

**Birthcare Huntly Limited
Midwife, RM C**

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

(Case 21HDC03151)

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He hōnore he korōria ki te Atua, he maungārongo ki te whenua

He whakaaro pai ki ngā tāngata katoa

He kura i tangihia he maimai aroha

Kia rātou te hunga kua moe

Kia koe e Baby A e moe

Moe iho rā koe i roto i te ngāwaritanga o te atua

Moe mai, moe mai, moe mai rā

Paimārire

Complaint and investigation

1. The Health and Disability Commissioner (HDC) received a complaint from Mrs B about the services provided to her daughter, Ms A, by Registered Midwife (RM) C and Birthcare Huntly Limited. The following issues were identified for investigation:
 - *Whether Lead Maternity Carer, Registered Midwife — RM C provided Ms A with an appropriate standard of care and culturally appropriate services in 2021.*
 - *Whether Birthcare Huntly Limited provided Ms A with an appropriate standard of care and culturally appropriate services in 2021.*
2. 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.
3. The parties directly involved in the investigation were:

Ms A	Consumer
Mr A	Ms A's partner, Baby A's father
Mrs B	Complainant
RM C	Lead Maternity Carer
4. Further information was received from:

RM D	Birthcare Huntly midwife
RM E	Birthcare Huntly midwife
RM F	Birthcare Huntly Clinical Manager
RM G	Lead Maternity Carer (present at Birthcare at time of events)
5. Independent advice was obtained from RM Mary Wood and is included as Appendix A.

Information gathered during investigation

6. This report discusses the concerns surrounding the care provided to Ms A by RM C and Birthcare Huntly Limited (Birthcare) in 2021.¹ I thank Ms A and her whānau for taking the time to bring their concerns to HDC.

Background

7. In 2021, Ms A became pregnant with her first child.
8. At the 20-week scan, Ms A and her whānau were excited to hear that their baby was a boy.
9. In the early hours of the morning at 40 weeks and 4 days' gestation (40+4), Ms A started to experience labour pains. As the labour pains intensified, Ms A, accompanied by Mr A and Ms A's mother, Mrs B, transferred to Birthcare. In response to the COVID-19 pandemic, the region had implemented public health restrictions,² and therefore whānau support was restricted.
10. At approximately 10.30am at 40+4 weeks, Baby A was delivered stillborn.
11. In their complaint to HDC, the whānau raised concerns surrounding the antenatal care and monitoring by RM C, the delivery of Baby A at Birthcare, the postnatal care, and the communication and cultural safety.
12. A timeline of Ms A's labour and delivery is included as Appendix B.

Ms A's antenatal care and monitoring

Antenatal care

13. Ms A registered with RM C on the day of her first visit when she was 20 weeks + 6 days into her pregnancy. Ms A then had antenatal visits at:
 - 26+3 weeks
 - 35+2 weeks
 - 36+2 weeks
 - 37+6 weeks
 - 38+5 weeks
 - 39+3 weeks
 - 40+3 weeks

¹ Birthcare Huntly is now closed.

² New Zealand had implemented the COVID-19 Alert system comprising four 'levels' of public health restrictions. The region was under the 'Alert Level 3 — restrict' public health restriction at the time, where the public were required to stay home and connect with only a small number of people. See: <https://covid19.govt.nz/about-our-covid-19-response/history-of-the-covid-19-alert-system>.

14. Mrs B and the whānau raised concerns around the lack of documentation, with no detailed notes completed for any of the antenatal visits. They are concerned that no routine bloods were checked during the pregnancy and that there is no written record of Ms A's birth plan.
15. RM C recorded minimal commentary in the clinical notes from any of the antenatal visits before 40+3 weeks, other than basic results such as blood pressure, urine analysis, fundal height, and presentation of the baby. For example, at 38+5 weeks the clinical narrative in RM C's electronic notes simply states: 'well mama.' At 39+3 weeks it states: 'Finally [on] maternity leave. Birthplan discussion with [Ms A, Mrs B, and Mr A] all well follow up next Tuesday.' No detail of the birth plan is recorded.
16. RM C acknowledged that the electronic documentation could have captured discussions more thoroughly.
17. RM C also stated:

'[Ms A] was provided with handheld notes during her initial booking, which included discussions about her diet and antenatal education. At each subsequent visit, additional information was added to her notes, and blood and scan forms were left inside the back of the notes for [Ms A] to complete. Unfortunately, [Ms A] stopped carrying these notes.'
18. Ms A refutes the statement that she stopped carrying the notes.
19. There are no blood test results in Ms A's antenatal record. When asked whether routine blood tests were taken and what the results were, RM C told HDC that normally she requests antenatal bloods routinely. RM C said that Ms A had already completed her first set of blood tests through her GP, and she obtained a copy of the results and discussed these with Ms A.
20. No first trimester screening scan or anatomy scan is included in the antenatal notes. An ultrasound report for a growth scan was completed at 29 weeks, with no notes made in the antenatal record as to why this scan was requested.
21. The 29-week scan noted marginal cord insertion³ and bilateral talipes.⁴ When asked whether RM C considered making a referral for these conditions and whether this was discussed with Ms A, RM C told HDC:

'If a decision is made to refer for bilateral talipes this would normally be carried out post birth not during the pregnancy. [Ms A] was aware of this decision and happy to wait until post-delivery of her baby. There was an Anatomy Scan at 29 weeks — I did not receive the results of the scan and was not aware of the marginal cord insertion.'

³ Abnormal umbilical cord insertion.

⁴ A condition in which the feet are rotated inward and downward.

22. RM C also told HDC that the visit schedule for Ms A did not meet the usual standards.⁵ She stated: '[T]he irregular schedule was because Ms A frequently cancelled and rescheduled her appointments, resulting in fragmented antenatal care.'
23. Ms A refutes this statement.
24. Mrs B and her whānau are concerned about the care Ms A received from RM C. Mrs B and the whānau told HDC that Ms A attended every antenatal appointment and took her health and the health of her baby seriously, trusting that every test and scan was being recommended and done during her pregnancy.

Fetal monitoring at 40+3 weeks

25. During the final antenatal visit at 40+3 weeks, Ms A advised RM C that she had noticed fewer movements of her baby since 10pm the previous night and had become worried.
26. RM C arranged with Ms A to go to Birthcare to carry out CTG monitoring. The CTG trace demonstrated a baseline fetal heart rate of 140bpm, which is considered within the normal range. RM C recorded in the antenatal notes that a CTG assessment had been arranged due to Ms A's concerns of reduced fetal movements at 40+3 weeks. There is no record of what was discussed, or comments from RM C about her interpretation of the CTG.
27. RM C told HDC:
- 'The findings from the CTG indicated that [Ms A] was experiencing early labour and I predicted that she would enter established labour within 24 hours. I informed her of this from my interpretation of the CTG, and she seemed to be in the early stages of labour. However, I should have recorded the results and discussion with [Ms A] and her partner. The baseline and CTG appeared to me to be within normal limits, therefore I did not consult.'

Transfer to Birthcare Huntly

28. Mrs B and the whānau referred to the birth plan and said that Ms A had made it clear that she wanted to deliver her baby at another location (Birthing Unit 2) because she knew the owner and it was closer to the public hospital in case of an emergency. In Ms A's antenatal notes, Birthing Unit 2 is noted as the intended location of birth, and this had been included at her booking visit.
29. Mrs B and the whānau recalled that in discussions between Ms A and RM C, RM C seemed to prefer Ms A to birth at Birthcare.
30. At approximately 1.20am at 40+4 weeks, Ms A started to experience the beginnings of labour pain. Mrs B said that she was able to make contact with RM C at around 3.03am, and at 4.05am RM C arrived at Ms A's house. An internal examination was not able to be completed, although there is no clear explanation of why, and RM C advised Ms A to move

⁵ Ms A had antenatal visits at 20+6, 26+3, 35+2, 36+2, 37+6, 38+5, and 39+3 weeks.

to Birthcare. Mrs B said that she was told that she could sit out on the deck at Birthcare (in response to the public health restrictions, which allowed only one support person in the birthing suite).

31. In response to the concerns around the change of birth location to Birthcare, RM C told HDC:

‘[Ms A’s] initial birthplace choice was [Birthing Unit 2]. Towards the later end of her pregnancy [Ms A] was anxious about her mother not being present at the birth due to COVID 19 restrictions and thought that a home birth might be a better option. However, this was changed [at 40+3 weeks]. I had mentioned Birthcare Huntly as an option as there was a deck outside the birth room where [Mrs B] could wait without ... entering the room. [Mrs B] was happy with this plan, and this was the reason I went to Birthcare Huntly. My rationale to direct [Ms A] and her whānau to Birthcare was based on the discussion with [Mrs B] who wanted to attend her daughter’s birth. I was trying to be accommodating however in hindsight this was not best decision.’

32. Ms A stated that this is inaccurate and that they moved to Birthcare on the advice of RM C.

33. RM C said that in preparation for [Ms A’s] arrival at Birthcare:

‘On route to Birthcare Huntly I rang the core Midwife on shift to inquire if I could bring [Ms A] to birth at Birthcare. The staff midwife raised no concerns, nor did I as I believed [Ms A] was a normal, well, pregnant mama in labour. I informed the staff Midwife [Ms A] wanted a waterbirth and requested she prepare the birth pool. I called [Ms A] to advise them to use the side entrance. [Ms A] arrived and entered the room and went straight into the pool. The room was set up by the core midwife.’

Monitoring during first stage of labour

34. Mrs B and the whānau said that at approximately 5.15am she, Ms A, and Mr A arrived at Birthcare, where Ms A went straight into the birthing pool. Mrs B raised concern that upon their arrival at Birthcare, no observations were taken, and the baby’s heartbeat was not being monitored ‘very often’, and the pool temperature was not checked.
35. RM D was on duty at Birthcare and received the calls from RM C saying that she was on her way with Ms A, who was not booked with Birthcare. In RM D’s retrospective records, she noted that at 5.30am RM C arrived, and RM D had not realised that Ms A had arrived until RM C told her that she had let in Ms A through the ranch slider.
36. RM D said that at approximately 5.40am she called out to RM C to check the temperature of the birth pool, as she had not done it. RM D said that RM C replied that she had checked it, and that Ms A was in the pool.
37. In response to the concerns raised around Ms A’s monitoring and the temperature of the pool, RM C said that Birthcare’s procedure during COVID-19 was that women in labour were not permitted to enter the building at the front entrance, and they were required to

enter through the ranch slider on the deck, directly into the labour and birth room, and Ms A was familiar with this entry as she had used it at 40+3 weeks. RM C said:

‘By the time I had made my way into the birth room, [Ms A] had already removed her clothing and climbed into the birth pool. Because of this, I did not have the opportunity to check the pool temperature prior to her getting in the pool. No dynamap or thermometer was available in the room for me to use or a portable BP cuff was set up in the room. There was a BP cuff permanently attached to the wall, but it did not reach the pool.’

38. Ms A disputed that she was already in the pool by the time RM C arrived.
39. RM C’s clinical notes from arrival at 5.15am until 10.40am are written in retrospect. RM C noted: ‘[Ms A] is enjoying the pool, now using gas with good effect, feeling well. Breathing through contractions ... Partner providing good support.’ There is a gap in documentation between 8.30am and 10.10am, which RM C explained was as a result of being actively involved in providing support to Ms A. RM C stated: ‘I was quite busy as I was the only person in the unit who was providing care during the labour.’
40. RM C told HDC that throughout Ms A’s labour, she was actively supporting her and coaching her through the labour pains, providing massage and cool cloths. RM C said:
- ‘I spent the duration of her labour providing this support while I was jotting down on the paper what the heartbeat was and actions I was taking during her labour. I was not offered any support from Birthcare staff throughout the duration of her labour and birth. This kept me quite busy as there was only myself, [Ms A] and partner in the room up until the stage where she started pushing. I could not write contemporaneous notes as I would normally do due to my taking an active role in the labour.’
41. No FHR is recorded between 5.15am and 7.10am. Several FHR recordings are noted within the retrospective notes but no times are recorded (see Appendix B). The rate slowly drops from 5.15am, when it is recorded as 142bpm, to 135bpm at 7.30am, 126bpm at 8.30am, 110bpm at 9.50am, 105bpm at 10.10am, then 102bpm.
42. Mrs B and the whānau noted in their complaint:
- ‘[RM C] is typing into a laptop which is up by the Ohio⁶ table a lot so much so that the clicking of the keyboard was annoying to [Ms A] she wishes she was more “present” and not so focused in presumably writing her notes in her laptop.’
43. RM C told HDC that the whānau were incorrect in their assumption of her using a laptop during the labour. She stated:

⁶ A table with a warmed pad for infants to lie on, which can be used during resuscitation.

'I generally do not make electronic notes during labour as I found it challenging to support the mama and make electronic notes. I usually make written notes and transfer them electronically at a later stage. I did use my phone, however, to present a text message to other patients to cancel my day. I recognise this could have been seen as me using my iPad.'

44. RM C's retrospective records state that Ms A was given IV fluids at 7.30am, but no rationale for this is recorded. RM C acknowledged that she should have documented a clear rationale for this action. She stated: '[Ms A's] fluid intake was minimal during the labour, she had appeared tired and [I] made the assessment that IV fluids could possibly benefit.'
45. There is no record of Ms A's heart rate being checked or recorded other than at 9.05am when it is documented as 72bpm. A comment at 9.50am notes that the heart rate was checked but the rate is not recorded.

Consideration of transfer to the public hospital from Birthcare

46. RM C's clinical notes at 9am record that she 'discussed going to the public hospital for help to assist with birth. Happy with progress await if not delivered by 10am to transfer to hospital.' However, there is no further explanation as to why this was being considered.
47. In their complaint, the whānau said that at no time was RM C's consideration of a possible transfer to the public hospital put to them as a whānau, and they were not asked to make a decision on this, and they were not happy about progress, as stated by RM C in her retrospective notes. The whānau said that they followed the advice and instructions of RM C as the professional in charge.

Care provided during final stage of labour

48. Mrs B and the whānau raised concerns around monitoring of the baby during the final stage of labour, and the lack of documentation. RM C told HDC that she disagreed with the whānau's recollection of the baby's monitoring. She said:

'During labour, I monitored [Ms A's] baby and took notes while also helping [Ms A] through the process. When [Ms A] entered the second stage of labour, I listened to the baby's heart rate between contractions. Looking back, I should have requested assistance from the Birthcare staff to help me manage my responsibilities more effectively.'

49. The labour records note that Ms A attempted some pushes in the pool and was told by RM C to hold and wait for contractions and to push with them, not in between. An internal examination had been completed in the pool at approximately 6.15am, but it is not clear from the retrospective notes whether Ms A was fully dilated at this time, and there is no documentation of when Ms A's membranes ruptured, but there is a note that a lip of cervix was present. RM C recorded that Ms A was advised to hold off pushing and 'wait until the last bit of cervix [had been] removed'.

50. RM D describes hearing active pushing with some coaching between 6am and 6.55am. She quoted RM C as saying: 'Down into your bum not into your throat.' RM D recorded that at approximately 7.10am during handover to day staff, RM C came out of the birthing suite and reported to RM D and RM E that there was still a lip of cervix, so Ms A had been discouraged from pushing.
51. Birthcare's delivery summary noted the time of full dilation as 9am; however, RM C recorded in retrospect that that at 7.30am Ms A was out of the pool and lying on the bed, and she was fully dilated. Between 8am and 8.30am Ms A was noted as pushing, with caput⁷ and mucousy discharge noted.
52. In their complaint, Mrs B and the whānau recall that Ms A was struggling to push and was unsure what to do but was trying so hard every single time, becoming more and more exhausted. They also said that RM C was not listening to the baby very often.

Delivery and resuscitation

53. Mrs B said that when baby's head finally pushed through, she observed baby's poor colouring and the cone shape of his head, and she recalled RM C saying not to worry as it was just because he had been in the cervix so long. In the next big push, Ms A was able to deliver her baby. Mrs B said that RM C placed him on Ms A and he did not make a sound, then she quickly took him off her chest and cut his cord. Mrs B recalled seeing some meconium by baby's mouth.
54. RM C's notes at 10.10am record:

'The FHR is noted as 105 bpm well done. Mum helping to support [Ms A] pushing, FHR 102 bpm, good pushing baby advancing spontaneous delivery — male infant in poor condition ... no response with stimulation, transferred onto ohio table — not responsive, called to staff for support.'
55. RM E documented that at approximately 10.36am there was a call from Birth Room one (Ms A's room), the same time at which RM F said that the LMC might need a hand. RM E stated that she went into the birth room and RM C was rubbing baby to stimulate him, and she said she needed help. RM E said: '[RM C] said baby is not breathing, I turn the apgar monitor⁸ on and asked what time was baby born, LMC responded she did not [know] ...'
56. RM E said that RM C put baby onto the Ohio table and then took the oxygen bottle from under the table. RM E stated that she had to find a stethoscope then she checked for baby's heart rate and took the oxygen blender from the cupboard and set it up. At this time, RM F was helping RM C with the resuscitation. RM E was then asked to call an ambulance. Another LMC, RM G, was at Birthcare at the time, and she was asked to assist.

⁷ An area of swelling in the scalp of a newborn, caused by pressure of the scalp against the dilating cervix.

⁸ The APGAR score is used to assess the condition of a baby at birth and is calculated at 1 minute and again at 5 minutes. It is an evaluation used to quickly identify a baby who needs resuscitation by assessing colour, respiration, heart rate, reflexes, and muscle tone with scores of 0, 1, or 2 being given for each parameter.

57. RM C told HDC that RM F initially directed the resuscitation and administered the bag valve mask. RM C said that she commenced chest compressions and continued until the ambulance arrived. After consulting with the public hospital NICU, the core midwife on duty, RM E, administered adrenaline following instructions from RM F.
58. In their retrospective notes, RM F and RM E both noted that baby had a large caput on his head and bilateral talipes and was very white in colour. RM E also noted 'meconium staining on baby'.
59. RM C said that she did not see any evidence of meconium staining on baby's body. She stated:

'However, I do agree that there was a small amount of meconium present when I suctioned baby's mouth. This was not thick meconium. Furthermore, the placenta was not stained with meconium as reported by Birthcare midwives. I recall checking the placenta for completion. After removing placenta samples post-delivery and taking cord blood, I believe I would have noted if the placenta was stained with meconium to a degree of visibility as reported by Birthcare midwives. I returned the placenta to the whānau.'

60. RM F's retrospective clinical records note that at 10.36am she arrived at the birth room and took over from RM C and gave baby a good rub with no response. At this time the Neopuff (infant resuscitator) was being retrieved from the back room and the oxygen still needed to be blended. RM F recorded:

'Mask applied by myself with a c grip under the chin and 5 slow long puffs were given. No response after the 5 long inflation breaths, advised LMC to start heart compressions. Lots of thick [meconium liquor] came out of mouth and nose, LMC got suction to clear out mouth. Oxygen increased to 70%.'

61. RM C's response to HDC acknowledged that she did not have sufficient resuscitation equipment ready in anticipation of Baby A's birth. She stated:

'However, I recognised [Baby A] was compromised immediately after birth and summoned for assistance. If a delay was noted between me requesting assistance to [RM E] entering the room, the delay was her response to recognise my need for urgent assistance. There is no emergency bell located in the birth rooms at Birthcare. To request emergency assistance, the Covid policy at the time was a LMC midwife must use the phone in the delivery room where calls are directed through the switchboard and then diverted to the hand-held phone the midwife holds. I used the phone installed in the room immediately and waited for assistance while continuing care. No onsite staff raised any concern about length of labour or enquired about the progress of labour.'

62. At approximately 10.40am, vitamin K was drawn up by RM E and given to baby with no response. RM F asked RM G to call NICU, and at 10.42am RM G conveyed to NICU that

ongoing full neonatal resuscitation had been underway for 7 minutes with no response from baby, and she was requesting advice.

63. RM G noted that she was told that the obstetric registrar was just heading into theatre and to call the Associate Clinical Nurse Manager (ACNM) instead. RM G then phoned the NICU ACNM and was advised to administer adrenaline. RM G stayed on the phone to NICU.
64. At approximately 10.47am, RM E administered adrenaline to baby's left leg while heart compressions and Neopuff inflations continued. However, there was no response from baby, and the oxygen was increased to 100%.
65. RM F noted that no fetal heartbeat was found, visually baby was very pale, and there was no response. The Neopuff and heart compressions continued.
66. The ambulance and fire crew arrived at Birthcare at approximately 10.50am, at which time RM F noted that she stepped aside and checked on mum and whānau.
67. RM G continued to relay information from the NICU staff, and a second dose of adrenaline was advised and administered. RM G noted that NICU advised the insertion of a UVC⁹ and then transport to the public hospital while continuing resuscitation en route. The call ended at approximately 10.56am.
68. RM G noted that at approximately 11.10am the placenta was checked. She recorded:

'[Placenta] appears complete, tissues noted gritty and greyish in colour, membranes appear complete, mild meconium staining. Two vessels were clearly identifiable in cord, third vessel uncertain.'
69. At 11.18am, RM G called the NICU ACNM to advise that the hospital no longer needed to prepare for arrival, as the advanced paramedic had determined that continued efforts to revive the neonate were not to go ahead, and the heart was in asystole.¹⁰

Communication with whānau following delivery and resuscitation

70. The whānau told HDC:

'This day changed our lives forever, we will never be the same people, ever. The hurt that stemmed from this day has been ongoing. The pain of a baby being born in such a way is of course unbearable but there are key incidents that hurt our whānau and this mamae (pain) remains ... When our baby was being resuscitated and worked on, on the ohio table, no one communicated to us what was happening! Not the LMC or the staff of Birthcare Huntly ... nothing was said to us, we were left there to watch in horror and guess what was going on.'

⁹ Umbilical vein catheter.

¹⁰ No electrical or mechanical activity of the heart.

71. Mrs B spoke about standing at the bedside of her daughter, holding her hand and asking twice what was happening, in a measured voice not wanting to distress her daughter, but not being given an answer. She stated:

‘[Ambulance service] staff enter the room; they use defibrillator paddles on the baby. No success. [RM F] comes over to the bed to us ... still nothing said about what is happening.’

72. Mrs B said that a man came into the room and examined baby then spoke with RM C and ambulance staff. ‘Then everyone in the room moved away from baby, everybody and left him alone on the Ohio table, it was so sad.’

73. Mrs B said that she went to baby and lifted him off the Ohio table, and it was at this time that she realised that he had passed away. She told HDC:

‘No one said he was gone that they had finished trying ... not one person in the room told us or verbalised to us that “sorry your baby has passed away” no one ... [Ms A] is still on the bed, placenta delivered, still unaware of what has happened, asking ... if her baby is alright, “Mama is he ok?” “Mum, what’s happening?”’

74. Mrs B said that because of the lack of communication to their whānau, they had no knowledge that baby had not taken a breath and did not have a heartbeat at the time of birth. Mrs B stated:

‘[B]ecause we heard his heartbeat at stages during his birth or what we thought was his heartbeat ... [w]e assumed that he had lived and had then died on that Ohio Table, because no one communicated to us otherwise. We his whānau had to assume that once everyone in the room walked away from the Ohio Table and left him lying there on his own.

We did not come to understand that in fact he was born stillborn until 4 days after his birth after talking to the Head Midwife of Delivery Unit [at the hospital] who took the time to explain this to us.’

Ms A’s postnatal care

75. The whānau raised concerns around the care provided to Ms A following delivery of her baby. Following a night of pain and high temperatures, Ms A was taken to the public hospital by ambulance. The whānau were advised by the treating specialist that Ms A had a primary diagnosis of postnatal sepsis, urinary tract infection, and pregnancy-induced hypertension.¹¹ The clinical records also note that a second-degree tear had ‘not [been] sutured and [was] infected’.
76. RM C said that the inspection of Ms A’s perineum was done by RM F at Birthcare, and the second-degree laceration was noted. RM C stated: ‘[Ms A’s] perineum had been assessed by [RM F] who advised of a secondary tear that she assessed as not requiring suturing.’

¹¹ High blood pressure.

77. The clinical notes contain no mention of an examination of Ms A's perineum, but a tick-box in the delivery summary records it as being 'intact'.
78. RM C told HDC that prior to Ms A's discharge, clinical assessments she conducted following delivery included a check of Ms A's blood pressure, heart rate, blood loss, and fundus.¹² However, these observations were not documented and Ms A's temperature was not taken, and the time of Ms A's discharge home from Birthcare was not recorded.
79. RM C said that following the delivery she had minimal support from Birthcare to help with postnatal care. She stated:
- 'I took postnatal observations at the best opportunity. I agree I should have taken her temperature, however, after [Ms A] finished in the shower, she left the room and sat inside her vehicle with her partner ... Under the circumstances I did my best to carry out [Ms A's] postnatal observations and provide a comfortable space for the whānau ...'
80. Ms A refutes this statement.
81. The whānau's complaint noted that following their return home from Birthcare, Mrs B sent a text message to RM C asking about pain relief for Ms A, and she was advised that Ms A should take paracetamol. The following day, RM C sent a text message to Mrs B regarding a check-up for Ms A and to see whether Ms A would prefer another midwife. Mrs B confirmed that Ms A wanted to see another midwife.
82. The midwife arrived at the house at approximately 11.45am. On examining Ms A, the midwife advised Ms A that she needed to go to the public hospital, so an ambulance was called. The following day, Ms A underwent surgery to repair the perineal tear. She remained in hospital for a further four days.

Communication and cultural safety following baby's stillbirth

83. In their complaint, the whānau spoke of the distress and disbelief not only of losing their baby, but also of navigating the process following a stillbirth. Mrs B said that after some time had passed, when everyone had left the birthing room, she had to go to find RM C to ask what would happen next. Mrs B said that she was advised that she could take baby home if she wished to, and that Mrs B could get up and have a shower and go home too.
84. Mrs B said she asked, 'I can take a dead baby away from here?' believing there must be some legalities around taking a deceased baby from the premises. She said that she was advised: '[Y]es if that's what you wish to do.'
85. Mrs B told HDC that RM F spoke to her about whether Ms A wanted a post-mortem and advised that this could be done at the public hospital, with swabs, angel casting, and photos. Not understanding the purposes of completing a post-mortem, Ms A declined the post-mortem, stating that she did not want her baby hurt any further.

¹² Top of the uterus.

86. RM F also advised that the swabs could be done at Birthcare, and they could take a piece of baby's placenta to send away for testing, and she would advise RM C.
87. RM C told HDC that RM F took the lead in providing information to the whānau regarding post-mortem options. RM C stated:
- 'They were encouraged to take [Baby A] to [the public hospital] for appropriate swabs and a post-mortem. The whānau declined and wanted to take [Baby A] home. The whānau subsequently requested placental test and swabs from [Baby A]. I carried out the Cord Blood, placental sample. Not all swabs could be carried out as [the] unit did not have the appropriate number of swabs to carry out the full range of tests.'
88. Mrs B described the room as being left in disarray, with soiled linen left lying around, until she specifically asked for the room to be cleaned up. She stated:
- '[I] [f]ound [RM E], asked if the room could be cleaned up and dirty stained linen etc be taken away. The room was paru¹³ and we were still sitting around in remnants of our baby's traumatic event. It was depressing and distressing not to mention disrespectful.'
89. Mrs B said that several times she had to go out of the room to look for RM C. She said: 'No one is in the room to support us, guide us and awhi us ... we were alone.'
90. Mrs B told HDC that they wanted to bathe baby. She said: '[W]e didn't want to take him home covered in his blood and meconium. We wanted him to have dignity restored and be loved and looked after.' Mrs B said that again she needed to go to find a midwife so that they could arrange this.
91. Sometime afterwards, RM C came to the door and advised Mrs B and the whānau to take baby to a separate room on the other side of the adjoining bathroom/toilet. Mrs B and Mr A's mother bathed baby. It was noted that RM C was in the room at different times.
92. Mrs B said she also needed to ask if baby could be weighed and measured, as the whānau had no idea of his weight and measurements.
93. Mrs B said that after baby had been dressed and taken back to his parents in the room:
- 'We took photos of our baby with his mummy and daddy on the bed, the saddest photo shoot in the world. No one can imagine how painful this was for [Ms A] and [Mr A], no one. [Ms A] and [Mr A] went to wait in their vehicle. They didn't want to be in that room any longer.'
94. Mrs B said that she went out to reception again to find RM C to advise that they were ready to leave. Mrs B spoke with RM F and was advised that a form needed to be filled out first, which she would bring to the room.

¹³ Dirty.

95. At this time, when the whānau were ready to leave, RM F gave them a 'Transfer of body' form to be completed and signed. Mrs B said:

'It was hard and traumatic and distressing to do 2 hours after losing her mokopuna. The form states "full description of place where you intend to dispose of the body" — how difficult is that to read, as the grandmother of the baby who had just died in childbirth. The word dispose haunts us.'

96. In response to the concerns of the whānau, RM C said that under the circumstances she did her best to carry out Ms A's postnatal observations and provide a comfortable space for the whānau. She stated:

'I assisted the whānau to my best ability during a stressful event. [Mrs B] assisted [Ms A] to the shower. I recall [Mrs B] coming out of the room to request extra towels and bedding. I asked if she needed a hand, [Mrs B] declined. I later supported both [Mrs B] and [Mr A's] mother to bathe and dress their mokopuna. I supported the whānau to take photos of [Baby A].

I do agree that I should have provided further assistance to provide a more culturally appropriate space for whānau and provide an opportunity for whānau to meet with me to debrief.'

97. In their complaint, the whānau spoke of the confusion and hurt experienced when the Certificate of Cause of fetal and neonatal death (medical certificate) was not filled out correctly. Mrs B said that they needed to pick up the medical certificate from Birthcare Huntly because RM C had not signed the form properly.

98. Mrs B said that when they read the certificate, it stated that baby was born at 10.30am and the time of death was recorded at 11.18am. The whānau were torn and confused, as what was written on the form led them to believe that their baby had lived and had died after birth, only to be advised later by RM Barnes that the certificate had been filled out incorrectly. Mrs B said:

'This was the first time that the family had had confirmation that their baby never took a breath or that he didn't have a heartbeat when he was born. Before this moment no one had told us that baby had been born stillborn, well no one had ever told us that baby died in the first place, we were all just left to assume, so again all new information.'

Birthcare Huntly's internal investigation

99. Birthcare completed a root cause analysis investigation. The purpose of the investigation was to understand why Baby A had been stillborn and to identify whether anything could have been done to prevent this outcome.
100. The investigation identified seven areas of concern:

1. During the time Ms A was in labour at Birthcare, there was very little evidence of coordination and communication between RM C and Birthcare staff. The core equipment, eg, clinical notes package/room folder, the blood pressure monitor and emergency equipment were available but not sought out by RM C or actively offered by Birthcare staff.
 2. The documentation record was not of an appropriate standard. Elements required by the Midwifery Council of New Zealand Standards (eg, care decisions with rationale, dates, times, a record of the narrative) are missing in the documentation.
 3. From the available information, it appears that the care provided by RM C regarding the monitoring during labour and delivery, did not adhere to Birthcare policies.
 4. The emergency bell was not activated, and the emergency resuscitation equipment (Neopuff and oxygen blender) was not immediately available as per policy.
 5. There is limited contemporaneous documentation surrounding the resuscitation.
 6. Clinical signs, including a lack of breathing effort at birth, an undetectable heart rate and the presence of meconium in the airways, suggest that Baby A was in a state of terminal apnoea at birth. This cannot be confirmed without formal investigation (eg, post-mortem).
 7. Ms A and her whānau did not receive clear communication from staff during the resuscitation efforts. Sadly, even after the resuscitation effort was stood down, Baby A's passing was not well communicated to them. It was not until some days later that they learned that he was stillborn, as they had believed that baby had been born alive but passed away shortly afterwards.
101. In response to the areas of concern identified, Birthcare Huntly's recommendations included:
1. The Unbooked Woman Arriving at a Birthcare Facility policy should be reviewed to clarify the criteria and expectations for LMCs who want to bring a client to Birthcare at short notice. LMCs and Birthcare staff should be made aware of the registration process and ensure that the process is followed.
 2. A protocol should be developed that sets out the expectations and responsibilities for communication between the LMC and Birthcare staff when a client is in labour. The unit manager or shift midwife should maintain communication with the LMC at regular intervals during the course of the labour, to ensure the LMC is adequately supported, and that unit staff are alert to any complications.
 3. Future in-service education should include a neonatal resuscitation scenario to ensure that staff have the opportunity to practise their skills with their colleagues. Specifically, training should focus on communication during clinical emergencies, assigning roles during resuscitation, such as a scribe to document, as well as practical skills. This would be in addition to the mandatory emergency skills training undertaken annually. Training should include communication with clients and families, both during the

resuscitation effort and in the time afterwards. Staff should be equipped with the skills to navigate these difficult conversations.

4. The Birthcare Stillbirth Policy should be reviewed to ensure that any learnings from this incident are used to inform future practice. A recommendation from Ms A and her whānau is that all women who experience a stillbirth or neonatal death are transferred to secondary care to ensure that they are counselled appropriately about the options available to them (for example, postmortem, placental tests, the bereavement service).
5. Ms A and her whānau should be offered the option of mediation with the staff involved — a service provided by the New Zealand College of Midwives Resolution Committee. This option was discussed at a meeting with Ms A and her whānau but the offer was declined.

Competency review

102. RM C underwent a competency review by the Midwifery Council of New Zealand, during which she practised under supervision. Following the process, in April 2022 the Council was reassured that RM C met the competency requirements for entry to the Register of Midwives and she was no longer required to practise under supervision. However, it was recommended that she engage in professional mentorship and practice development, specifically around documentation.

Responses to provisional opinion

103. Ms A and her whānau were given an opportunity to comment on the information gathered during the investigation section of the provisional opinion. They reiterated the impact this event has had on their lives. Mrs B stated: ‘Our lives changed forever, we will never be the same, never.’
104. RM C was given an opportunity to respond to the relevant sections of the provisional opinion. RM C acknowledged and accepted that:
 - a) There were shortcoming in the standard of care she provided to Ms A;
 - b) Aspects of her documentation could have been more detailed and completed to a higher standard; and
 - c) These matters warrant criticism and RM C is prepared to accept that they amount to a breach of the Code.
105. RM C also accepted the recommendations proposed in the provisional opinion (set out below).
106. RM C provided a Tikanga response to HDC, acknowledging Ms A’s and her whānau’s grievances regarding the lack of cultural support, and expressing regret that they were not provided with the support they were right to expect. This response has been provided to the whānau.

107. Birthcare was given an opportunity to respond to the relevant sections of the provisional opinion. It noted that Birthcare Huntly is now closed, but it has no hesitation apologising to Ms A and her whānau on behalf of Birthcare.
108. Birthcare stated that previously RM C worked at Birthcare Huntly, and prior to that role she had been an LMC with an access agreement to Birthcare for many years. Birthcare stated: '[I]t is incomprehensible that she was any way deficient in terms of knowing anything about Birthcare Huntly.'

My opinion

109. I acknowledge the significant loss for Ms A and her whānau. I also recognise the courage of the whānau in sharing their mamae and bringing their concerns to the Commissioner.
110. My report has focused on the following areas of concern surrounding the standard of care provided to Ms A while under the care of RM C and Birthcare Huntly:
1. The standard of antenatal care provided to Ms A by RM C during her pregnancy, from 20 weeks' gestation.
 2. The management of Ms A's labour.
 3. The standard of care surrounding the resuscitation.
 4. The standard of Ms A's postnatal care.
 5. The communication and cultural safety following baby's stillbirth.

Opinion: RM C — breach

Antenatal care

111. Ms A registered with RM C at 20+6 weeks' gestation. Ms A attended eight antenatal visits with RM C before her labour and delivery at Birthcare Huntly.

Documentation

112. Standard three of the New Zealand College of Midwives (NZCOM) *Midwives Handbook for Practice* provides that '[t]he midwife collates and documents comprehensive assessments of the woman and/or baby's health and wellbeing'. The criteria include personal and family/whānau details, physical, psychological, emotional wellbeing, cultural and spiritual dimensions, physical, social and cultural environment, and that '[t]he midwife documents her assessments and uses them as a basis for ongoing midwifery practice'.
113. Prior to 40+3 weeks, RM C's clinical notes from Ms A's antenatal visits record only basic results such as blood pressure, urine analysis, fundal height, and presentation of the baby, with no detailed commentary. Only the CTG assessment at Birthcare Huntly at 40+3 weeks, following Ms A's concerns of reported reduced fetal movements, is recorded.

114. My independent advisor, RM Mary Wood, also noted that very little family history is included in the notes, and the antenatal record does not indicate the reason for the growth scan at 29 weeks' gestation.
115. Further, no anatomy scan report or first trimester screening scan is included in the antenatal notes. RM Wood advised that while Ms A was already 20+6 days into her pregnancy and that these scans may have been requested by another provider, either way RM Wood would have expected them to be included as a part of a comprehensive antenatal record.
116. While there is mention in the antenatal notes of where Ms A intended to give birth (Birthing Unit 2), there is no written record of Ms A's birth plan.

Blood tests

117. There are also no blood test results in Ms A's antenatal notes. The whānau raised concern that no routine blood tests were completed for Ms A while she was under the care of RM C. RM Wood advised:

'While some midwives may choose not to request 36-week bloods, depending on individual circumstance, it would be very unusual in my experience for 28 week bloods not to be done. It is at this time antenatal diabetes screening is done and it is at this time when most midwives will evaluate the women's full blood count (FBC) ... I would consider this to be a moderate departure from acceptable standards of care.'

118. RM C told HDC that normally she requests antenatal bloods as a routine, but Ms A had already completed her first set of bloods, and these results were discussed with Ms A. However, the results are not included in the antenatal records.

29-week ultrasound scan

119. Ms A had a growth scan at 29 weeks. The results showed bilateral talipes and marginal cord insertion. RM C said that she did not receive the results of the scan and therefore was unaware of the marginal cord insertion. She also said that if a decision was made to make a referral regarding bilateral talipes, this would be carried out post-birth.

Frequency of visits

120. Ms A's antenatal notes indicate that RM C saw Ms A at 26 weeks and then at 35 weeks' gestation, after which weekly visits took place. RM Wood advised:

'The frequency of visits increases after 28 weeks because this is from when fetal growth is monitored more closely, usually by fundal height measurements and it is also a time when monitoring for complications of pregnancy such as pre-eclampsia becomes important. The antenatal schedule of visits does not fit within the expected standard of antenatal care midwives provide and I would regard this as a moderate departure from expected standard.'

121. RM C agreed that the visit schedule for Ms A did not meet the usual standards; however, RM C said this was because Ms A frequently cancelled and rescheduled her appointments.

Fetal monitoring at 40+3 weeks

122. When Ms A raised concern about reduced fetal movements, RM C advised her to complete CTG monitoring at Birthcare Huntly. RM Wood noted that while the trace demonstrated a baseline fetal heart rate of 140bpm, which was in the normal range, the CTG should have been continued for a longer period given the reduced variability and the possibility of decelerations at the beginning and the end, together with the fact that reduced fetal movement had been reported by Ms A.
123. RM Wood noted that she was unable to find any comments by RM C about her interpretation of the CTG, or any indication that she had any concerns about it. RM Wood considered that the failure to continue the CTG for a longer period was a mild departure from the acceptable standard of care.

Discussion — antenatal care

124. I find the standard of antenatal care provided to Ms A by RM C concerning. RM Wood was critical of the adequacy of RM C's antenatal care and monitoring and considered this well below the expected standard of care. RM Wood advised:

‘If [RM C] did not have any discussion nor offer information sharing during [Ms A's] pregnancy other than basic recordings I would regard this as a significant departure of care.’

125. I note that RM C explained that she did have discussions with Ms A around antenatal education and diet. However, the antenatal records are sparse and do not provide information about any discussions with Ms A. RM C acknowledged that the electronic documentation could have captured discussions more thoroughly. Further, the reasoning for requesting a scan at 29 weeks is not recorded, the earlier antenatal scan and blood test results are not included, and there is no recorded birth plan. In my view, the standard of RM C's record-keeping fell well short of acceptable standards, including the NZCOM guidance in the *Midwives Handbook for Practice*. In the absence of detailed documentation, I am unable to conclude that appropriate antenatal discussions with Ms A occurred.
126. RM C had a responsibility to Ms A and her whānau to ensure that the wellbeing of Ms A and her baby was assessed adequately during Ms A's antenatal care. Ms A trusted RM C to provide guidance and support during her pregnancy, which included education and guidance to complete relevant assessments and tests. Although RM C has said that it is her usual practice to request routine blood tests, in the absence of any evidence that she did so, I do not accept that this occurred for Ms A. I am particularly concerned that a 28-week blood test was not requested by RM C, as this was an important juncture at which to consider gestational diabetes and the woman's full blood count.
127. The frequency of antenatal visits also did not meet the expected standards, particularly after 28 weeks, when they should have occurred fortnightly. While RM C explained that this was because of regular rescheduling and cancelling of appointments, I do not accept

that a period of seven weeks (from 28–35 weeks' gestation) is an acceptable interval between visits at this stage of pregnancy, when monitoring becomes more critical.

128. I note with significant concern RM C's dismissive remarks (noted in paragraph 20) in which she states that she did not receive the results of the 29-week ultrasound scan and therefore was not aware of the marginal cord insertion. As the clinician responsible for ordering the scan, she was responsible for following up on the results and ensuring that appropriate action was taken. In the circumstances, I consider that the reporting of the marginal cord insertion and bilateral talipes warranted specialist follow-up with either an obstetrician or a neonatal fetal medicine specialist to ascertain the significance of the findings and, in particular, whether they represented any syndrome that may have required further investigation.
129. I am also critical that at 40+3 weeks, RM C did not undertake a longer period of fetal monitoring via CTG in the context of reduced variability and possible decelerations at the beginning and end, and that she did not document her interpretation of the CTG in the clinical records.
130. I accept RM Wood's advice in relation to RM C's antenatal care having fallen below the accepted standard. RM C had a responsibility, as Ms A's midwife, to ensure that Ms A received antenatal care of an appropriate standard. For the reasons set out above, I consider that this did not occur.

Management of labour

Transfer to Birthcare Huntly

131. Ms A's labour began in the early hours of the morning. Following a home visit, RM C advised Ms A to move to Birthcare Huntly. The whānau raised concern that Ms A's place of birth was changed from the preferred venue to Birthcare Huntly. I acknowledge RM C's reasoning for moving to Birthcare Huntly in response to the public health restrictions, and I consider that this was not unreasonable. However, I am concerned that there is no documentation of any discussions with Ms A or her whānau that would support Ms A having been well informed about the reasons for changing her intended place of delivery.

Maternal and fetal observations

132. When Ms A arrived at the birthing suite, she went straight into the birthing pool. There is no record of the pool temperature having been taken. In addition, no FHR is recorded between 5.15am and 7.10am, and several FHR measurements are recorded in the retrospective notes with no times noted. There is no record of the maternal heart rate having been checked or recorded other than at 9.05am, when it is noted as 72bpm, and at 9.50am, when the heart rate was said to have been checked but no rate is recorded.
133. RM Wood advised that the accepted standard of midwifery care for monitoring the wellbeing of a woman and baby during the labour process involves baseline observations of the woman, including initial blood pressure, temperature, and heart rate, and then four-hourly observations if all is normal. Further, the baby's heart rate should be assessed immediately after a contraction every 15 to 30 minutes during the active part of the first

stage of labour, then every 5 minutes or after every contraction during the second stage of labour.

134. RM Wood advised that RM C's lack of regular monitoring and recording of the maternal heart rate during labour, especially during the second stage, was a significant departure from the acceptable standard of care.
135. RM Wood advised that during the labour, particularly the active pushing stage, there is no way of knowing whether RM C was actually listening to the baby or to the maternal pulse. RM Wood stated:

'During the second stage of labour it can be sometimes challenging to pick up the fetal heart after every contraction. Sometimes when using a doppler through this time, just as you find the fetal heart another contraction begins so the woman may be moving which can make it challenging to locate and monitor the fetal heart rate for a reasonable length of time ... The reason that monitoring of a baby through this stage is more intensive is because this is the time that the baby is most likely to show signs of becoming distressed.'

136. RM Wood also commented that RM C recorded in her retrospective notes that the fetal heart rate was auscultated approximately every 30 minutes, and she described what would seem to be some decelerations of the fetal heart rate during contractions when Ms A was pushing. RM Wood noted that this is a common occurrence during this stage of labour, but without the maternal heart rate being recorded it is not possible to know what was actually being heard.
137. The FHR was recorded as slowly dropping between 5.15am (142bpm) and 10.10am (102bpm). RM Wood advised that it was likely to have been the maternal heart rate heard just prior to the birth rather than the FHR. RM Wood stated:

'If [RM C's] description of her monitoring of the fetal heart rate is correct then I would regard this as a moderate departure from the expected standard of care because of the lack of maternal pulse being noted at the same time, the failure to auscultate the fetal heart rate at the generally recommended and expected intervals and the failure to notice the apparent dropping baseline fetal heart rate. There is no fetal heart rate recorded between 0515 and 0710 despite [Ms A] being in the last part of the first stage of labour and her labour being described as progressing rapidly.'

138. Having baseline information in the form of maternal observations and regular fetal monitoring is essential for safe care during labour. Regular observations are important to ensure that emerging trends in a woman and her baby's wellbeing can be monitored. I am particularly concerned at the lack of monitoring of Ms A (in particular, the lack of temperature, blood pressure, and heart rate checks) and her baby's wellbeing (in particular, the irregularity of the FHR auscultation) throughout the labour.

Pool temperature

139. RM Wood advised that when a woman is using a pool for pain relief and relaxation, baseline observations are to be done prior to entering the pool, and the pool temperature and maternal temperature are to be checked hourly and recorded, with the aim of maintaining the water temperature between 35.5°C and 36.5°C during the first stage of labour and increasing that to a maximum of 37°C during the second stage of labour if the intention is for the woman to birth in the water.¹⁴ The Birthcare guidelines for water birth also note that the temperature should be measured hourly and documented on a partogram.¹⁵
140. I do not accept RM C's explanation that she did not have time to check the pool temperature prior to Ms A getting into the water. In my view, RM C could have done this once Ms A had entered the pool, to ensure that it was kept at a safe temperature. If no portable equipment was available to RM C in the room, I would have expected her to request assistance to locate the equipment elsewhere at Birthcare, particularly considering RM D's recollection that she reminded RM C to check the pool temperature. It is also concerning that according to RM D, when asked, RM C replied that she had checked the temperature of the water, which clearly was not correct.
141. RM C failed to satisfy herself that the temperature of the birthing pool for Ms A and baby was appropriate. The failure to complete pool temperature checks fell short of the appropriate standard of care.

Retrospective documentation

142. RM C's clinical notes were written in retrospect from the time of Ms A's arrival at Birthcare at 5.15am until 10.40am, and a gap in the documentation is noted between 8.30am and 10.10am. RM C told HDC that throughout Ms A's labour, she was actively supporting her and coaching her through the labour pains, and the gap in documentation was a result of being actively involved in providing support to Ms A. RM C stated: 'I was quite busy as I was the only person in the unit who was providing care during the labour.'
143. RM Wood advised that this was not in keeping with the acceptable standard of documentation and would be unusual in general midwifery practice. She stated:

'[T]here is normally only one midwife with the woman during the labour process if everything is progressing normally so this should not be a barrier to recording the process of her labour as it unfolded in normal circumstances.'

¹⁴ NZCOM Consensus Statement: [The use of water for labour and birth / Water for Labour and Birth](#), National Women's Health [NZCOM Practice Guidance document 2020 Intermittent Auscultation for the assessment of Intrapartum Fetal Wellbeing](#).

¹⁵ A composite graphical record of key data (maternal and fetal) during labour entered against time on a single sheet of paper. Relevant measurements may include statistics such as cervical dilation, fetal heart rate, duration of labour, and vital signs.

144. Whilst I appreciate that RM C was appropriately taking time to support Ms A through her labour, it is my view that this should not have prevented her from making contemporaneous clinical records.

Omissions in documentation during labour

145. RM C noted that at 7.30am Ms A was administered IV fluids, but no rationale is documented for this. In addition, RM C did not record when the membranes ruptured, whether any membranes were felt, or the presence or lack of liquor, although a mucousy discharge was noted.
146. RM Wood advised that oligohydramnios¹⁶ around a baby is an indication that either the membranes had ruptured at some time prior to the labour, or that the placenta was no longer functioning well (placental insufficiency). Anhydramnios (no liquor present) is a considerable risk factor and an indication for transfer of care because of the increased risk of cord compression during contractions, and because a lack of liquor may indicate a problem with the placenta. It would also warrant close continuous monitoring of the fetal heart rate during labour. RM Wood stated: 'It would appear from the available notes and reflections that this was never considered [by RM C].'
147. The records contain no mention of meconium having been seen during the labour. RM Wood advised:
- 'There is no mention of meconium being noted through the labour although it was clear from the presence of meconium coming from [Baby A's] mouth and nose during the resuscitation that there had been meconium aspiration. Meconium staining of the placenta was noted and [Baby A] had meconium on his body at birth which was noted by the Birthcare midwives and the whānau. This scenario would be in keeping with anhydramnios as meconium is thick and sticky so the passage of meconium may be hidden if there is no liquor around the baby. If there is at least some liquor present it would most likely have been noted as meconium stained and have been observed during the second stage when active pushing is happening.'
148. Having considered the accounts of the whānau, the Birthcare midwives, and RM C, there is more evidence supporting that meconium was seen on Baby A's body at delivery. Therefore, I find that meconium was present on Baby A's body.
149. From the information gathered it is not clear when Ms A's second stage of labour began. RM C's retrospective notes describe Ms A as pushing between 8am and 8.30am. However, RM D said that between 6am and 6.55am she heard RM C encouraging active pushing.

¹⁶ Reduced liquor.

150. I also note that Birthcare’s delivery summary includes the time of full dilation as 9am, but the retrospective clinical notes state that an anterior lip of cervix¹⁷ was present from 6.15am until 7.30am, when full dilation was confirmed by vaginal examination.
151. RM Wood advised that a second stage longer than two hours would be considered somewhat prolonged for a woman’s first labour. Ms A’s second stage of labour appears to have been 2.5 to 3 hours in length, but she was heard to be actively pushing with encouragement as early as 6am. Based on this evidence, I consider that there had been active pushing, albeit with some breaks, for up to 4.5 hours prior to Baby A’s delivery.
152. The *Referral Guidelines*¹⁸ define prolonged second stage requiring consultation (for a first labour) as being longer than two hours with no progress. In Ms A’s case there was progress, although it was slow.
153. I accept RM Wood’s advice that Ms A’s labour was not progressing normally and should have warranted closer fetal monitoring, such as continuous CTG monitoring, especially considering the reduced variability and possible decelerations that had been evident on the CTG the previous day.
154. I also note that the whānau’s complaint mentioned that a ‘Plan B’, to consider a transfer to the public hospital, was recorded in RM C’s notes, yet there is no further documentation or explanation as to why this was being considered. RM Wood advised:
- ‘Closer monitoring of the baby’s heart rate especially during the second stage and the recognition of the lack of liquor may have alerted [RM C] to a significant concern with the baby’s wellbeing that would have resulted in a transfer to hospital for delivery of the baby. It is my opinion that the progress of the labour was not concerning to the point of needing to transfer but closer monitoring of the baby may well have resulted in a transfer if he had been shown to be under distress.’
155. I find it concerning that neither ‘Plan B’ nor any other options were considered further and that no reasoning was documented or discussed with Ms A and her whānau.

Discussion — management of labour

156. I have multiple concerns about the standard of RM C’s care of Ms A during her labour. In making this comment, I have considered RM Wood’s advice:

‘It is my opinion that the adequacy of the care and monitoring of both the mother and baby during this labour constituted a moderate departure from accepted standard of care and would be viewed as concerning by midwifery peers. Neither fetal nor maternal observations were done that would be considered to be of an appropriate standard of care, there was no consideration of the dropping fetal heart rate during

¹⁷ An anterior lip of cervix acts like a tight rubber band and will prevent descent of the fetal head when the woman is pushing.

¹⁸ Health New Zealand | Te Whatu Ora, *Guidelines for Consultation with Obstetric and Related Medical Services (Referral Guidelines)*.

the time [Ms A] was in labour at Birthcare and there was no recognition nor consideration given to the apparent anhydramnios.’

157. I am critical of the lack of monitoring of Ms A (in particular, the lack of temperature, blood pressure, and heart rate checks) and baby’s wellbeing (in particular, the irregularity of the FHR auscultation) throughout the labour, and that the birthing pool temperature was not checked regularly.
158. The retrospective and sparse documentation by RM C also means that I have been unable to determine the rationale for giving fluids at 7.30am, the time at which Ms A’s membranes ruptured, the presence or lack of liquor or meconium, the time at which the second stage of labour started, and the reasons for consideration of transfer to the public hospital. More fulsome documentation and recording of observations and key decision points would have provided a better overall picture of how slowly Ms A’s labour was progressing and would have assisted RM C in informed decision-making about the appropriate next steps, including consultation with a specialist and possible referral to secondary care for ongoing management.
159. In my opinion, the cumulative deficiencies in the care provided by RM C to Ms A during her labour amount to a failure to provide services with reasonable care and skill.

Management of resuscitation

160. RM C’s retrospective notes incorrectly record the spontaneous delivery of a male infant in poor condition at 10.10am. Mrs B said that RM C placed baby on Ms A and he did not make a sound, and RM C ‘quickly took him off her chest and cut his cord’. Mrs B noted that baby’s colouring was not good, and there was blood and meconium on his body and around his mouth. The Birthcare delivery summary noted that baby was delivered at 10.30am.
161. RM E documented that RM C’s call for assistance came at 10.36am. RM E said that when she entered the room, RM C was rubbing baby to stimulate him. RM E stated that she turned on the APGAR monitor and, when she asked what time baby was born, RM C responded that she did not know. RM C then moved baby to the Ohio table. RM E said that she located a stethoscope and checked for baby’s heart rate, and then set up the oxygen bottle with a blender from the cupboard.
162. RM Wood advised that in practice, midwives assess the condition of a baby as soon as they are born, particularly the colour, tone, and respiratory effort of the baby. Baby A, however, was delivered with no signs of life and APGARS of 0 and 0. When RM E entered the room at 10.36am, the baby was already six minutes old. RM Wood advised that there was a considerable delay in calling for help and commencing resuscitation other than providing stimulation, which in her opinion was a significant departure from the accepted standard of care. She advised:

‘[Baby A] did not display any reassuring signs of life and it would be my expectation that calling for help (using the emergency call bell) and commencing resuscitation

would have happened within the first minute ... Providing stimulation to [Baby A] was the correct initial action to take but this is something I would expect to be done for perhaps 20 to 30 seconds, 6 minutes is a very long time to be persisting with stimulation of a baby in the condition [Baby A] was described as being in.'

163. It is also clear from the description in RM E's and RM F's notes that there were further delays, as the resuscitation equipment needed to be gathered and assembled. RM Wood advised:

'It has been my experience that most midwives will do this during the labour so they can be better prepared to manage an emergency such as this, as even with no risk factors or concerns babies will sometimes arrive unexpectedly "flat" and require resuscitation.'

164. RM C acknowledged that she did not have sufficient resuscitation equipment ready in anticipation of the birth of Baby A. In response to RM Wood's concern about a delay in commencing resuscitation, she stated:

'I recognised [Baby A] was compromised immediately after birth and summoned for assistance. If a delay was noted between me requesting assistance to [RM E] entering the room, the delay was her response to recognise my need for urgent assistance.'

165. Notwithstanding this explanation, I note that there was a six-minute delay in receiving assistance from a Birthcare midwife, and that during that time RM C had not commenced resuscitation. I am critical of RM C's actions surrounding the delivery and resuscitation. RM C's delay in seeking assistance from Birthcare midwives, her delay in commencing the resuscitation, her failure to have the resuscitation equipment prepared adequately prior to the delivery, and her incorrect recording of the time of delivery did not meet the standards expected of an LMC midwife. In my view, this amounted to RM C failing to provide services with reasonable care and skill.

Conclusion — antenatal care, management of labour, and management of resuscitation

166. RM C had a responsibility to provide Ms A midwifery services with reasonable care and skill. As discussed above, on several occasions she failed to do so. I am critical of the standard of RM C's antenatal care, her management of Ms A's labour, and her management of the resuscitation, and therefore I find that she breached Right 4(1)¹⁹ of the Code of Health and Disability Services Consumers' Rights (the Code).
167. Further, RM C's documentation of Ms A's antenatal care, labour, and time of delivery did not meet the required standards, and therefore I find that she also breached Right 4(2)²⁰ of the Code.

¹⁹ Right 4(1) of the Code states that every consumer has the right to have services provided with reasonable care and skill.

²⁰ Right 4(2) of the Code states that every consumer has the right to have services provided that comply with legal, professional, ethical, and other relevant standards.

Ms A's postnatal care — adverse comment

168. Following Baby A's stillbirth, RM C's focus was on Baby A and the resuscitation.
169. According to the Birthcare Huntly internal investigation report, RM E delivered the placenta and RM G documented the inspection of the placenta at 11.10am. RM C said that the inspection of Ms A's perineum was done by RM F and that the second-degree laceration was noted as not requiring suturing. The clinical notes contain no information about an examination of Ms A's perineum, but the delivery summary is ticked as it being 'intact'.
170. RM C stated that she conducted clinical assessments prior to Ms A's discharge. However, these observations were not documented, and Ms A's temperature was not taken.
171. It is understandable that RM C's focus needed to be on the baby following his delivery. However, I am concerned that the common theme surrounding these events is the lack of supporting documentation. Whilst I acknowledge the distressing circumstances following Baby A's delivery, in the absence of documentation I am unable to determine the validity of RM C's statement that she undertook observations and assessments of Ms A prior to discharge.
172. Ms A required hospitalisation following her discharge from Birthcare Huntly to repair a perineal tear that had not been sutured and became infected. While it was very unfortunate that Ms A required medical intervention in hospital, I am unable to conclude that this was as a result of inappropriate care in relation to her perineal tear in the immediate postnatal period.
173. Following their return home from Birthcare, Mrs B sent a text message to RM C to request pain relief advice for Ms A. Ms A's ongoing postnatal care was handed over to another LMC the following day, which was appropriate in the circumstances. RM Wood advised: 'It is not uncommon for a woman to want a different midwife to take over the care following an unexpected outcome regardless of the circumstances so this was certainly in keeping with expected midwifery practice.'

Communication and cultural safety

Communication following stillbirth — breach

174. I accept that RM C's initial focus needed to be on Baby A and the resuscitation following his delivery. I also acknowledge the trauma that surrounded these events and that individual midwives' responses will vary.
175. However, RM C had a responsibility to Ms A and her whānau to ensure that they were communicated with effectively about what had happened. It is clear from the complaint by the whānau that little communication and cultural and emotional support was provided to them on the day of these events. I am critical that the whānau did not know that Baby A had been stillborn until four days after the delivery, when the Delivery Unit manager at the public hospital spent time with the whānau and explained this to them. The whānau should

not have been left thinking that Baby A had been born alive and then passed away during the resuscitation.

176. Mrs B described needing to leave her daughter's side several times to search for RM C to find out 'what happens next' or when they could leave. It is clear from the complaint that the whānau were left feeling abandoned and confused after this traumatic event.
177. The whānau were asked whether they wanted a post mortem. The whānau said that they did not understand the purpose of completing a post mortem, and therefore Ms A declined this because she did not want her baby to be hurt any further. I am disappointed that Ms A and her whānau were not provided with sufficient information to enable them to make an informed decision in this circumstance.
178. RM Wood advised:

'[RM C] would have been busy with the paperwork involved when a stillbirth happens but failing to provide a culturally appropriate and comfortable space for the whānau was below the standards expected given the circumstances. [RM C] was still the LMC at this stage and I consider that it was primarily her responsibility to provide support and care and to document that care, despite the distress and upset she herself would have been experiencing.'

179. I agree with RM Wood that it was RM C's responsibility to provide support and care and to document that care. In considering the concerns raised by the whānau, and with no supporting documentation of any discussions had, in my view RM C failed to provide effective communication to Ms A about what had happened to Baby A, what steps needed to happen next, and about the post-mortem process. Therefore, I find that RM C breached Right 6(1) of the Code — the right to information that a reasonable consumer, in that consumer's circumstances, would expect to receive.

Cultural safety — adverse comment

180. The Māori Health Strategy|He Korowai Oranga was developed to address health inequities while delivering effective services that support Māori aspirations for health and wellbeing — pae ora.²¹ RM C had an obligation to ensure that her practices were culturally safe and upheld the mana of Ms A and her cultural beliefs.
181. In te ao Māori, the level of tapu surrounding birth and death are heightened. Tikanga is practised to ensure that the rules surrounding tapu are observed. When certain practices are not observed, this can be considered a breach of tikanga. Tikanga underpins culturally safe practices. The NZCOM defines unsafe cultural practice as 'any action that diminishes, demeans or dis-empowers the cultural identity of an individual'.²²

²¹ He Korowai Aroha|Māori Health Strategy 2014.

²² NZCOM, 2008 p 48.

182. In the complaint, the whānau describes Baby A's whakapapa and his standing in his whānau as the first-born son and grandson, and of the mana te mātāmua²³ holds. Baby A's arrival was much anticipated by his whānau.
183. The way in which these events were handled continues to have traumatic ramifications for Ms A and her whānau.
184. The tikanga that surrounds the tapu of death acknowledges that te ara wairua²⁴ can involve reciting appropriate karakia and takutaku.²⁵ What is clear from the recollections of staff, and the documentation provided, is that there was no offer of karakia and/or guidance by a relevant person, eg, a kaumātua, to Ms A and her whānau. Ms A and her whānau had a right to be provided with services that took into account the needs and beliefs of their cultural practice.
185. It should not have been Mrs B's role to seek and find support and ask for things to be done or provided to her whānau. The whānau's perspective is that they were left to navigate the loss of their baby by themselves. In my view, as the LMC, RM C had an obligation to ensure that the whānau were comfortable and supported.
186. Mrs B spoke of the room being paru and the whānau still sitting around in remnants of the traumatic events, and she said she needed to ask for the room to be cleaned up. Blood from the delivery process is tapu and must be treated with care. It was disrespectful for Mrs B and her whānau to be expected to sit among the remnants of their baby's trauma for a considerable time.
187. I am critical of RM C's cultural response, and I consider that the cultural services and support were lacking for Ms A and her whānau.
188. I also draw attention to the importance of the tikanga that surrounds tangihanga. For many, tangihanga is about upholding the mana of the person who has passed and the whānau pani.²⁶ It is also the start of the healing process for the whānau pani. When Ms A and her whānau discovered that Baby A had passed, their tangihanga process began. While I cannot attribute fault to RM C for this, it is an unfortunate outcome that Ms A needed to be admitted to hospital for a period of five days, which had a negative impact on the whānau's ability to manage the tangihanga process and therefore their healing process.

²³ The eldest.

²⁴ The spiritual pathway followed after death to Hine-nui-te-pō (afterworld). On death the wairua also becomes tapu. Wairua is believed to remain with or near the tūpāpaku (deceased body). Tikanga such as karakia encourage the wairua on its journey to Te Hono-i-Wairua (the gathering place of spirits).

²⁵ Incantations.

²⁶ The bereaved family.

Opinion: Birthcare Huntly

Adequacy of care while at Birthcare Huntly — adverse comment

189. During Birthcare’s internal investigation, it was noted that the core equipment, including the clinical notes package/room folder, blood pressure monitor, and emergency equipment, were not sought out by RM C or actively offered by Birthcare staff.
190. In addition, RM C stated that no emergency bell was located in the Birthcare Huntly rooms, and she understood that the policy during the COVID-19 pandemic was to use the phone in the room to seek assistance. However, the Birthcare internal investigation found that the call bell in the room had not been activated. RM Wood stated:
- ‘The emergency bell was not used but rather the normal call bell was used, so the initial response from [RM E] was based on walking into an emergency situation that she was in no way expecting. She was also faced with the resuscitation equipment not being immediately available as it hadn’t been set up earlier.’
191. RM Wood advised that as an LMC, RM C is an independent practitioner, and the Birthcare staff would be expected to enter the birthing room only at the request of the LMC or if summoned by the woman or whānau in the absence of the LMC.
192. I agree that the role of LMC is independent. However, the omissions in this case in terms of RM C not seeking out core equipment and having a different understanding of the emergency bell process at Birthcare suggests to me that her orientation to the available resources and the emergency processes at the facility could have been strengthened.
193. I am not critical of the actions of the Birthcare staff in relation to their involvement in the resuscitation, and I note that RM Wood considers that they ‘acted completely within the expected standards of practice’. She commented that it would have been better for the APGAR timer to have been turned on earlier and an airway used when air entry was unable to be achieved, but she noted that this did not make any difference to the outcome.
194. RM Wood also commented that in her view, the documentation of the Birthcare midwives departed from acceptable standards mildly, given the situation they were dealing with. She said that this was because all the notes were made retrospectively, and it is unclear who was providing midwifery care to Ms A following delivery. RM Wood stated: ‘[I]t would seem to have been somewhat of a collective effort.’ I accept this advice, and whilst ideally more fulsome clinical records would have been kept following delivery, I acknowledge that the distressing situation faced by all involved may have prevented this.

Cultural safety — breach

195. Birthcare Huntly had an obligation to ensure that its practices were culturally safe and upheld Ms A’s mana and her cultural beliefs.

196. Birthcare Huntly's Cultural Policy provides that Birthcare Huntly's staff will ensure that each woman and their whānau's cultural, spiritual, social and ethnic identities are maintained while they are clients at Birthcare Huntly. Birthcare Huntly therefore had an obligation to ensure that Ms A and her whānau's cultural beliefs were maintained. From the documentation available, there is no mention of cultural support having been offered to Ms A and her whānau. The experience of the whānau was that they were left to navigate their loss alone, and how these events were handled continues to have traumatic ramifications for Ms A and her whānau.
197. I note that Birthcare Huntly's Cultural Policy mentions the pivotal role of kaumātua in the organisation, including blessings. I also note that Birthcare Huntly's Stillbirth Policy provides for support of a religious provider or kaumātua. I am disappointed that the whānau did not have this support and guidance made available to them, and that there was no offer of karakia to Ms A and her whānau. As mentioned previously, the level of tapu surrounding death is heightened. Tikanga is practised to ensure that the rules surrounding tapu are observed to provide safety, and the whānau should have been supported throughout this process. They had a right to be provided with services that took into account the needs and beliefs of their cultural practice.
198. I am also concerned that Mrs B had to ask to have the room cleaned up following the delivery. Birthcare Huntly staff needed to ensure that all cultural elements were considered in their response to the whānau, and this included the tikanga that surrounded the tapu of blood. I am concerned that the whānau were left to follow up this. I consider that it was disrespectful for Mrs B and her whānau to have been expected to sit among the remnants of their baby's trauma for a considerable time.
199. In my view, Birthcare Huntly, as the organisation providing the facility in which Baby A was delivered, had a higher responsibility than RM C to provide culturally appropriate care. I am critical of Birthcare Huntly's cultural response following Baby A's delivery and consider that the cultural services and support provided to Ms A and her whānau were inadequate and a breach of Right 1(3)²⁷ of the Code.
200. Birthcare Huntly midwives completed Ms A's postnatal checks. As mentioned previously, following discharge Ms A was admitted to the public hospital with a second-degree tear that had not been sutured and had become infected. While it was very unfortunate that Ms A required medical intervention in hospital, I am unable to conclude that this was as a result of inappropriate care in relation to her perineal tear in the immediate postnatal period. When Ms A and her whānau discovered that Baby A had passed, their tangihanga process had begun. Unfortunately, Ms A's hospital admission had a negative impact on the whānau's ability to manage the tangihanga process and therefore their healing process.

²⁷ Right 1(3) states that every consumer has the right to be provided with services that take into account the needs, values, and beliefs of different cultural, religious, social, and ethnic groups, including the needs, values, and beliefs of Māori.

Changes made since events

201. Birthcare Huntly advised that after these events the following changes were made and incorporated the recommendations in the internal investigation:
- a) The unbooked labouring woman guideline was updated.
 - b) A formal letter outlining the requirements of teamwork and effective communication was sent to all LMC midwife access holders at Birthcare facilities.
 - c) The labour and delivery policy was reviewed to further strengthen expectations around communications between LMC midwives and Birthcare staff.
 - d) Birthcare purchased a newborn resuscitation mannequin, and an education framework was developed to deliver regular neonatal resuscitation skills and drills training, incorporating teamwork, communication, documentation, and New Zealand Resuscitation Council guidelines.
 - e) A birthcare neonatal resuscitation record was developed.
202. Birthcare Huntly closed at the end of October 2023.
203. As set out above, RM C underwent a competency review process with the Midwifery Council of New Zealand. She undertook further education in the areas of fetal surveillance, documentation, resuscitation, and navigating unexpected outcomes.
204. RM C no longer practises as a midwife.
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Recommendations

RM C

205. Considering that RM C no longer practises as a midwife in any capacity and has undertaken further education as part of the competency review process, I consider that no further educational recommendations are necessary. However, in light of the concerns detailed in this report, I recommend that in the event RM C returns to practice, the Midwifery Council of New Zealand consider whether a further review of RM C's competence is required, and report back to HDC.
206. I recommend that RM C provide an opportunity to Ms A and her whānau to meet and allow the whānau to speak of their experience and mamae. This meeting can be facilitated in consultation with HDC's Director Māori|Mātāmua Māori. The purpose of the meeting would be to support the healing process for all parties involved and allow RM C the opportunity to express her apologies to Ms A and her whānau. If Ms A does not wish to proceed with a hui kano ki-kano|face-to-face meeting, I recommend that RM C provide a written apology to Ms A and her whānau. The written apology is to be sent to

HDC within three weeks of the date of this report. The apology will follow Ms A's response to a hui in the first instance.

Birthcare Huntly

207. In the provisional opinion, I recommended that Birthcare provide a written apology to Ms A and her whānau for the issues identified in the report. The apology has been provided to HDC and will be given to Ms A and her whānau with this report.
208. I acknowledge the actions taken by Birthcare Huntly in response to the recommendations made in its internal investigation and understand that the Huntly facility is now closed. However, at the date of this report, the company is still registered, and the company's other Birthcare facility remains operational. Birthcare did not consider that recommendations to its other facility were necessary, but it advised that it would take on board the following recommendations:
- a) That Birthcare confirm whether its updated Unbooked Woman Arriving at a Birthcare Facility Policy has been communicated to LMCs with access agreements to its facility, within three months of the date of this report.
 - b) That Birthcare reflect on whether its orientation process for LMCs to the physical facility (including access to core and emergency equipment and the emergency call process) is sufficiently robust, in light of the issues identified in this case. If improvements are required to its process, I recommend that these are communicated to HDC within three months of the date of this report.
 - c) That Birthcare review its Cultural Safety policy to include, for instance, the practice of tikanga that surrounds the tapu of blood and the tapu of death, including the provision for relevant cultural leader/s or kaumātua to complete karakia and relevant cultural rituals. A copy of this updated policy should be provided to HDC within six months of the date of this report.
 - d) That Birthcare update its Stillbirth Policy to include tikanga considerations for tūpāpaku and whānau pani (bereaved family). A copy of the updated policy should be provided to HDC within six months of the date of this report.

Follow-up actions

209. In light of the significant concerns I have about RM C's care of Ms A before, during, and after the delivery of Baby A, I will refer RM C to the Director of Proceedings in accordance with section 45(2)(f) of the Health and Disability Commissioner Act 1994 for the purpose of deciding whether any proceedings should be taken.
210. A copy of this report with details identifying the parties removed, except Birthcare Huntly Ltd and the advisor on this case, will be sent to the New Zealand Midwifery Council, and it will be advised of RM C's name in covering correspondence.

211. A copy of this report with details identifying the parties removed, except Birthcare Huntly Ltd and the advisor on this case, will be sent to Health New Zealand|Te Whatu Ora and placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

Appendix A: Independent clinical advice to Commissioner

The following independent advice was obtained from RM Wood:

'My name is Mary Wood. After completing a diploma in Comprehensive Nursing at Carrington Polytech (now Unitec) in 1989 I completed a Diploma in Midwifery at AUT in 1990. I went on to complete a Bachelor of Health Science Midwifery at AUT in 2001. I worked as a midwife in the delivery unit at North Shore Hospital from January 1991 until September 1991, after which I began working as an independent midwife on the North Shore in Auckland. I worked as a full-time self employed (LMC) midwife on the North Shore until April 2013 when I took up a position as an Associate Clinical Charge midwife working primarily in the Birthing Suite of North Shore Hospital. In this role I was responsible for co-ordinating, teaching and supporting midwifery staff in the provision of midwifery care to women and their whānau, general management of the labour ward, responding to and managing emergency situations and liaising with obstetric staff.

I combined a small part-time self-employed caseload (LMC work) with my part-time work as a CCM at the hospital from April 2013 until December 2020. As a full time self-employed midwife I worked within a practice with a number of other midwives each of whom carried their own caseloads. I provided midwifery care for women throughout pregnancy from positive pregnancy test until six weeks after the birth of the baby, delivering either at home or at North Shore Hospital. I provided continuity of midwifery care for women in low, moderate and high risk pregnancies throughout these years.

In January of 2021 my husband and I moved from Auckland to Horopito in the Central North Island where I took up a position working for the Whanganui DHB providing locum midwifery cover and support for the two midwives who provide the midwifery service out of the Waimarino Health Centre in Raetihi. The midwifery service here provides antenatal and postnatal care, as well as birthing care either at home or at the Waimarino Unit for women from Raetihi, Ohakune and surrounding areas.

I have been asked to provide an opinion to the Commissioner on case number 21HDC03151. I have read and agree to follow the HDC 'Guidelines for Independent Advisors' and I am not aware of any conflicting interests either professionally or personally in this case.

Expert advice requested:

Please review the enclosed documentation and CTGs and advise whether you consider the care provided to [Ms A] by [RM C] and Birthcare Huntly Limited was reasonable in the circumstances, and why.

In particular, please comment on:

[RM C] overall management

1. The adequacy of [Ms A's] antenatal monitoring by [RM C].
2. [RM C's] interpretation of the CTG trace [at 40+3 weeks].
3. Whether the CTG trace indicated earlier assistance was required.
4. The adequacy of monitoring of the mother and baby during labour.
5. Whether [RM C] provided an appropriate standard of care to [Ms A] once she presented in the delivery suite.
6. Whether [RM C] needed to consider a transfer for [Ms A] to [the public hospital] sooner.
7. The adequacy of [RM C's] clinical notes.
8. Whether [RM C's] communication with [Ms A] and her whānau during the labour and delivery phase was reasonable.
9. Whether [RM C] provided an appropriate standard of care to [Ms A] and her whānau, immediately following [Baby A's] delivery.
10. Whether [RM C's] management of the resuscitation process following [Baby A's] delivery was of an appropriate standard.
11. Whether [Ms A's] post-natal care by [RM C] was reasonable.
12. Any other aspects of care provided to [Ms A] that you consider warrant comment.

Birthcare Huntly Limited overall management

1. Whether the care provided by Birthcare Huntly to [Ms A] and her whānau was of an appropriate standard.
2. The adequacy of Birthcare Huntly Limited's emergency response management following [Baby A's] delivery.
3. The adequacy of Birthcare Huntly's clinical notes.
4. Whether the communication between Birthcare Huntly Limited and [RM C] at [40+4 weeks], was of an appropriate standard.
5. Whether Birthcare Huntly Limited's communication and guidance with [Ms A] and her whānau following [Baby A's] birth and still birth was of an appropriate standard.
6. Any other aspects of care provided to [Ms A] that you consider warrant comment.

For each question, please advise:

- a. What is the standard of care/accepted practice?
- b. If there has been a departure from the standard of care or accepted practice, how significant a departure (mild, moderate, or severe) do you consider this to be?
- c. How would it be viewed by your peers?
- d. Recommendations for improvement that may help to prevent a similar occurrence in future.

If you note that there are different versions of events in the information provided, please provide your advice in the alternative. For example, whether the care was

appropriate based on scenario (a), and whether it was appropriate based on scenario (b).

I have reviewed the following documentation provided:

1. Letter of complaint from [Mrs B], dated [2021]
2. [RM C's] response to HDC, dated 23 September 2022
3. [RM C's] reflection of [Ms A's] labour (not dated)
4. Clinical records from [RM C] covering the period [of the pregnancy]
5. [Public hospital] Obstetric notes
6. [Public hospital] clinical notes covering the period [of admission]
7. Birthcare Huntly's response to HDC [2022]
8. Birthcare Huntly clinical records (in reflection written [two days after the birth]) for [the day of the birth]
9. Birthcare Huntly's Investigation Incident Report dated [2021]
10. Birthcare Huntly's Cultural Safety Policy
11. Birthcare Huntly's Stillbirth Policy
12. Birthcare Huntly's Adrenaline Administration Guideline for Newborn Resuscitation.

I will work through each question systematically.

[RM C] overall management:

1. The adequacy of [Ms A's] antenatal monitoring by [RM C].

The antenatal notes I have reviewed include printouts from the computer program [RM C] has used indicating booking information collected as regards maternal and family history. There is very little family history noted but it is not clear whether this was because there was no family history of note or questions regarding family history had not been asked. There is a copy of an ultrasound report for a growth scan that was done at 29 weeks and was normal but there is nothing noted in the antenatal record as to why this scan was done. There is no anatomy scan report included in the antenatal notes nor a 1st trimester screening scan. [Ms A] booked with [RM C] [in] 2021 when she was already 20 + 6 days into her pregnancy so these may have been requested by the GP or another midwife but either way I would expect them to be included as part of a comprehensive antenatal record.

There are no blood results in the antenatal notes other than a reference to [Ms A's] blood group. The initial antenatal booking blood may have been done by the GP but I would have expected these to be included in the midwifery antenatal record. There do not appear to be any 28 week blood results nor any 36 week blood results. While some midwives may choose not to request 36 week bloods, depending on individual circumstances, it would be very unusual in my experience for 28 week bloods not to be done. It is at this time antenatal diabetes screening is done and it is a time when most midwives will evaluate the woman's FBC and iron stores and consider whether iron supplementation is advised. If no bloods were done other than booking bloods

and there was no discussion with [Ms A] about these blood tests and she had declined to have them done, I would consider this to be a moderate departure from acceptable standards of care.

It would appear from the notes that [RM C] saw [Ms A] at 26 weeks and not again until 35 weeks after which weekly visits took place. Normally antenatal visits take place every two weeks from 28 weeks and then weekly from 36 weeks. The frequency of visits increases after 28 weeks because this is from when fetal growth is monitored more closely, usually by fundal height measurements and it is also a time when monitoring for complications of pregnancy such as pre-eclampsia becomes more important. The antenatal schedule of visits does not fit within the expected standard of antenatal care midwives provide and I would regard this as a moderate departure from the expected standard.

There are no written commentaries included in the antenatal records I have reviewed, only an Antenatal Appointments chart with basic results such as BP, urine analysis, fundal height measurement and presentation/lie of the baby noted. The only note I can find is the note regarding the follow up CTG assessment at Birthcare being arranged for reported reduced fetal movements [at 40+3 weeks]. Discussions that may or may not have taken place during the antenatal visits are not noted so I am unable to determine if there was any information sharing or birth planning discussed (other than the intended place of birth) from these notes.

NZCOM Midwives Handbook for Practice:

Standard Three

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

Criteria:

The midwife collects information which includes:

Personal and family/whānau details

Physical, psychological, emotional wellbeing

Cultural and spiritual dimensions

Physical, social and cultural environment

The midwife documents her assessments and uses them as a basis for on-going midwifery practice.

Standard Four :

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

Criteria:

The midwife reviews and updates records at each professional contact with the woman

Standard Five:

Criteria:

The midwife ensures the care plan is woman-centred

This midwife demonstrates in the midwifery care plan an analysis of the information gained from the woman

The midwife sets out specific midwifery decisions and actions in an effort to meet the woman's goals and expectations and documents these.

The midwife considers the safety of the woman and baby in all planning and prescribing of care.

It is my opinion the adequacy of [RM C's] antenatal care and monitoring was below the accepted standard of care expected. If [RM C] did not have any discussion nor offer any information sharing during [Ms A's] pregnancy other than taking basic recordings I would regard this as a significant departure from the expected standard of care. If she did have such discussions with [Ms A] but did not detail any aspect of these discussions I would regard this as a moderate departure from the accepted standard. Examples of what might be discussed would include, immunisation recommendations for pregnant women, antenatal education options, what sort of whānau support is available particularly after the birth, diet and exercise to name just a few. Most midwives will follow some sort of plan for what to discuss and when to have certain discussions. I can find no sign that any of these type of discussions took place through [Ms A's] pregnancy.

2. [RM C's] interpretation of the CTG trace [at 40+3 weeks].

3. Whether the CTG trace indicated earlier assistance was required.

I will respond to questions 2 and 3 together as they are closely related to each other.

[RM C] took [Ms A] into Birthcare Huntly for a CTG [at 40+3 weeks] after [Ms A] reported that she had been feeling reduced fetal movements at an antenatal home visit that day and a 40 minute CTG was done. The trace demonstrated a baseline fetal heart rate of 140 BPM which is in the normal range. There are 14 fetal movements that are indicated on the trace, some (not all) of which are associated with a brief rise in the fetal heart rate (acceleration) which is a normal indication of a healthy baby. The baseline variability is reduced (between 3 and 5) which can be an indication of fetal compromise and there appears to be variable decelerations at the very beginning and at the end of the trace although this may be due to a loss of contact rather than a true deceleration.

Contractions are showing up on the CTG at approximately 3 to 4 minute intervals, [Ms A] appears to be in the early stages of labour during this time. I am unable to find any comments by [RM C] about her interpretation of the CTG or any indication that she had any concerns with it.

It is my opinion that the CTG should have been continued for a longer period of time given the reduced variability and the possibility of decelerations at the beginning and end together with the fact that reduced fetal movements had been reported by [Ms A]. At the least a follow up CTG would have been wise when she was admitted the following day in established labour. However at the time it was done the baseline was within normal limits and there does appear to be accelerations present with fetal movements and given this I would regard this as a mild departure from acceptable standards at this stage.

4. The adequacy of monitoring of the mother and baby during labour.

5. Whether [RM C] provided an appropriate standard of care to [Ms A] once she presented in the delivery suite at 40+4 weeks.

I will respond to questions 4 and 5 together as the responses are essentially the same.

The accepted standard of midwifery care for monitoring the wellbeing of a woman and baby during the labour process, involves performing baseline observations of the woman, in particular blood pressure, temperature and pulse rate initially, then every 4 hours if all is normal and to listen to the baby's heart rate immediately after a contraction every 15 to 30 minutes during the active part of the first stage of labour then every 5 minutes or after every contraction during the second stage of labour. When the woman is using a pool for pain relief and relaxation, baseline observations are done prior to entering the pool then pool temperature and maternal temperature are checked hourly and recorded with the aim of maintaining the water temperature between 35.5°C and 36.5°C during the first stage of labour and increasing that to a maximum of 37°C during the second stage of labour if the intention is for her to birth in the water. *NZCOM Consensus Statement: The use of water for labour and birth/ Water for Labour and Birth, National Women's Health NZCOM Practice Guidance document 2020 Intermittent Auscultation for the assessment of Intrapartum Fetal Wellbeing.*

The LMC's notes for throughout the 5 hours from arrival at Birthcare Huntly at 0515 until 1040 are entirely written in retrospect. It would be my experience that this is not in keeping with the acceptable standard of documentation and would be unusual in general midwifery practice. [RM C's] rationale for this is that she was too busy to write in the clinical notes and that she had recorded the observations she undertook on pieces of scrap paper. She states '*I was quite busy as I was the only person in the unit who was providing care during the labour*'. However, there is normally only one midwife with the woman during the labour process if everything is progressing normally so this should not be a barrier to recording the process of her labour as it unfolded in normal circumstances. [RM C] states in her retrospective labour notes that *[Ms A] is enjoying the pool, now using gas with good effect, feeling well breathing through contractions and that her partner is providing good support.*

(0515). During these times in the course of the first stage of labour, in between listening to the fetal heart or taking maternal observations, the midwife is very often sitting quietly, observing the events and may be making some suggestions about positioning etc but is often not actively supporting the woman, so as not to interfere with the role of the partner or whānau. So I am unclear as to why [RM C] was too busy to be keeping adequate contemporaneous notes. The whānau have described [RM C] spending time using her laptop in the room and thinking that she was using the laptop to write notes.

It has been my experience that in practice midwives do write notes and observations on all sorts of readily available paper, especially on a CTG trace for example when it is being used as it has the benefit of having the time noted at 10 minute intervals. But this is normally something that happens during an emergency or when some issue is occurring that makes access to the clinical notes impossible at that particular time. It would not be an acceptable way of keeping contemporaneous notes during the entire

labour. In my experience a midwife will make short comments in the clinical notes and or on the partogram during the labour at least every 30 minutes if all is progressing normally and more extensive and often retrospective notes are added if something out of the normal is occurring.

The LMC describes siting an IV line and giving [Ms A] IV fluids at 0730 during this time in the pool but she doesn't give any rationale for doing this. IV hydration during labour is a fairly common intervention used but in NZ it is not done as a part of routine labour care for a low risk woman. It might be used for significant dehydration (which is fairly common in a long labour) or if the woman is vomiting or her pattern of contractions has become erratic or is slowing down. There is no reason I can find documented in the notes as to why this intervention was decided upon or if there was a concern at this time making it warranted. I am concerned that there is no record of the maternal pulse being checked or recorded other than at 0905 when it is documented to be 72 bpm although there is a comment at 0950 that the pulse was checked but the rate is not recorded.

This being the case, during the labour, particularly during the active pushing stage, there is no way of knowing whether [RM C] was actually listening to the baby or to the maternal pulse. During the second stage of labour it can be sometimes challenging to pick up the fetal heart after every contraction. Sometimes when using a doppler through this time, just as you find the fetal heart another contraction begins so the woman may be moving which can make it challenging to locate and monitor the fetal heart rate for a reasonable length of time. Monitoring the wellbeing of a baby through the second stage of labour and in particular when the woman is actively pushing involves listening to the fetal heart immediately after the end of every contraction, or at 5 minute intervals for 30 to 60 seconds. The reason that monitoring of a baby through this stage is more intensive is because this is the time that the baby is most likely to show signs of becoming distressed.

In the Birthcare delivery summary the time of full dilation is noted to be 0900 but the retrospective clinical notes state that there is an anterior lip of cervix present from 0615 until 0730 when full dilation is confirmed by vaginal examination. The first Birthcare midwife ([RM D]) describes hearing coached active pushing every 2 to 3 minutes between 0600 and 0655 which was then stopped when [RM C] discovered that there was still a lip of cervix present. An Anterior lip of cervix is a front rim of the cervix that acts like a tight rubber band and will prevent the descent of the fetal head when the woman is pushing.

The retrospective notes describe [Ms A] as 'pushing +++' at 0800. Midwives will make a comment such as this to mean the woman is pushing strongly and frequently. At 0830 the notes record 'PP (*presenting part of the baby*) seen with good pushing'. The start of the second stage of labour is sometimes defined from the point of full dilation and sometimes defined as the commencement of active pushing, so a woman may well be fully dilated for a period of time before active pushing. When a woman is labouring with an epidural for example, it is normal practice in NZ to allow an hour for

what is described as passive descent of the fetal head prior to the start of active pushing. The intention of which is to shorten the length of time needed for the active pushing, which can reduce the stress on both mother and baby.

In this situation it would seem that the onset of the actual second stage of labour was sometime between 0730 and 0800 not 0900. However there was a period between 0600 and 0655 when active pushing was heard being encouraged by [RM C]. Given the conflicting information available I am unable to determine exactly how long the second stage was, but a second stage longer than 2 hours for a first labour would be considered somewhat prolonged. [Ms A's] second stage of labour appeared to be 2.5 to 3 hours in length, but she was heard to be actively pushing with encouragement as early as 0600. Based on this there had been active pushing albeit with some breaks for up to 4.5 hours prior to the birth. The NZ Referral guidelines define prolonged second stage requiring consultation (*for a first labour*) as being longer than 2 hours with no progress. In this case there was progress although slow. It is my opinion however that this was not normal progress and should have warranted some closer fetal monitoring, such as continuous monitoring with the use of a CTG at some stage during this time to check on the wellbeing of the baby, especially in light of the reduced variability and possible decelerations that had been evident on the CTG the previous day.

The whānau's description of the events during the labour differs from [RM C] in describing how both [Ms A] and her baby were monitored. The complaint clearly describes that the temperature of the water in the pool was never checked nor were there any observations done on [Ms A]. The whānau also state that the baby's heart beat was not being monitored 'very often'. The complaint refers to a discussion about moving to a 'plan B' which would mean a transfer to hospital, although there is nothing in the clinical notes to indicate any concern that would warrant this so I am unable to determine if [RM C] had concerns about the labour that were not documented nor discussed. The whānau describe [RM C's] language changing and becoming more assertive during the later part of the second stage of labour and that she stopped [Ms A] from using the gas at some stage. It is not unusual in my experience for many midwives to be quite directive during this stage of labour and to discourage the use of gas at this time as it can slow the progress down if the woman is breathing on the gas and not pushing, although some midwives will encourage the use of gas in between contractions in second stage if it helps the woman relax during these breaks. The description of [RM C's] language through this time would be in keeping with normal practice.

If [RM C's] description of events and recording in her retrospective record are correct then I would be concerned that this does not meet the expected standard of midwifery care and would be viewed as such by peers. It is my opinion also that the failure to monitor or record the maternal pulse through the labour, especially during the second stage is a significant departure from an acceptable standard of care and would be viewed as concerning by peers. [RM C] records in her retrospective notes that the fetal heart rate was auscultated approximately every 30 mins and she does

describe what would seem to be some decelerations of the fetal heart rate during contractions when [Ms A] was pushing which is a common occurrence during this stage of labour, but again, without the maternal pulse being noted it is not possible to know what was actually being heard. The last recorded fetal heart rate (102) is documented as being heard between 1010 and the time of birth which was 1030. There are no other time notations so I am not sure whether this was just prior to the birth or some 20 mins earlier. [Baby A] was born with no heart beat so if it was heard just prior to the birth I would be concerned that it was maternal rather than fetal.

The whānau's description of the monitoring that was done to auscultate the fetal heart rate during the labour, especially through the second stage is at odds with the retrospective notes provided by [RM C]. They describe the baby's heart rate being listened to very infrequently.

NZCOM Consensus Statement: Foetal monitoring in labour

Prior to any form of foetal monitoring, the maternal pulse should be palpated simultaneously with FHR auscultation in order to differentiate between maternal and foetal heart rates.

NZCOM Practice guidance document: Intermittent Auscultation for the Assessment of Intrapartum Fetal Wellbeing. July 2020 An assessment of the woman's wellbeing generally includes vital signs including temperature, blood pressure and pulse.

Palpating the maternal pulse in conjunction with fetal heart auscultation enables the midwife to differentiate between the two heart rates. Page 5

If [RM C's] description of her monitoring of the fetal heart rate is correct I would regard this as a moderate departure from the expected standard of care because of the lack of maternal pulse being noted at the same time, the failure to auscultate the fetal heart rate at the generally recommended and expected intervals and the failure to notice the apparent dropping baseline fetal heart rate. There is no fetal heart rate recorded between 0515 and 0710 despite [Ms A] being in the last part of the first stage of labour and her labour being described as progressing rapidly.

If the whānau's description of the monitoring of both [Ms A] and her baby are correct, especially in their description of infrequent or no monitoring of the baby's heart rate, I would regard this as a serious departure from acceptable standards of care and I believe it would be viewed as such by midwifery peers.

Times FHR recorded in the retrospective notes:

0515 FHR142

0615 VE no FH recorded

0710 FHR 133

0730 FHR 135

0800 FHR 142 after VE

Between 0800 and 0830 FHR 132

0830 FHR 126

0830 after position change FHR 105 recovered to 135 after contraction
0905 FHR 115 then 110
0935 FHR 115
0950 FHR 121 dropping to 99 with good recovery noted
0950 to 1010 FHR 110. ? pulse checked
1010 FHR 105 then 102 ? time
Time of birth 1030

There is no FHR recorded between 0515 and 0710, there are a number of FHR noted without time notations and of note, the rate slowly drops between 0515 when it is recorded as 142, 0730 135, 0830 126, 0950 110 and finally at 1010 105 then 102. Had [RM C] been recording these FHRs on a partogram this downward trend may have alerted her to a developing problem and prompted her to use an electronic fetal monitor to check on baby's wellbeing. I am unaware if Birthcare Huntly has access to a telemetry fetal monitor but if so, this could have been used without the need for [Ms A] to get out of the pool. It is unknown when the membranes ruptured but the presence of membranes can usually (although not always) be felt during vaginal examinations in labour. [RM C] doesn't refer to any membranes being felt nor does she mention the presence or lack of liquor but does refer to mucousy discharge.

Oligohydramnios (reduced liquor) around a baby is an indication that either the membranes had ruptured at some time prior to the labour, or the placenta was no longer functioning well (placental insufficiency). Anhydramnios (no liquor present) is a considerable risk factor and an indication for transfer of care. (*Guidelines for Consultation with Obstetric and Related Medical Services*). This is because of the concern about the increased risk of cord compression during contractions, and that the reason for the lack of liquor may indicate a problem with the placenta. It would also have warranted close continuous monitoring of the fetal heart rate during labour. It would appear from the available notes and reflections that this was never considered.

There is no mention of meconium being noted through the labour although it was clear from the presence of meconium coming from [Baby A's] mouth and nose during the resuscitation that there had been meconium aspiration. Meconium staining of the placenta was noted and [Baby A] had meconium on his body at birth which was noted by the Birthcare midwives and the whānau. This scenario would be in keeping with anhydramnios as meconium is thick and sticky so the passage of meconium may be hidden if there is no liquor around the baby. If there is at least some liquor present it would most likely have been noted as meconium stained and have been observed during the second stage when active pushing is happening.

It is my opinion that the adequacy of the care and monitoring of both the mother and baby during this labour constituted a moderate departure from accepted standard of care and would be viewed as concerning by midwifery peers. Neither fetal nor maternal observations were done that would be considered to be of an appropriate standard of care, there was no consideration of the dropping fetal heart rate during

the time [Ms A] was in labour at Birthcare and there was no recognition nor consideration given to the apparent anhydramnios.

6. Whether [RM C] needed to consider a transfer for [Ms A] to [the public hospital] sooner.

Although [RM C] does mention considering a transfer to hospital in the clinical notes she does not elaborate as to why this was being considered at all. I can only assume it was because of the progress of labour which had initially been rapid but slowed at about 9 cm dilated with the presence of an anterior lip of cervix persisting from 0615 until between 0730 and 0800. In their complaint the whānau refer to the statement made by [RM C] regarding a possible transfer to hospital but are not aware of the reason as there was no discussion about this, rather just a statement. The progress of the labour itself is not abnormal for a first labour so I would not consider a transfer to hospital necessary as regards the labour progress. However as previously discussed, closer monitoring of the baby's heart rate especially during the second stage and the recognition of the lack of liquor may have alerted [RM C] to a significant concern with the baby's wellbeing that would have resulted in a transfer to hospital for delivery of the baby. It is my opinion that the progress of the labour was not concerning to the point of needing to transfer but closer monitoring of the baby may well have resulted in a transfer if he had been shown to be under distress.

7. The adequacy of [RM C's] clinical notes (during labour and birth)

It is my opinion that the adequacy of [RM C's] clinical notes was below what would be considered acceptable and I would regard this as a moderate departure from acceptable standards for the reasons I have outlined earlier.

8. Whether [RM C's] communication with [Ms A] and her whānau during the labour and delivery phase was reasonable.

After the initial home visit at 0405 (noted in the complaint but not in the midwifery notes) the LMC advised transfer to Birthcare Huntly, although [Ms A's] preference for birthing location is clearly stated to be [Birthing Unit 2]. The travel time from [her home] to Birthcare Huntly is 17 to 21 mins and from home to the Birthing Unit 2 is 21 to 28 mins. (*Google Maps*) The whānau in their complaint refer to the agreed birth plan which involved [Ms A] birthing at [Birthing Unit 2] rather than the Huntly Birthcare Centre. They state that they had a personal connection with the owner of [Birthing Unit 2] and it was closer to the hospital if there was any emergency during the labour and birth. They describe a discussion about the need to use Birthcare in Huntly if it was peak traffic time, or if the labour was progressing very fast. It would be normal for a midwife to have a contingency plan for place of birth in circumstances such as this so as to avoid having to manage a birthing woman in the back a car potentially in the middle of the night. The transfer to Birthcare actually happened at around 0500 so traffic would not have been a factor in the decision but the labour did appear to be progressing rapidly and the extra factor considered was the limitation the Covid lock down had on the number of support people [Ms A] would have been

able to have with her at the Unit. [RM C's] reasoning about this is explained in her letter of 23 Sept 2022 and in my opinion is reasonable given the circumstances. The whānau indicate in their complaint that they felt there was always a strong preference on [RM C's] part toward Huntly Birthcare over [Birthing Unit 2] and that this preference was pushed at the expense of [Ms A's] choice. It is my opinion that it would have been wise for further discussion about this prior to the labour but I don't regard this as a departure from acceptable practice.

The communication between [RM C] and [Ms A] and her whānau through the course of the labour at Birthcare as it is described in the complaint and reflected in the notes is below the expected standard. The whānau describe [RM C] spending time working on her laptop in the labour room to the point that the clicking of the keys was annoying [Ms A] and they assumed that [RM C] was writing notes. There seems to have been no discussion about the reason for the IV fluids being given. There was a comment made at around 0900 about transferring to the hospital if the baby was not born by 1000 but no rationale is given in the notes for this. The whānau describe this as a statement being made by [RM C] rather than a discussion.

NZCOM Consensus Statement: Informed Consent and Decision Making

Practice Notes: • Information should be provided in a way that the woman and her family can understand. It must be accurate, objective, relevant and culturally appropriate. It should include: • the proposed treatment/intervention • the benefits of the treatment/intervention • the risks of the treatment/intervention • the alternatives to the treatment proposed and their risks and benefits of what would happen if no treatment/intervention were used • Where there is more than one professional perspective on a given issue this should be acknowledged and information given on, and how to access, this perspective. • Women should be given time to think about the information and discuss it with others. • Documentation should include a brief outline of the information given and when this occurred. All decisions should be clearly documented. Written consent must be obtained where either party requests it. • Informed consent is dynamic. If new evidence comes to light, the woman and the family have the right to change their minds.

It is my opinion that the communication between [RM C] and [Ms A] and her whānau during the labour up until the birth did not meet the standard of care in the circumstances discussed above. I would regard this as mild departure from the accepted standard of care.

9. Whether [RM C] provided an appropriate standard of care to [Ms A] and her whānau, immediately following [Baby A's] delivery.

After [Baby A's] birth [RM C's] focus was initially entirely on him. The ongoing midwifery care for [Ms A] was taken over by midwife 2 ([RM E]) according to the Birthcare investigation report and she delivered the placenta at 11.00. Mw [RM G] documents the inspection of the placenta at 1110. There is nothing written in the clinical notes about any examination of [Ms A's] perineum but it is ticked as being 'intact' in the Delivery Summary. [RM C] describes the inspection of [Ms A's] perineum being done by [RM F] and that the second degree laceration was noted but that suturing was not required in her response letter to the HDC. It became clear in the following days that in fact there was a 2nd degree laceration that was later repaired at

[the public hospital]. At 1050 the ambulance crew arrived and took over the resuscitation efforts from [RM F] (CCM/midwife 3) at which time she immediately moved her focus to supporting [Ms A] and her whānau. [RM C] states that she did some clinical assessments (BP, Pulse, blood loss and fundus) prior to [Ms A's] discharge from Birthcare although these are not documented in the notes. Her temperature was not done. The time [Ms A] was discharged home from Birthcare is not documented nor are any post natal observations in any of the documentation I have reviewed. The whānau documents a text from ([Mrs B]) and [RM C] at 1546 to ask about what pain relief [Ms A] could use so I assume the discharge happened at some time between midday and 1546. The following morning the postnatal midwifery care is handed over to [another LMC midwife].

An event such as this tragedy is very unusual to the point that many midwives will never be faced with such. In this situation the majority of midwives will be deeply shocked and distressed and individual responses will vary from midwife to midwife. The focus had been entirely on the baby, which is understandable but essentially [Ms A] was left sitting on the bed with her whānau around her without any ongoing communication about what was unfolding. There didn't seem to be any consideration given to any potential bleeding, which was a risk at this time especially given that the second stage of labour had been longer than usual.

It is my opinion that the midwifery care [RM C] provided to [Ms A] and her whānau in the immediate aftermath of this tragedy was below the accepted standard of care and would be viewed as a mild departure given the stress of this particular situation.

10. Whether [RM C's] management of the resuscitation process following [Baby A's] delivery was of an appropriate standard.

[Baby A] was born at 1030. He was born in very poor condition, pale, floppy, not breathing and with no detectable heart rate.

In her retrospective notes [RM C] describes delivering baby onto [Ms A's] abdomen and immediately rubbing him down to stimulate him, then transferring him to the Ohio bed and calling for assistance. The notes from Birthcare Midwife [RM E] document (from the phone time) that the initial call for assistance was at 1036 and that when she entered the room [RM C] was rubbing baby, who was still on [Ms A's] abdomen, to stimulate him. [RM E] then called the clinical manager RM F into the room for more support and started to set up the mixer and Neopuff for ventilation of baby. [RM C] states in her notes that the ambulance was present at 1040 but the notes from the Birthcare staff state the ambulance was called at 1040 and arrived between 1049 and 1050, at which time the resuscitation was taken over by the ambulance staff.

Timeline:

1030: [Baby A] born

1036: initial call for assistance by [RM C], [RM E] enters the room and calls for extra assistance from the clinical manager [RM F]

1036: baby repositioned on the resuscitation table and positive pressure ventilation commenced, LMC instructed to commence chest compressions

1040: ambulance called and LMC midwife [RM G] called into to the room for further assistance

1047: [RM G] in phone discussion with the [public hospital] and advised to administer IM adrenaline

1050: fire and ambulance arrive and resuscitation taken over by ambulance staff.

1052: [RM F] talking with the whānau.

1118: resuscitation stopped on advice from the advanced paramedic and baby declared to be deceased. (Stillborn)

The APGAR score is used to assess the condition of a baby at birth and is calculated at 1 minute and again at 5 minutes. It is an evaluation measure intended to quickly identify a baby who needs resuscitation by assessing colour, respiration, heart rate, reflexes and muscle tone with scores of 0, 1 or 2 being given for each parameter. Further assessments are done at 5 minute intervals until 20 minutes if the 5 minute APGAR is 6 or less. In practice, midwives assess the condition of a baby *as soon as* he or she is born, in particular the colour, tone and respiratory effort of the baby. When a baby is active, (good tone) crying (so clearly breathing) pinking up during that first minute (most babies are not pink at the point of birth) and behaving normally as would be expected with a healthy baby, the APGAR score is often assumed and not actually formally taken. So a midwife won't normally record the respiration rate or heart rate of a baby in this situation, especially as the baby is normally skin to skin with the mother and there would be no reason to interfere with this very special time with a baby who is clearly seen to be well.

[Baby A] however, was born with no signs of life, APGARS of 0 and 0. When [RM E] was called and entered the room he was 6 minutes old. She states that he was moved to the resuscitation table (Ohio Bed) after she entered. There was a considerable delay in calling for help and commencing resuscitation other than providing stimulation, which in my opinion was a significant departure from the accepted standard of care. From the description in the notes it is also clear that the resuscitation equipment was not prepared and further time was lost in getting the oxygen, mixer and Neopuff assembled. It has been my experience that most midwives will do this during the labour so they can be better prepared to manage an emergency such as this, as even with no risk factors or concerns babies will sometimes arrive unexpectedly 'flat' and require resuscitation. So the oxygen will be assembled, warm towels ready, ambubag or neopuff assembled (depending on what equipment is

available) either at home or in a birthing unit and the resuscitation table (in a birthing unit or hospital) turned onto prewarm so it is not cold if needed in an emergency.

In my experience in hospital settings, this equipment is checked at least once each day. It is my opinion that [RM C's] actions in not having the resuscitation equipment adequately prepared prior to the birth, is a departure from the expected standard of care and would be regarded as moderate given the circumstances of this case. [Baby A] did not display any reassuring signs of life and it would be my expectation that calling for help (using the emergency call bell) and commencing resuscitation would have happened within the first minute. I certainly acknowledge the stress of the situation and being confronted with a baby in this condition unexpectedly can be very shocking. Providing stimulation to [Baby A] was the correct initial action to take but this is something I would expect to be done for perhaps 20 to 30 seconds, 6 minutes is a very long time to be persisting with stimulation of a baby in the condition [Baby A] was described as being in. The failure to recognise the seriousness of [Baby A's] condition when he was born did not meet the acceptable standard of care expected and I would regard this as a moderate to severe departure.

11. Whether [Ms A's] post-natal care by [RM C] was reasonable.

I have addressed the immediate postnatal care provided by [RM C] in question 9.

After the resuscitation efforts were stopped the ongoing care of [Ms A] was still the responsibility of [RM C] and I understand from her letter to the HDC (23 September 2022) that another LMC midwife came into the unit at some stage to support her with the paper work. But from reading the whānau's complaint letter it is clear that there was little in the way of emotional support offered on that day. They describe for example, not knowing that [Baby A] had been stillborn until 4 days after the birth when the Delivery Unit manager from [the public hospital] spent time with them explaining the events. Up until that time the whānau were under the impression that he had been born alive and had passed away during the resuscitation. It is clear from the complaint that the whānau were left feeling abandoned and confused after the stillbirth and I can find no evidence in the notes that would dispute this. The whānau describe the room being left in disarray with soiled linen being left lying around until [Ms A's] mother [Mrs B] specifically asked for the room to be cleaned up. They describe having to go out of the room to look for [RM C] several times. [RM C] would have been busy with the paperwork involved when a stillbirth happens but failing to provide a culturally appropriate and comfortable space for the whānau was below the standards expected given the circumstances. [RM C] was still the LMC at this stage and I consider that it was primarily her responsibility to provide support and care and to document that care, despite the distress and upset she herself would have been experiencing.

Overall, it is my opinion that the care provided through this time was below the standard expected and I would regard this as moderate departure given the circumstances.

The ongoing postnatal care was transferred to [another LMC midwife] the following day. [RM C] offered this option to [Ms A] and her whānau via text the following morning and this was appropriate given the circumstances. It is not uncommon for a woman to want a different midwife to take over the care following an unexpected outcome regardless of the circumstances so this was certainly in keeping with expected midwifery practice.

12. Any other aspects of care provided to [Ms A] that you consider warrant comment.

I have no further comments here as I have endeavoured to explore each aspect of the care provided as it came up through the questions posed in this report.

Birthcare Huntly Limited overall management:

1. Whether the care provided by Birthcare Huntly to [Ms A] and her whānau at 40+4 weeks was of an appropriate standard.

The Birthcare staff were not involved in any way in providing the midwifery care during the course of the labour from [Ms A's] admission until after the birth of [Baby A]. As an LMC, [RM C] is an independent practitioner and the staff would only be expected to enter the birthing room at the request of the LMC or if summoned by the woman or whānau in the absence of the LMC. When they were called, the Birthcare midwives immediately responded and provided help and support of an appropriate standard.

2. The adequacy of Birthcare Huntly Limited's emergency response management following [Baby A's] delivery.

The midwives at Birthcare Huntly that day were involved in the care provided to [Ms A] and [Baby A] and in the provision of midwifery support and guidance to LMC midwife [RM C] from 1036 when the call bell was used and assistance was sought by [RM C]. The emergency bell was not used but rather the normal call bell was used, so the initial response from [RM E] was based on walking into an emergency situation that she was in no way expecting. She was also faced with the resuscitation equipment not being immediately available as it hadn't been set up earlier. She immediately identified that there was a significant problem and asked the LMC what she needed. She also called the Clinical Manager [RM F] for more support. When called by [RM E], [RM F] attended immediately and took over the management of the resuscitation by repositioning [Baby A] correctly on the resuscitation table, beginning inflation breaths and directing the LMC [RM C] to commence chest compressions. She was also directing the other midwives in their actions, such as calling 111, getting extra help from another LMC who was in the Unit and phoning the NBU (Newborn Unit at [the public hospital]) for paediatric advice and support.

It's always possible to reflect on actions that were taken or not taken during a situation such as this in retrospect and think of things that could have been done better. But under the circumstances that the Birthcare Staff were presented with that day it is my opinion that they acted completely within the expected standards of

practice. The things that could have been done somewhat better would include turning the APGAR timer on (it was turned on at 1039) and perhaps using an airway when air entry was unable to be achieved with the neopuff but in my opinion these things did not make any difference to the outcome.

Midwifery Council: Code of Professional Midwifery Practice.

1. Interprofessional relationships

Through their conduct, Midwives ensure that:

1.3 When there is an emergency, they provide appropriate care to women. When a midwife calls for help, all midwives have a duty and obligation to attend and assist as able.

3. The adequacy of Birthcare Huntly's clinical notes.

All of the notes from the Birthcare midwives that day as regards the resuscitation were made in retrospect as I would expect that given the situation that they were dealing with. The only notes that address any ongoing midwifery care of [Ms A] after the birth other than a brief note at 1210 and 1410 in [RM C's] retrospective notes, until her discharge home are written by LMC midwife [RM G] so I am unable to comment on who was actually providing this portion of the midwifery care. It would seem to have been somewhat of a collective effort by the LMC [RM C], the Birthcare midwives and the other LMC [RM G] who had come in to help.

Given the distress and upset all of these women would have been experiencing at the tragic outcome for this whānau I would consider this a mild departure from acceptable standards in the circumstances.

4. Whether the communication between Birthcare Huntly Limited and [RM C] [at 40+4 weeks], was of an appropriate standard.

The initial communication that day was between the LMC and Birthcare midwife [RM D]. There were two phone calls from the LMC to [RM D] at 0500 then 0503 and an in person discussion at 0530 when [RM C] arrived at the Unit. [Ms A] had not been booked to deliver at Birthcare Huntly but [RM C] had made the decision to transfer her from home to Birthcare rather than make the slightly longer trip to [Birthing Unit 2] where [Ms A] was booked, as she was initially thought to be fully dilated or near fully dilated. The LMC came out of the birthing room at 0710 during the staff hand over to report that [Ms A] had an anterior lip of cervix and was being discouraged to push at that time. There was no further communication between the LMC [RM C] and the Birthcare midwives until 1036 when the LMC called for assistance.

There are some LMC midwives who will make it their practice to come out of the birthing room regularly and update the charge midwife or the co-ordinating midwife with how the progress of the labour is going. This will usually take the form of a quick conversation to let the charge midwife know where the labouring woman is in her labour, — just starting to push, how dilated she is, that her membranes have ruptured

etc. The benefit in doing this is that the charge midwife has a better overview of what is happening in the delivery suite at any given moment and is better able to anticipate potential impending issues and respond to and provide support to both the LMC midwife and to the woman and her whānau.

Other LMC midwives will not do this but rather will provide an initial update then keep a more private closed door environment for the woman and whānau. Sometimes this can be the wishes of the woman and sometimes it can be because the midwife may have had a negative experience in dealing with hospital staff at some stage. Neither style is wrong so to say, it really comes down to style of practice. However, the responsibility for communication sharing between the LMC and the hospital or birthing centre staff about the labouring woman is the LMC's.

It is my opinion that in this situation the communication between the staff at Birthcare Huntly and the LMC that day was appropriate on the part of the Birthcare midwives.

5. Whether Birthcare Huntly Limited's communication and guidance with [Ms A] and her whānau following [Baby A's] birth and still birth was of an appropriate standard.

There is nothing in the retrospective notes from the Birthcare midwives that addresses the support, advice and care offered to [Ms A] and her whānau. There is a great deal of paper work and tasks that need to be done when a stillborn baby is delivered and even in a hospital setting it can be confusing and take a great deal of time. The whānau describe the CMM [RM F] spending some time with them talking through options for Post Mortem or other less invasive investigations and the option to transfer to [the public hospital] for ongoing support and care. It is my opinion that the communication between the Birthcare midwives and [Ms A] and her whānau was of an appropriate standard given the circumstances of this situation.

6. Any other aspects of care provided to [Ms A] that you consider warrant comment.

I have no further comments to offer but would like to express my deepest condolences to [Ms A], [Mr A] and their respective whānau for the loss of [Baby A].

Mary Wood
Midwifery Expert Advisor
14th June 2023

References:

Midwifery Council of NZ: Code of Conduct
NZCOM Guidance for practice: Consensus Statements/Multi-disciplinary and general guidance
NZCOM Midwives Handbook for Practice
NZCOM Unexpected Outcome: Information for Midwives
RANZCOG Intrapartum Fetal Surveillance: Clinical Guideline — Fourth Edition 2019
Te Whatu Ora: Guidelines for Consultation with Obstetric and Related Medical Services (Referral Guidelines 2021)

During the course of preparing this opinion I consulted with fellow expert midwifery advisor Nicky Emerson to clarify some issues regarding the classifications of mild, moderate or severe departures from accepted standard of midwifery practice.'

Appendix B: Timeline of labour and delivery

Date/Time	Action
[40+3 weeks] 2pm	CTG monitoring at Birthcare Huntly — Following concerns by [Ms A] of decreased movements.
[40+4 weeks] 01:30	Labour pains started
02:39	[Mrs B] text messages [RM C], to advise that pains had begun at 2am and had now picked up in intensity and frequency.
02:56	Phone call to [RM C] — no answer
03:03	Phone call — [RM C] discussed [Ms A's] progress, advised she would come to the house.
04:05	[RM C] arrived at the house. Attempted an internal examination which was unsuccessful at this time.
04.45	[RM C] advised [Ms A] to move to Birthcare.
05:00	Call received by [RM D] at Birthcare from [RM C], to advise that she was bringing [Ms A] to Birthcare.
05:03	2 nd call made by [RM C] to request the birth pool be filled.
05:15	[Ms A] and whānau arrive at Birthcare. [Ms A] was in established labour and went straight into the birth pool. No maternal heart rate, temperature or blood pressure was recorded. Fetal hear rate (FHR) was 142 bpm (Recorded in retrospect by [RM C]).
06:15	(Recorded in retrospect by [RM C]) Vaginal examination. Noted possible lip of cervix. [Ms A] advised not to push. However whānau advised that at this time [RM C] said to 'push if you want to, go with it'.
07:00	Change of shift. Handover from night shift [RM D] to [RM E] to day shift.
07:10	(Recorded in retrospect by [RM C]) FHR 133 bpm
07:30	(Recorded in retrospect by [RM C]) [Ms A] out of the bath onto bed for check. Using Entonox. Fully dilated. (However full dilation was noted on the delivery summary as 9.00am.)
08:00–08:30	(Recorded in retrospect by [RM C]) [Ms A] pushing with contractions, caput noted. FHR 142 bpm, position change to hands

	and knees, FHR 132 bpm, FHR 126 bpm, FHR 105 bpm recovered to 135 bpm after contraction, FHR heard during contraction 135 bpm.
09:00	(Recorded in retrospect by [RM C]) Potential transfer to [the public hospital]. 'Happy with progress, await, if not delivered by 10:00am to transfer to hospital.'
09:05	(Recorded in retrospect by [RM C]) FHR 115 bpm. Maternal Pulse 99(?) bpm.
09:50	(Recorded in retrospect by [RM C]) FHR 121 bpm, deceleration down to 99 bpm with good recovery. 'Pushing +++'. FHR 105 bpm. Well done' and 'Good pushing, baby advancing' and 'FHR 110 bpm. Pulse checked.'
	[Mrs B] noted baby's head crown twice, but it retracted all the way back.
10.30	Time taken from birth documentation recorded in retrospect. (Recorded in retrospect by [RM C]) 'Spontaneous delivery of male infant, in poor condition placed onto mum's abdomen. Not responsive called to staff for support.'
10.36	(Recorded in retrospect from [RM E]) Call from birth room 1 to midwife phone. No one on the line. [RM E] enters the birthing room, sees that [RM C] is rubbing baby with towel. Clinical Manager [RM F] also into the room helping with resuscitation.
	Neopuff and oxygen blender not yet available. Retrieved from cupboard by [RM E].
	Inflation breaths with Neopuff, no chest rise noted.
10:38	(Recorded in retrospect) [RM E] left the birth room to make 111 call for neonatal emergency. [RM G] asked to come and help.
	[RM C] commenced chest compressions using 2 finger technique. [RM G] present in room.
10.40	(Recorded in retrospect) [RM G] administered Vitamin K 1mg intramuscularly as directed by [RM C]. Noted that there was no response to injection stimulus. (Noted as out of room to retrieve this).
	(Recorded in retrospect) [RM G] listened with stethoscope, no air entry audible in lungs. No HR heard. Advised [RM F] to reposition mask. O2 increased to 70% and 10L flow. Neopuff mask resealed over Baby's nose and mouth by [RM F]. C grip used. Head in flexed position.

10.42	Oxygen increased to 100% by [RM G].
	(Recorded in retrospect as per call logs) [RM G] called [the public hospital] Neonatal on-call Registrar. Advised that a full resuscitation effort was underway, baby was approx. 7 minutes old and not responding to resuscitation. Registrar advised that they were heading to theatre and asked to call the NICU Associate Clinical Nursing Manager.
10.44	2nd call by [RM G] to NICU. Advised to give adrenaline (by the paediatrician over the phone).
10:45	Thick meconium being expelled from baby's nose and mouth. Airways suctioned by [RM C] as per advice of NICU. Ventilation via Neopuff recommenced.
10.46 - 10.50	(Recorded in retrospect) Adrenaline drawn up by [RM E]. Checked by [RM F]. Recorded on Birthcare Drug Sheet as: Adrenaline 1:1000 1mg/ml. Further investigation shows that the ampule was 1mg in 10ml (1;10,000 concentration) therefore the correct dose of 0.1mg was administered.
	[RM E] took over the neopuff to relieve [RM F]
	Ambulance and Fire crew arrived at Birthcare, ambulance crew took over and led the resuscitation
	2nd dose of Adrenaline administered by ambulance officer. Airway inserted by ambulance officer. Air entry heard on right side only.
10.56	Resuscitation continued, awaiting the arrival of advanced paramedic to insert Umbilical Venous Catheter (UVC). The plan was to insert an UVC and then transport to [the public hospital] with resuscitation continuing en route
	(Recorded in retrospect) [RM G] noted the call ended with [the public hospital], and 17 minutes had elapsed since the APGAR timer started.
11.10	Placenta delivered by [RM E] and checked by [RM G].
11:18	Heart rhythm asystole (flat line). Resuscitation team stood down.