here, the underpinning partnership between the midwife with the woman/birthing person/whānau is founded on an expectation that an action/inaction is discussed and informed consent is sought. Clinical documentation regarding the birth plan

[55] RM Emerson advised that the issue in relation to the documentation and the issue in relation to the location of birth each represents a moderate departure from the accepted standard of care.
[56] RM A was not involved in the location of birth and, as such, this issue will be dealt with separately and does not form part of this investigation.

on [dates] outline birth plan discussion, stating that the birth plan is completed on [date]. Vaginal examinations are not documented as discussed.

The following has been considered in forming an opinion.

- New Zealand College of Midwives (NZCOM) standards of practice. Standard 5, Midwifery care is planned with the woman. *The midwife facilitates the decision-making process, provides information from her knowledge and experience.*
- *Midwifery Council Competency One "The midwife works in partnership with the woman/wahine throughout the maternity experience." Explanation The word midwife has an inherent meaning of being "with woman". The midwife acts as a professional companion to promote each woman's right to empowerment to make informed choices about her pregnancy, birth experience, and early parenthood. The midwifery relationship enhances the health and well-being of the woman/wahine, the baby/tamaiti, and their family/whānau. The onus is on the midwife to create a functional partnership. The balance of "power" within the partnership fluctuates but it is always understood that the woman/wahine has control over her own experience.*

Retrospectively it cannot be determined whether the decision not to undertake an admission vaginal examination or palpation was discussed or consented, what can be determined is the lack of clinical documentation regarding decision making. In addition, none of the documentation by the student midwife has been counter signed by [RM A]. There is no documentation regarding the lead up to admission in terms of phone calls and assessments. For the reasons outlined above, the **documentation** represents a **moderate departure** from accepted practice.

[Ms F] 2020

According to her complaint response, [RM A] was backing up LMC midwife [RM S] for [Ms F]. The plan had been for another practice member (RM T) to be back up however she was off call at the time of [Ms F's] birth. [RM A] was in the hospital attending to one of her own women when she was asked to attend [Ms F]. The staff midwives attended [Ms F] until [RM A] was available. According to the clinical notes [Ms F] had returned to hospital in established labour at 2.30am, following a previous assessment at 11.30pm. [Ms F] was cared for by staff midwives until [RM A] was available at 3.28am. [RM A] called a second midwife into the room at 4.52am. [Baby F] was born at 4.58am. There does not appear to be a formal handover in the clinical notes, however staff midwife documentation at 7.53am follows [RM A's] previous documentation at 7.50am.

Health NZ has expressed concern that [RM A] did not provide all relevant information about significant Oranga Tamariki and social work concerns affecting care provision to [Ms F] and her baby. *Only when curious about MCOT flag (MCOT*

is Chief Executive of Ministry for Children, Oranga Tamariki) did it become clear that there was a lot of relevant info not provided by RM — particularly about the need for a sitter during the postnatal stay. This was subsequently difficult to arrange at short notice. [RM A] handed over no information and did not appear to be aware of any MCOT information.

In her complaint response [RM A] states that the handover from [RM S] did not contain any MCOT information. The handover on the caseload list from [RM S] in the documentation

[Public hospital] for birth

Home for postnatal

For 3rd trimester scans (smoking and no palpations)

NEEDLE PHOBIC

Birth care plan updated.

The birth plan was not in the Management Information System (MIS) notes so was unable to access according to [RM A].

At the last antenatal appointment [RM S] documented

Given form for USS for follow up growth as unable to palpate and hx of smoking. OT meeting last week reported to have gone well. They will update me if any plans are made.

There was no further mention of Oranga Tamariki in the clinical notes.

In forming an opinion, the following has been considered.

- OT involvement is documented in the clinical notes at 11.50pm (02 [Month4]) when [Ms F] was assessed in early labour by [RM S] and sent home prior to returning in established labour at 2.30am (03 [Month4])).

A) If it is accepted that [RM A] was not the intended back up and stepped in an hour and a half prior to [Ms F] birthing, then there is a **moderate departure** in accepted practice **in not documenting a thorough handover to the staff.**

B) If it is accepted that [RM A] handed over to the core staff without reviewing the documentation in full then there is a **moderate departure** from accepted practice in **not reviewing [Ms F's] history and not adequately documenting handover in the clinical notes**.

Midwives Handbook for practice (2018) (page 38) **First decision point in labour,** reviews history to date, documentation, laboratory results, any scan results, outcomes of referrals made and plans for birth.

[Ms H] 2021

[Ms H], a G1PO booked with LMC Midwife [RM O] at approximately 8 weeks' gestation. [Ms H] had a normal pregnancy with nil medical or surgical history of note. Spontaneous labour commenced at 40 weeks and 2 days' gestation. [RM A] was covering for [RM O] who was unwell. [RM T] was the arranged back up to [RM A].

The first entry into the clinical documentation by [RM A] indicates that [Ms H] had started to feel abdominal cramps at approximately 6am in the morning and texted [RM A] at 1.23pm to say she was in early labour. [RM A] undertook a clinical assessment in [Ms H's] home at 2.55pm. A set of baseline observations are recorded, as is an abdominal palpation. It is documented that the fetal heart is hard to hear but is finally heard at 140bpm (normal). The fetal heart is documented as differentiated from maternal heart rate at 94–112bpm. [RM A] left [Ms H] at this point to establish in labour. These actions are in keeping with accepted midwifery practice with no departures identified.

Following a phone call from [Ms H's partner], [RM A] returned to [Ms H's] home later in the evening. The next entry into the clinical notes is at 6.06pm.

6.06pm Fetal heart heard at 138bpm (normal)

6.56pm Fetal heart heard at 144bpm (normal)

7.07pm Fetal heart heard at 115bpm (normal)

At 7.49 pm clinical notes indicate that [RM A] has tried to hear the fetal heart between contractions. *Heard it a couple of times momentarily but not long enough to get a read out.*

At 8.33pm a text from [RM A] to [RM T].

She said she is feeling a bit of pressure. I'm stressed as the heartbeat is really hard to get. I'm probably just tired and they have techno music playing which probably increasing my heart rate. Could you please come over. Hopefully parking on the street. I'm in front of their garage. [Address].

8.37pm fetal heart heard at 120bpm (normal)

According to clinical notes back up midwife [RM T] was asked to attend at 8.44pm.

[RM T] arrived at 9.13pm. [RM T] could not hear the fetal heart on arrival, so she asked [Ms H] to exit the pool which [Ms H] did. A vaginal examination was performed by [RM T] with consent. [Ms H] was found to be 9cms dilated but a fetal heartbeat could not be found. Immediate transfer to [hospital] was arranged. The reason that the transfer did not occur via ambulance was that [Ms

H] was clinically stable coupled with the short distance to the hospital, and therefore own transport was a timelier transfer.

Of note: The clinical documentation states that at 9.32pm [RM T] had heard the fetal heart faintly (120 bpm). This clinical note entry has been completed by [RM A]. In [RM T's] account, she was never able to auscultate the fetal heart from the time of her arrival.

Sadly, no fetal heart was found on arrival [at the hospital].

Reviewed accepted clinical guidelines regarding auscultation of fetal heart in labour state.

- RANZCOG intrapartum fetal surveillance (fourth addition 2019), fetal heart should be listened to at 15–30-minute intervals in the active first stage of labour.
- [The] DHB guidelines (2017) agree with RANZCOG guidelines, further stating that the fetal heart should be listened to for 30–60 seconds on each occasion.
- *In addition, the fetal surveillance education programme (FSEP) is offered and mandatory for all [DHB] health professionals undertaking any aspect of fetal heart monitoring. This programme is a strong recommendation for all Lead Maternity Carers.*

In her complaint response [RM A] states *[The] District Health Board guidelines on Fetal Heart Monitoring suggest listening every 15–30 minutes in active labour. During [the] labour I realise that, despite listening in at least every 30 minutes I only documented when I clearly heard and could count the baby's heartbeat. [Ms H's] contractions were coming so fast and furiously that it was difficult to locate the precise spot to hear the baby's heartbeat clearly in the time available. I omitted to document every time I could not clearly do so and even though I listened to the fetal heart frequently, comparing it with [Ms H's] pulse if it was unclear, I did not record those attempts. That is a fault in my record keeping which I will never allow to happen again.*

- [The] complaint states *When asked, [RM A] said she "had trouble all day" trying to hear the FHR. There seemed to be a lack of realisation from [RM A] about the severity of struggling to hear the FHR "all day" and no reflection of the need in such a situation to conduct a full assessment to feel confident about hearing the fetal heart rate and then to act earlier if there were concerns.*
- In response [RM A] states, *It is true that I struggled to hear clearly, but always did, in fact, hear a good and regular heartbeat, which I documented. There was no "concern" because I always did hear the heartbeat, it was just not easy to locate it. I was therefore stunned when there was no heartbeat on the scan*

at the public hospital and was subsequently in profound shock. If that looked like "a lack realisation" then the inference was wrongly made.

A) If it is accepted that the fetal heart was heard at least every 30 minutes throughout the course of the first stage of labour, the heart rate was heard and differentiated from maternal pulse but not documented then this represents a **moderate to severe departure from accepted midwifery documentation practice especially in the context of the difficulty hearing fetal heart**.

B) If it is accepted that the fetal heart was not heard a minimum of every 30 minutes in the first stage of labour and the notes do not adequately represent the difficulty or do not document a differentiated maternal heart rate and additional confirmation and support was not sought in a timely manner, this represents a **moderate to severe departure** from accepted midwifery practice in **both midwifery care and documentation**.

Competency Two for entry to the register of Midwives *Explanation The competent midwife integrates knowledge and understanding, personal, professional, and clinical skills within a legal and ethical framework. The actions of the midwife are directed towards a safe and satisfying outcome. The midwife utilises midwifery skills that facilitate the physiological processes of childbirth and balances these with the judicious use of intervention when appropriate.*

2.6 identifies factors in the woman/wahine or her baby/tamaiti during labour and birth which indicate the necessity for consultation with, or referral to, another midwife or a specialist medical practitioner.

[Ms C] 2019

[Ms C], a G1 P0 at the time of booking with LMC [RM A]. Her pregnancy had progressed normally with unremarkable routine test results. In the last few weeks of pregnancy [Ms C] is documented as being very thirsty and unable to eat much. Weight loss is recorded in the clinical notes on 9 [Month3]. Labour commenced on 10 [Month3] and [Ms C] was assessed at home by [RM A] 8.37pm. The fetal heart was recorded and documented in the normal range. [RM A] has not recorded a full set of Maternal baseline observations or a palpation at the time of assessment.

No fetal heartbeat was heard at [the birthing unit] the following morning, and this was confirmed shortly afterwards on admission to [the public hospital]. [Ms C] went on to become severely unwell and experienced multiple organ failure attributable at various times to a placental abruption, postpartum haemorrhage, disseminated intravascular coagulation (DIC), sepsis, acute fatty liver, preeclampsia, Haemolysis, elevated liver enzymes and low platelet count (HELLP).

Discharge documentation states the diagnosis as Severe HELLP with acute kidney injury/failure (AKI) and multi organ failure.

[Ms C] went on to make a full recovery and engaged [RM A] as a LMC in the subsequent pregnancy where [RM A] referred her for gestational diabetes. [Ms C] birthed a healthy baby.

- Health NZ states in their complaint that there were no records shared with [the public hospital] regarding assessments that may or may not have been done to the point of admission to [the birthing unit]. They further comment that [Ms C] had been unwell in the previous weeks with thirst and nausea.
- [RM A's] retrospective clinical notes 11 [Month3] 11.20am record a phone call at 5.01am to say contractions were more frequent and waters had broken at 2.20am. The notes state that after listening to contractions and discussions for about 15 minutes then the decision was made to go to the primary birthing facility. The documentation is not clear whether this assessment occurred via phone or in person. The fetal heart could not be heard on admission to [the birthing unit] at 7am so assistance was immediately sought by [RM A].
- Clinical documentation at [the birthing unit] records admission at 7.00am and a call for assistance at 7.10am. At 7.25am maternal heart rate is recorded at 69 (normal) and BP 147/101 (meeting criteria for referral). [Primary birthing facility] clinical notes state that [Ms C's] husband states that fetal movements were felt at 7am but nothing overnight.

On review of the clinical notes, blood pressure had been in the normal range throughout the pregnancy with a rise around mid-[Month2]. The blood pressure remained within the normal range and did not meet the criteria for referral antenatally. 1+ of protein was present on 9 [Month3] and this did not meet the criteria for referral.

Guideline for Consultation with Obstetric and Related Medical Services (referral guidelines 2012–2023)

4022/Pre-eclampsia BP ≥140/90 and/or relative rise of > 30/15mmHg from booking

2+ protein on dipstick

Note: The referral guideline was updated in 2023 and is now in keeping with the National Diagnosis and treatment of Hypertension and Pre-eclampsia in Pregnancy clinical guideline (2018). [Ms C] did not meet the criteria for referral antenatally by either guideline.

Further review of the clinical notes record *[Ms C] as experiencing a lot of heartburn and thirsty a lot of the time. She is trying to eat but can not eat that much.*

[Ms C's] weight has dropped from 58.6kg on 25 [Month2] to 55.6kg on 9 [Month3] (a loss of 3kgs).

Whilst pre-eclampsia can have a sudden onset and BP was recorded within the normal range (110/78) when assessed on 9 [Month3] it may have been prudent to at least suggest a visit to the GP given the ongoing thirst, weight loss and difficulty eating.

Labour commenced the following day and retrospectively it is impossible to determine whether [Ms C] had a raised blood pressure at assessment at home in early labour on 10 [Month3], or whether the outcome may have been different. Baseline observations including BP are not documented.

A) If it is accepted that a palpation and baseline observations were done and not recorded at assessment on 10 [Month3], then there is a **moderate departure** from accepted practice in not documenting these observations.

B) If it is accepted that no baseline observations were performed at assessment on 10 [Month3], then this is a **moderate departure** from accepted midwifery practice.

Further follow up on 9 [Month3] following extended period of excessive thirst, inability to eat and weight loss would be in keeping with accepted midwifery practice, and not to have referred to at least the GP on the 3 or 9 [Month3] represents a **moderate departure** from accepted midwifery practice.

[Ms D] 2019

[Ms D] booked with [RM A] at 8 weeks' gestation. She had a history of 2 previous large babies and a shoulder dystocia with her second baby. At booking [Ms D] had a BMI of 41. Pregnancy progressed normally until labour. Gestational diabetes was tested for on two occasions because of glucose being present repeatedly in [Ms D's] urine. The result was negative. Spontaneous labour commenced at term and a breech presentation was diagnosed in the second stage of labour.

It is noted that [Ms D's] BMI was 41 at booking.

1. There is no documented discussion regarding obstetric referral on this basis.

2. Serial growth scans have not been documented as offered or undertaken.

Guidelines for consultation with Obstetric and Related Medical Services (Referral Guidelines) 2012 have the following recommendation.

Page 25 (4017) — Morbid Obesity Body Mass Index (BMI) >40: may include an anaesthetic consultation — **Transfer of care**.

That said: with the increase in pregnancy obesity, the former DHBs have not always accepted a referral based on BMI, and it is noted that current guidelines updated 2023 now suggest **consultation** and anaesthetic review with BMI 40–49 and not transfer of care. This is likely to reflect the increasing number of birthing people with increased BMI. The change reflected since 2012 and the practice of each DHB, does not mitigate the need for a LMC to discuss the guideline recommendations at that time (2019) with the woman/birthing person and recommend obstetric consultation. In addition, [Ms D's] BMI and obstetric history of a previous shoulder dystocia compounds the recommendation for Obstetric consultation. A previous shoulder dystocia is an independent reason to refer for obstetric consultation.

Guidelines) 2012 have the following recommendation.

*Page 24 (3016) Previous Shoulder Dystocia — **consultation** (noting that this remains a reason for consultation in updated 2023 guidelines)*

3. Serial growth scans have not been offered despite difficulty obtaining clear fetal views due to maternal habitus on 3 anatomy scans.

According to National Women's Hospital 2012.

A woman with BMI >35 The BMI at which fundal height measurement is unreliable is difficult to determine as it depends on distribution of maternal adipose tissue and also maternal height. As a guide, a plan for growth scan(s) is usually recommended with a BMI of >35 (RCOG Guideline 2013, NZMFM SGA Guideline 2014). Estimated fetal weight measurements from growth scans should be plotted on the GROW chart as well as on the population ultrasound charts. Growth scans in a woman with BMI >35 should be performed if clinical assessment is not possible because of body habitus (which is often the case). Suggested timings for ultrasound growth assessment(s) are 30–32 and 36–38 weeks. A scan in late pregnancy is more likely to detect aberrations in growth but serial scans enable growth velocity to be assessed.

It is noted that a scan is declined in the clinical notes however there is no documented discussion regarding why the scan is being recommended.

Place of Birth — Documentation suggests [the birthing unit] as a place of birth. This is changed to [the public hospital] based on CYFS social worker preference. Based on previous shoulder dystocia and BMI above 40, [the birthing unit] would not have been a suitable place to recommend birthing.

Unexpected breech.

The diagnosis of a breech presentation in the second stage of labour can occur and this is considered an obstetric emergency. Appropriate support was obtained immediately by [RM A] on recognition of a footling breech presenting.

In some cases, the diagnosis of breech presentation will be made near to delivery, especially when a labour is progressing rapidly. This will allow only a very small window for decision-making regarding the mode of delivery.

RANZCOG clinical guidance on Management of breech presentation (current)

Accepting that diagnosis of a breech presentation can occur in labour, reasonable steps were not taken by [RM A] to mitigate this possibility. Reasonable steps would have included recommendation for obstetric consultation as outlined above, based on previous shoulder dystocia and elevated BMI. In addition, a recommendation for serial growth scans in the later stages of pregnancy. Palpation on admission to [hospital] in labour could possibly have diagnosed the breech presentation.

It is impossible to determine retrospectively if the breech presentation would have been diagnosed prior to labour with Obstetric consultation, serial scans and palpation on admission in labour, however all these actions would be in keeping with accepted midwifery practice for the reasons outlined above.

A) If it is accepted that a referral was recommended based on increased BMI, previous shoulder dystocia and serial growth scans were recommended but not documented, then there is a **moderate departure** from accepted midwifery practice in not documenting these discussions and a moderate departure in not undertaking baseline maternal observations including palpation at admission in labour.

B) If it is accepted that referral for raised BMI and previous shoulder dystocia was not discussed with [Ms D] and serial growth scans were not discussed, then this would represent a **moderate departure** from accepted midwifery practice. Omission of baseline observations and palpation at the admission in labour also represents a **moderate departure** from accepted midwifery practice as does the standard of documentation.

[Ms G] 2021

[RM A] was back up for [RM O] and had been introduced to [Ms G] prior to the onset of labour. The pregnancy had been unremarkable, and labour commenced at 40 weeks + 3 days. [RM A] attended in the latent phase of labour on [Day 3] and supported [Ms G] and her partner at home until transfer to hospital on [Day 4] for slow progress.

[The public hospital] asserts that the Acting Charge Midwife Manager felt uncomfortable with [RM A] continuing labour cares as she appeared very tired. Handover to core staff occurred at 7.50pm. It is not possible to assess retrospectively what the circumstances around handover were, however all of [RM A's] clinical notes record antenatal discussion that she does not provide epidural care.

The first entry to the clinical notes at [the hospital] is 2.40pm. There is no baseline maternal observations or palpation recorded[57]. Handover has occurred at 7.50pm with sparse handover information documented.

It is impossible to assess under what circumstances the handover occurred as there is no explanatory documentation by either party regarding this.

Summary

Review of all seven case clinical notes has taken place. Comment from DHB and [RM A] have been considered and comment has been provided at the end of each case. There are themes that have emerged; they include:

- Documentation that does not meet the accepted midwifery standard.
- There is a lack of record of handover to secondary care.
- There is a lack of documented discussion both by text or phone and a sparsity of documentation regarding assessment.
- There are no growth charts (neither customised nor population based) completed for any women/birthing people.
- There is a sparsity of history review and consideration at the onset of care episodes.
- Lack of baseline observations, palpation, and evaluation of history at the commencement of labour.

For the above reasons, [RM A's] midwifery care **moderately departs** from accepted midwifery practice.

In her complaint response, [RM A] states that she has not practised as a midwife since 2021.

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[57] The responsibility for baseline observations rests with the LMC if they have not been recently completed by core midwives.