Midwife, Ms D

Midwife, Ms E

Midwife, Ms C

A Report by the

Health and Disability Commissioner

(Case 12HDC00460)

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

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Executive summary

1. In 2011, Ms A, aged 19 years, discovered that she was pregnant with her first baby. Ms A's estimated date of delivery (EDD) was 4 Month10[1]. Ms A's lead maternity carer (LMC) was registered midwife Ms D. Ms D's back-up midwife was Ms E.

2. Ms A discussed with Ms D her wish to have a water birth at home, but Ms D did not prepare a written care plan. The midwives conducted 13 antenatal visits.

3. Ms D started a customised fetal growth chart on which both Ms E and Ms D charted the fundal height[2] measurements in completed weeks of gestation, rather than by the more specific measure of weeks and days. On 29 Month8 the fundal height was 34cm. On 12 Month9 the fundal height measurement was again recorded as 34cm. No growth scan was arranged.

4. On 2 Month10, when Ms A was 39 weeks and 5 days' gestation, Ms E saw Ms A, who reported a reduction in her baby's movements. Ms D also saw Ms A at 5pm that day and noted on the Antenatal Record sheet that the fetal movements were "fine".

5. On 3 Month10, at 1.50am, Ms A's partner contacted Ms D and said that Ms A was having contractions every 2–3 minutes. At 3.15am Ms D arrived at Ms A's house. At 5.45am Ms A had an urge to push. Another back-up midwife, Ms C, arrived at 6.55am, at which stage Ms A was fully dilated and pushing.

6. At approximately 7.31am Baby A was born with the umbilical cord wrapped around her neck several times. She had poor muscle tone and was blue. Ms D was not carrying an oxygen cylinder. Ms E carried oxygen in her car, but was not the back-up midwife at that point. Ms C did not remember to place her home birth equipment in the car.

7. Resuscitation was commenced and, by 7.34am, there had been little improvement, so an ambulance was called. Ms C actively managed the third stage of labour. The paramedics performed advanced resuscitation. At 8.30am a helicopter arrived and conveyed the baby to hospital, arriving at the neonatal intensive care unit (NICU) at 9.31am. Ms C drove the parents to hospital.

8. Following NICU assessment, a decision was made to withdraw ventilation. Sadly, Baby A died at 12.45pm. A post mortem was carried out, reporting a final diagnosis of intrapartum asphyxia.[3]

Findings

9. During Ms A's labour, Ms D failed to monitor Ms A with reasonable care and skill and, accordingly, breached Right 4(1)[4] of the Code.

[1] To maintain privacy, relevant dates are referred to as Month1-Month11.
[2] The distance from the top of the uterus to the pubic bone, measured in centimetres. The fundal height is used to indicate fetal growth.
[3] A brain injury caused by oxygen deprivation during labour and birth.
[4] Right 4(1) states: "Every consumer has the right to have services provided with reasonable care and skill."

10. Ms D did not advise Ms A of the risk to her baby if she stayed in the bath and decided not to have an episiotomy, nor did Ms D advise Ms A that local anaesthetic was available. This was information that a reasonable consumer in Ms A's circumstances would need before choosing whether or not to have an episiotomy. Accordingly, Ms D breached Right 6(2)[5] of the Code.

11. It was the responsibility of Ms D as LMC to ensure the provision and availability of all home birth equipment, including oxygen. For failing to do so, Ms D breached Right 4(1) of the Code.

12. Ms D's actions following the birth were concerning and unprofessional. Ms D discussed with Ms A her interactions with the police and the preparation of her statement for the Coroner. Ms D sent her statement to the Coroner to the baby's grandmother, Ms B, and distributed her statement to the Coroner to a number of other local health professionals. Ms D should have communicated and engaged with Ms A in a more professional and objective manner. Ms D failed to comply with professional and ethical standards and, accordingly, breached Right 4(2)[6] of the Code.

13. Adverse comments were made about Ms E's actions in failing to complete the customised antenatal growth chart accurately, and regarding her limited assistance to Ms A on 2 Month10.

14. Adverse comments were made about the need for Ms C to be adequately prepared when attending a birth, and the maintenance of full and complete records.

Complaint and investigation

15. The Commissioner received a complaint from Ms B about the services provided to her son's partner, Ms A.

16. The following issues were identified for investigation:

- *Whether Ms D provided an appropriate standard of care to Ms A between Month2 and Month10.*
- *Whether Ms E provided an appropriate standard of care to Ms A between Month2 and Month10.*
- *Whether Ms C provided an appropriate standard of care to Ms A in Month10.*

17. An investigation was commenced on 10 April 2013.

18. The parties directly involved in the investigation were:

[5] Right 6(2) states: "Before making a choice or giving consent, every consumer has the right to the information that a reasonable consumer, in that consumer's circumstances, needs to make an informed choice or give informed consent."
[6] Right 4(2) states: "Every consumer has the right to have services provided that comply with legal, professional, ethical, and other relevant standards."

Ms A	Consumer
Ms B	Complainant
Ms D	LMC, registered midwife
Ms E	Registered midwife
Ms C	Registered midwife

19. Information was also reviewed from:

The Coroner
The Midwifery Council of New Zealand

20. Independent expert advice was obtained from a midwifery advisor, Ms Lesley Ansell (**Appendix A**).

Information gathered during investigation

Background

21. In 2011 Ms A, aged 19 years, discovered that she was pregnant with her first baby.

22. Her estimated date of delivery (EDD) was 4 Month10. Ms A's LMC was registered midwife Ms D. Ms D's back-up midwife was Ms E.

23. Ms A had no medical history of concern. She stated to the Coroner that prior to becoming pregnant she was in good health and that she remembers telling Ms D: "[M]y mum had a complicated birth with me. I think I got stuck and I was a forceps delivery." However, in Ms A's midwifery notes the section of the Maternal History Summary sheet relating to maternal maternity history is blank.

Antenatal care

Care plan

24. Ms A wanted to have a water birth at home.

25. Ms A said in her statement to the Coroner: "[Ms D] and I did discuss the birth but we didn't write up a plan as such." Ms A stated that Ms D "[got] a feel" for how Ms A wanted the birth to progress, but Ms D told her "not to write up a strict plan because things can often change quickly".

26. The Care Plan Checklist sheet in Ms A's midwifery notes states under the heading "Care plan": "17 [Month2] Discussed, aware safety yes." In response to the provisional opinion, Ms D stated that this was not the totality of the care plan, and that the plan was documented throughout the clinical notes.

Visits

27. Ms A's antenatal records show that the antenatal visits were as follows:[7]

[7] All visits were made by Ms D unless stated otherwise.

Date of visit	Gestation recorded in notes	Actual gestation (by EDD 4 Month10)
17 Month2	7 weeks — first visit	6+6 weeks
21 Month3	12 weeks	11+6 weeks
26 Month4	17 weeks	16+6 weeks
11 Month6	23 weeks	23+3 weeks
23 Month7	29 weeks	29+4 weeks
29 Month8	34 weeks — *seen by Ms E*	34+6 weeks
12 Month9	37 weeks	36+5 weeks
17 Month9	38 weeks	37+3 weeks
24 Month9	38 weeks	38+3 weeks
30 Month9	39 weeks	39+2 weeks
31 Month9	39 weeks	39+3 weeks
2 Month10 2pm	39 weeks — *seen by Ms E*	39+5 weeks
2 Month10 5pm	39 weeks	39+5 weeks

Growth chart use

28. Ms D started a customised fetal growth chart for Ms A (see **Appendix B**). Ms D said that her practice is to use growth charts for all women in her care. On 23 Month7 when Ms A was 29 weeks' gestation, Ms D recorded that the fundal height measurement was 28cm.

29. On 29 Month8, back-up midwife Ms E saw Ms A and recorded that she was 34 weeks' gestation, although the actual gestation was 34 weeks and six days. Ms E measured the fundal height, which was 34cm. There were no clinical concerns at that time.

30. On 12 Month9 Ms D saw Ms A. Ms D recorded the gestation as 37 weeks, although the actual gestation was 36 weeks and five days. The fundal height measurement was again recorded as 34cm — above the 10th percentile.

31. Ms D told HDC that if there was no further increase in fundal height, the plan was to undertake a growth scan investigation at the next appointment, which was to be on 17 Month9.

32. Ms D acknowledged that the measurements indicated that there may have been a plateau in growth, but said that this may have been due to different practitioners performing the measurements. The statement on the bottom of the growth chart suggests that when growth is static or there is a flat curve, a referral for a growth scan should be arranged. It also suggests that measurements to monitor growth should be every 2–3 weeks, and preferably by the same person.

33. The fundal height was again measured by Ms D five days later at the appointment on 17 Month9, and showed an increase, which was charted as 37cm — above the 50th percentile. No growth scan was arranged.

34. No information was recorded in the table on the growth chart form, which records the date of visit, gestation, fundal height, and whether there should be a growth scan (see **Appendix B** — Customised antenatal growth chart).

35. Both Ms E and Ms D charted the measurements in completed weeks of gestation, rather than by the more specific measure of weeks and days. For example, the fundal height measurement taken at 34 weeks and 6 days was plotted at 34 weeks on the chart.

Fetal movements

36. Ms A stated to the Coroner that on 27 Month9 she started having contractions, which were about five minutes apart. On 28 Month9 Ms D recorded in the clinical notes: "[P]ains have started, irregular, painful. Will keep me posted." Ms D stated that on 30 Month9 Ms A contacted her and reported that she was experiencing stronger uterine cramps, so Ms D visited and conducted a "full assessment" including a vaginal examination. On 31 Month9 Ms A was still experiencing contractions, and Ms D noted: "Still awaiting active labour." Ms A was not reviewed on 1 Month10.

37. At 2pm on 2 Month10, when Ms A was 39 weeks and 5 days' gestation, she was assessed by Ms E. Ms A mentioned a reduction in her baby's movements. Ms E said that Ms A advised her that she "didn't think she had felt movements since the day before".

38. Ms E recorded: "Baby movements have been less, 3 movements with accelerations when midwife palpated." Ms E stated that Ms A also felt the movements. The baby's heart rate was documented as 134 beats per minute (bpm). Ms E told HDC that the fetal heart baseline was 134bpm with accelerations of the fetal heart heard on the hand-held Doppler.[8]

39. Ms A was advised to note her baby's movements by placing a hand on her abdomen, and to keep in contact with her midwife. Ms E said that when she spoke to Ms D at around 4.30pm, she "did not express any concern to [Ms D] about the lack of movements".

40. Ms A recalls that she was told to lie down and feel for her baby's movements and, if she felt no movement, to call Ms E or her LMC, Ms D. Ms A stated to HDC that she was not particularly confident about what she was looking for or what was normal.

41. Ms D saw Ms A at 5pm that day. Ms D advised HDC: "During my visit there was no concern in relation to fetal movements." She said she discussed birthing options with Ms A.[9] The fetal heart rate is documented as 130–140 bpm. Ms D noted on the Antenatal Record sheet, but not in the clinical notes, that the fetal movements were "fine".

[8] A Doppler fetal heart rate monitor is a hand-held ultrasound transducer used to detect the heartbeat of a fetus. Doppler fetal monitors provide information about the fetus similar to that provided by a fetal stethoscope.

[9] Specifically, the options were to wait at home for active labour, go to the maternity unit for artificial membrane rupture once contractions were strong, or go to hospital for augmentation of labour.

42. Ms A cannot recall what Ms D told her that day.

43. It is not documented whether either midwife asked Ms A when the reduction in the baby's movement was first noted and for how long, or whether Ms A was advised what are acceptable movements and when to seek assistance.

Labour

First stage — midnight to 5.50am

44. Ms A's contractions became stronger from midnight on 3 Month10. Ms A's partner contacted Ms D at 1.50am and said that the contractions were every 2–3 minutes. Ms D stated that she spoke to Ms A's partner again at 2.20am, and he reported that Ms A had bloody vaginal mucous, and that he was filling the birth pool. Ms D stated that she contacted Ms A's partner again at 3.00am. He told her that the contractions were getting stronger, so she said she was on her way to assess the labour.

45. At 3.15am Ms D arrived at Ms A's home. Ms A's contractions were strong and regular. Ms D conducted a vaginal examination at 3.45am, which showed a thin 8cm dilated cervix. Ms D then auscultated (listened to) the fetal heartbeat, recording it as 130–150bpm. Ms A entered the birth pool at 3.50am.

46. At 5am Ms D conducted a further vaginal examination, which showed that the cervix had an anterior rim.[10] At 5.45am Ms A had an urge to push.

Monitoring — first stage

47. In the first stage of labour the baby's heart rate was auscultated four times (3.45am, 4.20am, 5.15am, and 5.45am post-contraction). There was an interval of 55 minutes between 4.20 and 5.15am when the baby's heart rate was not auscultated.

48. There is no record of an assessment of Ms A's temperature or blood pressure during the labour. Her pulse rate was recorded only once at 4.20am, as 80bpm.

Monitoring — second stage

49. It is unclear exactly when the second stage of labour commenced.[11] The labour and birth summary records the second stage beginning at 5.00am, but the clinical records state that Ms A's cervix was not fully dilated at that time, as an anterior rim of cervix was present. It is recorded that effective pushing began at 5.50am.

50. Ms D told the Coroner and HDC that her monitoring practice is to auscultate the baby's heart rate between contractions for 60 seconds.

51. The baby's heart rate was auscultated by Ms D a further eight times (6am, 6.10am post-contraction, 6.30am post-contraction, 6.40am, 7am post-contraction, 7.10am, 7.15am, and 7.20am).

[10] The anterior rim of the cervix is usually the last part of the woman's cervix to be finally taken up into the lower segment of the uterus.
[11] The second stage of labour begins when the cervix is fully dilated, and ends with the birth of the baby.

Second stage

52. At 6.00am Ms D conducted a further vaginal examination and noted: "Head just inside, bulging membranes."

53. At 6.10am another back-up midwife, Ms C, was organised to attend, as Ms D's usual back-up midwife, Ms E, was at another birth.

54. Ms D recorded at 6.40am: "Second midwife here. Peep visible." Ms D noted that the membranes had ruptured and the liquor was clear. In contrast, Ms C recorded retrospectively that she arrived at 6.55am, at which stage Ms A was fully dilated and pushing. Ms C stated that the difference in times recorded was probably due to not using the same timepiece, as she relied on her cell phone to ascertain the time.

55. At 7.00am Ms D noted: "Crowning gently." Ms C's retrospective notes record that at 7.15am Ms A was progressing well and baby's heart rate sounds were good. Ms D noted that the FHR was 130bpm.

56. Ms C stated that the presenting part was visible at 7.20am and on the perineum[12] at 7.25am.

57. At 7.25am Ms D recorded: "Pushing my hands against tight perineum, sliding progress." Ms D did not record or, in her initial responses to HDC, advise of, any discussion with Ms A regarding an episiotomy. However, in response to the expert advice, Ms D stated that she had had surgical scissors and local anaesthetic at hand. She stated that she "suggested to [Ms A] that a small cut could be helpful in expediting the birth", but that Ms A refused consent for this. In response to the provisional opinion, Ms D said she accepts that it would have been appropriate to be more forceful about the benefits of an episiotomy in the circumstances.

58. Ms A is adamant that she refused an episiotomy because she was told that there was no anaesthetic available. She cannot recall any other discussion about the matter. In response to the provisional opinion, Ms D said she did not say that there was no anaesthetic available, and added, "[N]ot only did I have my birth gear available, my back up midwife also carried local anaesthetic." She agreed that informed consent is reliant on good antenatal information.

Birth

59. Ms D recorded in the clinical notes that at 7.25am the baby's head was out, but the umbilical cord was wound around the baby's neck (CAN)[13] four times.

60. Ms D also recorded that Baby A was born at 7.31am and was "delivered immediately once head out". Ms D noted that thick meconium[14] was present, and that Baby A had

[12] The perineum is the region of the body inferior to the pelvic diaphragm and between the legs. It is a diamond-shaped area on the inferior surface of the trunk, and includes the anus and the vagina.
[13] A nuchal cord or CAN occurs when the umbilical cord becomes wrapped around the baby's neck 360 degrees. This is common, and the incidence increases with advancing gestation.
[14] Meconium is the earliest stool of an infant. Meconium is viscous and sticky like tar, and its colour is usually dark olive green. When diluted in amniotic fluid, it may appear in various shades of green, brown, or yellow. Its presence during labour can indicate fetal distress.

poor muscle tone and was blue. At 7.32am Ms C clamped the cord, which was cut by Ms A's partner.

61. However, in contrast to what she recorded in the clinical notes, Ms D said in her statement to the Coroner that, once the head began emerging,

> "[t]here was one more brief pause between contractions and I told [Ms A] the head would be born with the next push. She pushed strongly, and suddenly I felt the vaginal tissues slip, and with the same momentum the entire baby gushed out and pivoted back towards her perineum … I immediately saw the cord was tightly wrapped around the baby's neck four or five times. I instantly unravelled the cord and quickly placed the baby up against [Ms A's] chest."

62. Ms D told HDC that there was "no pause between the birth of the head and the birth of the body … the body shot out expulsively and pivoted back tightly to the perineum". In response to the provisional opinion, Ms A also confirmed to HDC that Baby A was born in one push, and that there was no pause between the birth of the head and of the body.

63. In her statement to the Coroner, Ms C stated that "[a]t approximately 07.31 Baby was born without restitution and came out in one push. The cord was wrapped around her neck several times."

Resuscitation

64. Resuscitation was commenced. Baby A had gasped but had had no regular respirations. Ms D commenced ventilation, and air entry appeared to be good. The heart rate was unable to be assessed clearly by Ms C using a stethoscope. It was thought to be less than 60bpm. Cardiac compressions were started.

65. Ms D has given conflicting accounts as to whether she used oxygen during this resuscitation. In her statement to the Coroner, she said that after the paramedics arrived, she "continued ventilating, using 100% oxygen …". She stated that "there was no equipment lacking … 100% oxygen was commenced for [Ms A's] baby and continued throughout the resuscitation efforts …".

66. In contrast, Ms D told HDC that "based on recent research,[15] [she has] felt confident about not carrying an oxygen cylinder ...". She said that Ms E does carry oxygen in her car, and Ms D can access it if needed, but that in this case, she found herself without oxygen because Ms E was not available to be the back-up midwife. Ms C stated that "this call came unexpected" and she did not remember to place her home birth equipment in the car.

67. At 7.34am there was little improvement in Baby A's condition, and so an ambulance was called. Resuscitation was continued and the baby was kept warm. Ms C

[15] Ms D said that she was strongly influenced by a 2010 Cochrane review: Pileggi Casto Souza C, "Air versus oxygen for resuscitation of infants at birth: RHL commentary", *The WHO Reproductive Health Library*, World Health Organization, Geneva (2010).

documented that there was no fetal heart rate and that CPR (cardiopulmonary resuscitation) continued with good air entry.

Ambulance arrival

68. Two ambulances attended the call-out. The primary ambulance arrived at 7.42am. Ms D continued to ventilate the baby following arrival of the ambulance crew, while the crew commenced advanced resuscitation.

69. The ambulance crew stated that on arrival Ms D was ventilating with air using a bag valve mask, but there was no oxygen in use with the bag. The ambulance crew cannot recall Ms D performing compressions.

Third stage management

70. Ms C actively managed the third stage of labour.[16] At 7.45am Ms C administered Syntocinon[17] intramuscularly to Ms A for management of the third stage.

71. Ms C examined Ms A's perineum. A second degree laceration was identified, which was not bleeding. The fundus of the uterus was checked, and the bleeding was not excessive. Ms A's blood pressure was normal.

72. At 7.52am the placenta was birthed by controlled cord traction.[18] The placenta was stained with meconium. The placenta was retained to be taken to hospital.

73. Ms A was moved out of the pool. Ms C stayed with Ms A for support.

Transfer to hospital

74. Ms D continued ventilation on the baby while the paramedics performed advanced resuscitation. At 8.30am a helicopter arrived and staff on board assisted with resuscitation. At 9.15am the helicopter departed, arriving at the hospital's neonatal unit at 9.31am.

75. Ms C stated that although the paramedics on one of the ambulances had been asked to return and transfer Ms A and her partner to hospital, the ambulance did not return. Ms C said that the parents were tired and distressed, and Ms A's partner wanted to drive Ms A to hospital. Ms C assessed Ms A's condition, which was satisfactory, and offered to drive the couple herself so they could be with their baby. Ms D also drove to the hospital.

76. The clinical notes do not record the method or time of Ms A's transfer to hospital, or Ms A's condition.

77. Following NICU assessment, a decision was made, in discussion with Ms A and her partner, to withdraw ventilation. Sadly, Baby A died at 12.45pm. A post mortem was carried out on 3 Month10, reporting a final diagnosis of intrapartum asphyxia.

[16] The third stage of labour is the period between the baby's birth and the delivery of the placenta.
[17] After the birth of a baby, Syntocinon may be given to the mother to stimulate contractions to help push out the placenta and prevent heavy bleeding.
[18] A method of delivering the placenta by slowly pulling on the umbilical cord with the assistance of a clamp.

Actions following birth

78. On 5 Month11 Ms D emailed Ms B (the mother of Ms A's partner) a copy of her statement to the Coroner, which was unsigned and undated. The email stated: "I have heard from [Ms A] that you have been making undermining comments in relation to [Ms A's] loss of [Baby A]. I find it regrettable that you have not informed yourself of the facts …"

79. Ms B said she had not asked for a copy of Ms D's statement to be sent to her, and was distressed to receive it. Ms D told HDC that she sent it at Ms A's request, and had checked with the Police and her lawyer before doing so. Subsequently, Ms D acknowledged that the statement regarding having obtained legal advice was incorrect, and said that it was an "innocent error" on her part.

80. Ms D said that she had no intention of causing Ms B distress, and thought she was assisting Ms B to understand what had happened. She stated: "In hindsight I made a very regrettable misjudgement."

81. Ms D also sent copies of the statement to other health professionals, including an obstetrician and local midwives. Ms D stated that she considered options to inform her colleagues of the events, as they "are all highly influenced by any adverse outcome that happens in [their] community … I felt it was important to communicate with local midwives who would have to confront the anxiety of their clients. I believe strongly in the transparency of my care and feel I have nothing to hide."

82. Ms D said that she sent copies of the statement to other health professionals because there was much speculation about the case, but she now accepts that her actions were not appropriate.

83. Ms A told HDC that she gave verbal permission for Ms D to discuss her case with other midwives, but cannot recall the circumstances of the request.

Communication with Ms A following birth

84. On 28 Month10 Ms D visited Ms A and recorded in the midwifery notes: "Visit by detective yesterday. Good discussion today about statement."

85. On 1 Month11 the midwifery notes state: "[Ms A] has read my statement —good to discuss." On 8 Month11 there is a record of a telephone call: "[Ms A] quite distressed by undermining comments. Informed [her] of my contact with lawyer and progress with case."

86. Ms D's documentation at the six-week discharge visit on 17 Month11 states:

> "[Ms A] — it has been so absolutely amazing and special getting to know you.
>
> What courage and dedication and love I have seen in you.
>
> I will forever treasure these memories and [Baby A] will always remain an angel dear to my heart.
>
> I will always be here for you.

I give you my absolute biggest respect and love to you always. Sadness today but joy for the future.

I will never forget you for the journey we have walked together. Stay in touch. Love always, [Ms D]"

Subsequent actions

87. In her response to HDC, Ms D included samples of notes written in the records of other clients to illustrate her usual practice with regard to her communication style with clients.

88. Ms D stated that she has made "both positive and negative changes" to her practice as follows:

- She now carries her own oxygen cylinder at all times.
- She now does more episiotomies. She said: "I wonder whether this has been beneficial to the women I have looked after, being a result of my quiet anxiety around babies' final descent through the pelvis after [Baby A's] tragic birth … The use of episiotomies in the event of a non-emergency has been proved by international evidence not to be of benefit."
- She is more reluctant to take on first-time mothers as clients.
- She now "would avoid providing care to someone who had a family member opposed to [her] care, regardless of their own preference".
- She now frequently orders third trimester scans.
- In the second stage of labour she now monitors the FHR at least every five minutes, "even when women have been somewhat annoyed to have [her] frequent interference".
- She considers every decision "through the perspective of being analysed critically". She considers this is "defensive practice" and, as a result, her approach is less individualised "and more in response to adhering to all protocols and guidelines".
- Her documentation is less "affirmative and warm" because "it has become evident to [her] that anything additional to structured clinical documentation is not approved of in the event of a review".

Relevant standards

89. The New Zealand College of Midwives *Midwives Handbook for Practice 2008* states:

"Standard One
The midwife works in partnership with the woman …

> Midwives respond to the social, psychological, physical, emotional, spiritual and cultural needs of women seeking midwifery care, whatever their circumstances, and facilitate opportunities for their expression …
>
> Midwives have responsibility to ensure that no action or omission on their part places the woman at risk.
>
> Midwives have a professional responsibility to refer to others when they have reached the limits of their expertise.
>
> Standard Two
> The midwife upholds each woman's right to free and informed choice and consent throughout the childbirth experience.
>
> Criteria
>
> The midwife:
>
> Shares relevant information, including birth options, and is satisfied that the woman understands the implications of her choices.
>
> Standard Three
> The midwife collates and documents comprehensive assessments of the woman and/or baby's health and wellbeing.
>
> Standard Four
> The midwife maintains purposeful, on-going, updated records and makes them available to the woman and other relevant persons.
>
> Standard Five
> Midwifery care is planned with the woman."

90. The Midwifery Council of New Zealand publication *Competencies for Entry to the Register of Midwives* (2007) states:

> "3.5 demonstrates an understanding of the needs of women/wahine and their families/whanau in relation to infertility, complicated pregnancy, unexpected outcomes, abortion, adoption, loss and grief, and applies this understanding to the care of women and their families/whanau as required;"

Opinion: Ms D

Antenatal visits — No breach

91. The midwives (either Ms D or Ms E) visited Ms A 13 times during Ms A's pregnancy, with eight of those visits being in the third trimester. I accept the advice of

my independent expert advisor, midwife Ms Lesley Ansell, that "although they did not follow the traditional pattern, the frequency of appointments was adequate".

Growth chart — No breach

92. A customised fetal growth chart was completed by Ms D and Ms E (see **Appendix B**). Ms Ansell advised me that the growth chart was completed inaccurately, as measurements were plotted on the chart by full weeks, rather than by the accurate gestational age. Ms Ansell said that this would have caused "a discrepancy in the perceived growth for gestational age".

93. On 29 Month8, Ms E recorded that Ms A was 34 weeks' gestation, and measured the fundal height, which was 34cm. Ms D measured the fundal height on 12 Month9, and again the measurement was 34cm, which indicated that there had been no growth since the visit two weeks earlier. Ms D recorded the gestation as 37 weeks, although the actual gestation was 36 weeks and five days. The fundal height measurement was just above the 10th percentile. Ms D acknowledged that there may have been a plateau in growth, but said that this could have been due to different practitioners performing the measurements. Ms D checked the fundal height again on 17 Month9 and it was then 37cm.

94. The customised antenatal growth chart states that a referral for a growth scan should be arranged if there is no growth, a static or flat curve, or slow growth (see **Appendix B**). However, no referral was made.

95. Ms Ansell advised me:

> "[T]he Customised Fetal Growth Chart was not documented or used correctly. It would be common midwifery practice that when a plateau in growth has been recorded, regardless of possibility of practitioner difference, the findings would be acted upon and a growth scan advised at that time."

96. However, Ms Ansell further advised that, as Ms D remeasured the fundal height again five days later, her failure to act upon the findings and arrange a growth scan would be viewed with mild disapproval by most midwives. In my view, the failures to complete the customised antenatal growth chart correctly and to order a growth scan were sub-optimal but, in the circumstances of having remeasured the fundal height five days later, do not amount to a breach of the Code.

Decreased fetal movements — No breach

97. On 27 Month9 Ms A started to have contractions, which were about five minutes apart. On 30 Month9 Ms A contacted Ms D and reported that she was experiencing uterine cramps. Ms D visited Ms A that day and conducted a full assessment.

98. On 2 Month10 Ms E performed an antenatal check. Ms A told Ms E that her baby's movements had reduced and that she "didn't think she had felt movement since the day before". Ms E recorded the concern and the advice she gave but, when she spoke to Ms D at around 4.30pm that day, did not discuss with her the concern regarding fetal movements.

99. Ms D saw Ms A at 5pm on 2 Month10. Ms D advised HDC that during the visit Ms A expressed no concern regarding fetal movements. Ms D recorded that "the movements were fine". It is not documented whether Ms D gave Ms A any advice about what to watch for with regard to fetal movements or what steps she should take if she was concerned.

100. Ms Ansell advised me that a perception of decreased fetal movements is an indicator for pregnancies at increased risk of adverse outcome, including stillbirth and neonatal death, even in pregnancies that are otherwise deemed low risk. She stated: "[T]he mother is advised to lie on her side and concentrate on fetal movements. The mother should report less than ten movements in two hours … It is important that it is the mother's perception of fetal movements that is considered." Ms Ansell advised that "[i]n this case the midwife palpating the abdomen and stating that she could feel fetal movements may have falsely reassured [Ms A]".

101. Ms Ansell stated that given the very prolonged latent phase of labour and the report of decreased fetal movements, the appropriate action would have been to perform a cardiotocograph (CTG)[19] to exclude fetal compromise. However, if during the visit on 2 Month10 Ms D asked Ms A about the fetal movements and ascertained that the movements were normal at that time, then Ms Ansell considered that it would have been appropriate not to perform a CTG.

102. As stated, Ms D told HDC that Ms A expressed no concern in relation to fetal movements at that visit, and Ms D recorded in the Antenatal Record that fetal movements at that visit were "fine". Ms A cannot recall what Ms D told her. Accordingly, I am unable to determine whether Ms D specifically asked Ms A about the reduction in the baby's movements (which was recorded in the clinical notes by Ms E) or when that reduction had been first noted, or whether Ms D gave Ms A advice about an acceptable level of movement and when she should seek assistance.

Maternal and fetal monitoring — Breach

103. Ms Ansell advised that, as Baby A was not breathing and still required full ventilation 29 minutes after her birth, she was born in the stage of terminal apnoea. Ms Ansell stated that "fetal hypoxia during labour is associated with fetal heart rate abnormalities (NICE, 2007) and would have been present in this case as the baby was profoundly hypoxic at birth".

First stage

104. Ms Ansell advised that the fetal heart rate should be auscultated every 15–30 minutes during the first stage of labour, and that this should be done towards the end of a contraction, and continue for 30 seconds after the contraction.

105. Ms D arrived at Ms A's home at 3.15am, but the fetal heart rate was not auscultated until 3.45am, following a vaginal examination which found that the cervix was 8cm dilated. Ms Ansell advised that "it is standard practice to listen to the fetal heart rate

[19] Cardiotocography (CTG) is a means of recording the fetal heartbeat and the uterine contractions during pregnancy, typically in the third trimester. The machine used for CTG is called a cardiotocograph, and is commonly known as an electronic fetal monitor (EFM).

prior to vaginal examination and as [Ms A] had been contracting strongly for over two hours it would have been good practice to listen to the fetal heart soon after arrival".

106. Ms Ansell advised that Ms D auscultated the fetal heart almost every 30 minutes during the first stage of labour, "which is just acceptable to a minimum standard".

Second stage

107. Ms Ansell advised that during the second stage of labour the fetal heart should be auscultated at least every five minutes in the absence of pushing, and for at least 30 seconds after each contraction during active pushing. Ms Ansell said that "vigilant monitoring of the fetal heart is required particularly during active pushing when fetal oxygenation is prone to change more rapidly".

108. It is unclear from the records exactly when the second stage of labour commenced. The Labour and Birth Summary sheet records the onset of the second stage as 5.00am, but the clinical notes state that the cervix was not fully dilated at that time because an anterior rim of cervix was present. At 5.45am Ms A had an urge to push. Effective pushing was recorded as beginning at 5.50am. Therefore, the latest point that the second stage could have commenced is around 5.45am.

109. The fetal heart rate was auscultated at 6.00am, 6.10am, 6.30am, 6.40am, 7.00am, 7.10am, 7.15am and 7.20am. As noted by Ms Ansell, "the fetal heart was auscultated after a five minute interval on only two occasions, the rest of the time auscultation occurred every 10–20 minutes. For 12 minutes prior to the birth, the fetal heart was not auscultated at all. The fetus was not adequately monitored particularly during the second stage of labour."

110. Ms D noted that the fetal head was "[c]rowning gently" at 7.00am. Ms Ansell noted that the fetal head was not born for at least 16 minutes and possibly as long as 31 minutes following crowning. Ms Ansell stated that "this combined with the tightening nuchal cord would have caused further hypoxia in the fetus and subsequent fetal heart rate abnormalities". Ms Ansell advised that vigilant monitoring would likely have identified the fetal heart rate abnormalities, which would have alerted Ms D to the increasing fetal hypoxia. Ms Ansell also noted that the maternal temperature and blood pressure were never measured.

111. I agree with Ms Ansell that the inadequate monitoring during the second stage of labour was a moderate departure from an accepted standard of care. Ms D failed to monitor Ms A with reasonable care and skill and, accordingly, breached Right 4(1) of the Code.

Episiotomy — Breach

112. Ms D made no record of any discussion with Ms A during the labour regarding an episiotomy. However, Ms D advised HDC that she had had surgical scissors and local anaesthetic at hand. Ms D stated that she "suggested to [Ms A] that a small cut could be helpful in expediting the birth", and that Ms A refused consent. Ms A stated that the reason she refused an episiotomy was that she was told there was no anaesthetic available. She said that she cannot recall any other discussion about an episiotomy. In response to the provisional opinion, Ms D said that during their antenatal discussions

about episiotomy, "we focussed more on the ongoing effects of sustaining a cut". Ms D said that she did emphasise that there were times when an episiotomy was necessary, and did not say that there was no anaesthetic available. However, she did not explain what information she gave to Ms A about pain relief.

113. Ms Ansell advised that the appropriate course of action would have been to remove the mother from the water and strongly advise her that an episiotomy be performed to expedite the birth for the well-being of the fetus. Ms Ansell stated that the perineum should have been infiltrated with local anaesthetic and the episiotomy performed.

114. Ms A had the right to refuse services.[20] However, in order to do so she needed to be fully informed about the availability of anaesthetic and the risks of failing to have an episiotomy. Ms A should have been informed about the reasons why an episiotomy was necessary and the possible consequences for the baby if the fetal head remained in the crowned position for a significant period of time. In response to the provisional opinion, Ms D accepted that it would have been appropriate to be more forceful regarding the benefits of an episiotomy.

115. As stated by Ms Ansell, "If the mother is fully informed and still declines the procedure then it is entirely appropriate not to perform an episiotomy. If the woman is not fully informed of the possible consequences for the baby then this would be viewed by most midwives with moderate disapproval."

116. I find it is more likely than not that the necessary information to make an informed decision was not provided to Ms A. She was not advised of the risk to her baby if she stayed in the bath and decided not to have an episiotomy, and she was not aware that local anaesthetic was available if she did have an episiotomy. This was information that a reasonable consumer in Ms A's circumstances would need before making a choice whether or not to have an episiotomy. Accordingly, I find that Ms D breached Right 6(2) of the Code.

Availability of oxygen — Breach

117. Ms D has given conflicting accounts as to whether she had oxygen available at the birth. In her statement to the Coroner she asserted that there was no equipment lacking and that 100% oxygen was used throughout the resuscitation efforts. In contrast, Ms D told HDC that Ms E carried oxygen in her car, which Ms D could access if needed but, in this case, she found herself without oxygen because Ms E was not the back-up midwife. Ms D also told HDC that she felt confident about not carrying an oxygen cylinder. Accordingly, I find that Ms D did not have oxygen available at the birth.

118. Ms Ansell advised me that "[h]ome birth midwives still carry oxygen as part of their neonatal resuscitation equipment as oxygen needs to be available for those babies who do not respond to initial resuscitation". Ms Ansell also stated that to not carry oxygen would be viewed with moderate disapproval by most midwives. In my view, it was inadequate not to have oxygen available. It was the responsibility of Ms D as LMC to

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

ensure the provision and availability of all home birth equipment. For failing to do so, I find that Ms D breached Right 4(1) of the Code.

Professional conduct — Breach

119. On 28 Month10 Ms D visited Ms A and recorded: "Visit by detective yesterday. Good discussion today about statement." On 1 Month11 the record states: "[Ms A] has read my statement — good to discuss." On 8 Month11 there is a record of a telephone call: "[Ms A] quite distressed by undermining comments. Informed [her] of my contact with lawyer and progress with case."

120. Following Baby A's birth, Ms D emailed a copy of her statement to the Coroner to Ms B. The email stated: "I have heard from [Ms A] that you have been making undermining comments in relation to [Ms A's] loss of [Baby A]. I find it regrettable that you have not informed yourself of the facts …" When asked about this issue, Ms D told HDC that she sent the statement to Ms B at Ms A's request after having checked with the Police and her lawyer that it was appropriate to do so. Subsequently, Ms D acknowledged that the statement regarding her having obtained legal advice was incorrect.

121. Ms D also sent copies of her statement to other health professionals, including an obstetrician and local midwives. Ms D stated that she considered options to inform local colleagues of the events, as they "are all highly influenced by any adverse outcome that happens in [their] community … I felt it was important to communicate with local midwives who would have to confront the anxiety of their clients." Ms A told HDC that she gave her verbal permission for Ms D to discuss her case with other midwives, but she cannot recall the circumstances of the request. In response to the provisional opinion, Ms D advised that the Midwifery Council of New Zealand considered that it would have been more appropriate for her to have asked Ms A to post a copy of the notes to Ms B and others, and considered that Ms D's actions related to her competency, rather than to a matter of conduct or a breach of professional boundaries.

122. Furthermore, at the six weeks postnatal discharge visit on 17 Month11, Ms D recorded:

> "[Ms A] — it has been so absolutely amazing and special getting to know you.
>
> What courage and dedication and love I have seen in you.
>
> I will always treasure these memories and [Baby A] will always remain an angel dear to my heart.
>
> I will always be here for you.
>
> I give you my absolute biggest respect and love to you always. Sadness today but joy for the future.
>
> I will never forget you for the journey we have walked together. Stay in touch.
>
> Love always, [Ms D]"

123. Ms D failed to demonstrate an appropriate understanding of the needs of Ms A's family following Baby A's tragic death, as required by the *Competencies for Entry to the Register of Midwives*. Ms Ansell advised me that Ms D's first priority for care and compassion should have been to the family and to minimise the impact of the shock and grief they were suffering. Ms Ansell said that the issue regarding Ms B could have been dealt with in a more sympathetic and compassionate manner, such as by way of a mediated discussion. In response to the provisional opinion, Ms D said that neither consumers nor third parties have a legal right to compassion, and that she considers that the "warmth in documentation" cannot be equated with harm to any family relationships.

124. Ms Ansell also stated: "The level of personal attachment of [Ms D] to [Ms A] following the death of [Baby A] is of concern. I am disquieted by the documentation which alludes to the personal/emotional response of the midwife." Ms Ansell noted that the documentation on 17 Month11 demonstrates a relationship that has transgressed professional boundaries and is not in the best interests of the family concerned. Ms Ansell stated that "the clinical records should be objective and appropriate and the midwife client relationship should be caring and sympathetic but professional … this is a serious breach of professional standards". In response to the provisional opinion, Ms D said that the Midwifery Council of New Zealand did not criticise this aspect of her documentation.

125. I note that Ms D generally uses an effusive and emotive tone when communicating with her clients.[21] After having considered Ms Ansell's advice, Ms D stated that her documentation is now less "affirmative and warm" because "it has become evident to [her] that anything additional to structured clinical documentation is not approved of in the event of a review". In my view, such a response demonstrates a concerning lack of insight and awareness of professional standards. I agree with Ms Ansell that although it is appropriate to be caring and compassionate, a midwife should make records and behave in a manner that is objective and professional. This does not necessitate a lack of warmth or positivity. Overall, I find that Ms D's actions following the birth were concerning and unprofessional. In my view, Ms D also should not have communicated with Ms B in the manner she did, and should not have distributed her statement to the Coroner so widely to other health professionals. I agree with Ms D's submission that it would have been more appropriate for Ms A herself to send her health information to other parties if she chose to do so. Furthermore, Ms D should have communicated and engaged with Ms A in a more professional and objective manner. Accordingly, I find that Ms D failed to comply with professional and ethical standards and breached Right 4(2) of the Code.

Summary

126. Ms D failed to monitor Ms A adequately during the second stage of labour and, accordingly, Ms D breached Right 4(1) of the Code.

[21] In her response to HDC, Ms D included samples of notes written in the records of other clients.

127. Ms D failed to provide Ms A with the information that a reasonable consumer in Ms A's circumstances would need before making a choice whether or not to have an episiotomy. Accordingly, Ms D breached Right 6(2) of the Code.

128. Ms D's actions following the birth were unprofessional. She failed to comply with professional and ethical standards and, accordingly, breached Right 4(2) of the Code.

Opinion: Adverse comment — Ms E

129. Ms E was Ms D's usual back-up midwife. Ms E saw Ms A on two occasions, 29 Month8 and 2 Month10.

130. When Ms E saw Ms A on 29 Month8 she recorded that Ms A was 34 weeks' gestation, and measured the fundal height as being 34cm. Ms Ansell advised me that Ms E completed the customised antenatal growth chart inaccurately because she charted the measurements in completed weeks rather than by the accurate gestation of the pregnancy in weeks and days. As advised by Ms Ansell, this causes a discrepancy in the perceived growth for gestational age. Furthermore, the area below the growth chart regarding date of visit, gestation, fundal height and growth scan has not been completed.

131. When Ms E reviewed Ms A on 1 Month10 and performed an antenatal check, Ms A had been experiencing contractions for several days. At that visit, Ms A reported a reduction in fetal movements. Ms E said that Ms A "didn't think she had felt movement since the day before". Ms E recorded: "Baby movements have been less, 3 movements with accelerations when midwife palpated." The baby's heart rate was documented at 134bpm. Ms E told HDC that the fetal heart baseline was 134bpm with accelerations of the fetal heart heard on the Doppler. Ms E said she advised Ms A to note the baby's movements by placing a hand on her abdomen, and to keep in contact with her midwife.

132. Ms Ansell advised that this was not the baseline rate but the fetal heart rate counted over a one-minute period, and that the baseline heart rate can be determined only by using electronic fetal heart monitoring, not intermittent auscultation, as happened in this case. She stated that it is difficult to determine true accelerations of the fetal heart using a hand-held Doppler.

133. Ms E did not advise Ms D of Ms A's concerns about the lack of fetal movements. However, Ms E did take steps to ensure that Ms D reviewed Ms A later that day. In my view, Ms E should have given Ms A more information about how to check the baby's movements, how frequent the movements should be, and what to do if she remained concerned. This information should also have been recorded. Ms E should also have discussed the reduced fetal movements with Ms D. I consider that Ms E's actions in failing to complete the customised antenatal growth chart accurately, and her limited assistance to Ms A on 2 Month10, were poor practice and sub-optimal

care. In response to the provisional opinion, Ms E said that she is happy to write an apology to Ms A.

Opinion: Adverse comment — Ms C

134. As Ms D's usual back-up midwife, Ms E, was not available during the final stages of Ms A's labour, Ms C was called to assist Ms D at about 6.10am, and arrived at Ms A's home at around 6.55am. At that time Ms A was fully dilated and pushing.

135. Ms D stated that following the birth, she found herself without oxygen to use while resuscitating the baby because Ms E, who was her usual back-up midwife, had not attended. Ms C stated that "this call came unexpected" and she did not remember to place her home birth equipment in her car. Given that Ms D was the LMC, it was her responsibility to ensure that all equipment was available. However, Ms C was aware that she was attending a home birth, and it would be expected that she would ensure she had the equipment she might require. In response to the provisional opinion, Ms C said that she is happy to write an apology to Ms A.

136. Following her assistance with Baby A's resuscitation, Ms C provided postnatal care to Ms A. Ms C stated that she requested the paramedics to arrange for an ambulance to return and transfer Ms A and her partner to hospital, but no ambulance returned. Ms C said that the parents were tired and distressed, and Ms A's partner wanted to drive Ms A to hospital. Ms C said that she assessed Ms A's condition and offered to drive the couple herself.

137. Ms Ansell advised that it is common practice for women to transfer between birthing units, home or hospital by car. She stated that "most midwives would have acted in the same manner in these circumstances and it was the safest and compassionate course of action". Accordingly, I accept that the transport arrangements were appropriate.

138. Ms C stated that she actively managed the third stage of labour, and examined Ms A's perineum and identified a second degree laceration. However, Ms C made no records of the method or time of transfer to hospital, or of Ms A's condition.

139. In my view, Ms C should reflect on the need to be adequately prepared when attending a birth, and on the importance of maintaining full and complete records.

Recommendations

140. I recommend that Ms D:

- Apologise in writing to Ms A for her breaches of the Code. The apology is to be sent to this Office within three weeks of the date of this report, for forwarding to Ms A.
- Organise a Special Midwifery Standards Review through the New Zealand College of Midwives.
- Undertake further training with regard to informed consent, record-keeping and professional boundaries, and provide HDC with evidence of this training.
- Undertake further education and training on documentation in conjunction with the New Zealand College of Midwives and/or the Midwifery Council of New Zealand. Ms D has commenced an audit programme, which includes a tool for the audit of notes.
- Provide a report to this Office, within three months of the date of this report, confirming her compliance with the recommendations in this report, including confirmation of her attendance at the agreed workshops, or confirming her enrolment at a relevant upcoming workshop.

141. I recommend that Ms E:

- Apologise to Ms A for the failings identified in this report. The apology is to be sent to this Office within three weeks of issue of this report, for forwarding to Ms A.

142. I recommend that Ms C:

- Apologise to Ms A for the failings identified in this report. The apology is to be sent to this Office within three weeks of the date of issue of this report, for forwarding to Ms A.

Follow-up actions

143.
- A copy of this report with details identifying the parties removed, except the expert who advised on this case, will be provided to the Perinatal and Maternal Mortality Review Committee.
- A copy of this report with details identifying the parties removed, except the expert who advised on this case, will be sent to the Coroner and to the Midwifery Council of New Zealand, and both will be advised of the names of Ms D, Ms E and Ms C.
- A copy of this report with details identifying the parties removed, except the expert who advised on this case, will be sent to the New Zealand College of Midwives and to the District Health Board, and they will be advised of Ms D's name.
- A copy of this report with details identifying the parties removed, except the expert who advised on this case, will be placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

Appendix A — Independent midwifery advice to the Commissioner

The following expert advice was obtained from midwife Ms Lesley Ansell:

"My name is Lesley Ansell. Following submission of further information I have been asked by the Health and Disability Commission[er] (HDC) [staff member] to provide further independent advice regarding the above complaint.

I am a Registered General Nurse (1981) and Registered Midwife (1983). I have a Masters Degree in Health Science (Midwifery) (Hons.) (2010). I am employed as an Associate Clinical Charge Midwife Manager of the Assessment, Labour and Birth Unit at Middlemore Hospital, Auckland. Prior to this appointment I worked as a Lead Maternity Carer (LMC) for 10 years working in both primary and tertiary settings. I have experience in births at home and in primary birthing units. I have also worked as a Midwifery Educator (5 years), Midwifery Manager (UK) (3 years) and Midwifery Sister (UK) (8 years).

I have read and agree to follow the HDC 'Guidelines for Independent Advisors' and have read the file provided by the HDC which contains:

- Preliminary expert advice to HDC dated 3 November 2012; (A).
- Complaint received from [Ms B] [date], including appendices of her contact with [the Legal Advisor] of the College of Midwives in [Month11]; (B1 and B2).
- The post mortem report 3 [Month10]; (C).
- [Ms D's] statement to the Coroner (unsigned and undated copy); (D).
- [Ms C's] statement to the Coroner (unsigned and undated copy); (E).
- Antenatal and labour midwifery notes; (F).
- [Ms C's] initial response to HDC, 27 June 2012; (G).
- [Ms D's] initial response to HDC, 27 June 2012; (H).
- [Ms E's] initial response to HDC, 28 June 2012; (I).
- [Ms D's] additional information, September 2012; (J).
- Lesley Ansell, further advice, emailed 28 February 2013; (K).
- HDC letters of investigation notification dated 10 April 2013; (L).
- Further response from [Ms D], dated 4 June 2013; (M1).
- Further response from [Ms E], dated 22 April 2013; (M2).
- Further response from [Ms C], dated 28 April 2013; (M3).
- Various consumer feedback submitted by [Ms D], received 4 June 2013 (N).

Background complaint summary:

[Ms A] decided to have a water birth at home. In short, on 3 [Month10], [Ms A] went into labour (her due date was 4 [Month10]). [Ms D] attended [Ms A] at 3.45am and internally examined her. [Ms A] was 8cm dilated. She entered the birth pool.

At this time it was noted the baby's heart rate was normal and there was no indication of fetal distress. At 6.45am [Ms C] also attended. The fetal heart was

still within the norm. At 7.28am the baby 'gushed out' suddenly and the cord was wrapped around the baby's neck.

Resuscitation was commenced immediately and [Ms C] also called an ambulance (two attended). When the paramedic arrived, [Ms D] and [Ms C] continued resuscitation and an endotracheal tube was inserted. Air transport to [hospital] was arranged where she was immediately transferred to NICU but sadly died later the same day.

The hospital made contact with [the Coroner]. A post mortem was carried out on 3 [Month10], reporting a final diagnosis of intrapartum asphyxia.

Advice requested:

Comment on the standard of midwifery care provided to [Ms A] in relation to:

1. Frequency of antenatal appointments
2. Growth chart completion
3. The latent phase and maternal report of decreased fetal movements
4. Availability of oxygen cylinder equipment
5. Maternal and fetal monitoring
6. Transfer to hospital process
7. Professional boundary issues

For the purpose of this report I have addressed the areas relevant to each practitioner.

[Ms D]

1. Frequency of antenatal appointments.

Preliminary advice:

The significance of the frequency and interval between antenatal appointments has not been scientifically tested but a moderate reduction in the traditional number of antenatal visits has not been shown to be associated with adverse maternal and perinatal outcomes (NICE, 2007). For a woman in her first pregnancy a schedule of 10 antenatal appointments should be adequate (NICE, 2007). The antenatal records indicate that [Ms A] received 13 antenatal visits in total, 8 of those in the third trimester (>28 weeks gestation) and although they did not follow the traditional pattern, the frequency of appointments was adequate.

Further advice:

In accordance with previous advice, most midwives would consider the frequency of the antenatal appointments was appropriate.

2. Growth chart completion.

Preliminary advice:

The customised antenatal growth chart completed by [Ms D] and [Ms E] was inaccurately charted. The measurements are charted in completed weeks rather

than the accurate gestation of the pregnancy by weeks and days, for example, the fundal height measurement plotted at 34 weeks should have been plotted at 34 weeks and 6 days according to the expected date of delivery. This causes a discrepancy in the perceived growth for gestational age. The area below the growth chart: date of visit, gestation, fundal height and for growth scan was not completed.

The fundal height measurement taken by [Ms E] on 29 [Month8] was 34cm. When [Ms A] was seen by [Ms D] two weeks later (12 [Month9]) the fundal height measurement was again 34cm. In her statement [Ms D] states that she acknowledged that there may have been a plateau in growth but that this may have been due to different practitioners performing the measurements. She also states that this had been discussed with [Ms A] and that no further action should be taken. [Ms D] checked the fundal height again five days later on 17 [Month9].

The customised growth chart was not documented or used correctly. It would be common midwifery practice that when a plateau in growth has been recorded, regardless of the possibility of practitioner difference, the findings would be acted upon and a growth scan advised at that time. There was however a follow up check within a five day period so this is viewed as a minor departure from an acceptable standard of care.

Further advice:

In accordance with the preliminary advice, the growth was charted inaccurately as it was documented in completed weeks rather than the accurate gestational age. When the fundal height was measured by [Ms D] on 12 [Month9] the measurement of 34 cm indicated that there had been no growth since the visit 2 weeks previously. The growth had also fallen from the 50th percentile to the 25th percentile when compared with the measurement [Ms D] herself had taken at the 29 week visit on 23 [Month7]. In these circumstances, most midwives would act upon the findings and advise a growth scan. [Ms D] did however re-measure the fundal height again 5 days later as a follow up of the growth so this would be viewed with mild disapproval by most midwives.

3. The latent phase and report of decreased fetal movements.

Preliminary advice:

There is some evidence to suggest that there is an association between a long latent phase (defined as >12 hours in nulliparous women) with lower APGAR scores and increased need for resuscitation (Chelmow, Kilpatrick & Laros, 1993; Maghoma & Buchmann, 2002) and commonly, experienced practitioners will voice their concerns regarding fetal outcome in such circumstances. The optimal management of prolonged latent phase is still uncertain however and there are no clear guidelines for practice available. Midwives individualise care in accordance with client needs in these circumstances.

The clinical records indicate that on 28 [Month9], [Ms A] had begun to experience painful contractions. On 29 [Month9] at 22.30hrs, the contractions

were 8 minutes apart. On 30 [Month9] the contractions were described as becoming 'stronger again' and a vaginal examination was performed at 12.15hrs that day. The cervix was found to be 2–3 centimetres dilated and fully effaced indicating that [Ms A] was in the latent phase of labour (NICE, 2007). On 31 [Month9] [Ms A] was still experiencing contractions. She was not reviewed on 1 [Month10]. An antenatal check was performed by [Ms E] on 2 [Month10] at 2pm at which time [Ms A] had been experiencing contractions for five days. At this visit, [Ms A] reported a reduction in fetal movements. [Ms E] palpated the abdomen, felt fetal movements and advised [Ms A] to check movements by placing a hand on her abdomen. She was reviewed by [Ms D] at 5pm that day and options for labour management discussed. There is no indication of fetal movements having been discussed during that visit.

Maternal perception of decreased fetal movements is an indicator for pregnancies at increased risk of adverse outcome including stillbirth and neonatal death even in pregnancies that are deemed low risk (Preston et al., 2010). It is recommended that to check movements the mother is advised to lie on her side and concentrate on fetal movements. The mother should report less than 10 movements in 2 hours (Preston et al., 2010). It is important that it is the mother's perception of fetal movements that is considered. In this case the midwife palpating the abdomen and stating that she could feel fetal movements may have falsely reassured [Ms A].

[Ms E] states in her letter to [staff member] (HDC) dated 28 June 2012 that the fetal heart baseline was 134bpm with accelerations of the fetal heart heard on the hand held Doppler. This is not the baseline rate but the fetal heart rate counted over a one minute period. The baseline heart rate can only be determined by using electronic fetal heart monitoring (EFM), not intermittent auscultation as happened in this case. It is therefore difficult to determine true accelerations of the fetal heart (which are reassuring) using a hand held Doppler.

Given the very prolonged latent phase of labour [Ms A] was experiencing and maternal report of decreased fetal movements, the appropriate course of action would have been to perform a Cardiotocograph (CTG) to exclude fetal compromise (Preston et al., 2010).

This departure from an acceptable standard would be viewed as moderate.

Further advice:

The issue of decreased fetal movements was initially raised with [Ms E] on 2 [Month10] at 2pm. [Ms A] was subsequently visited by [Ms D] at 5pm on the same day. I now note however that a comment regarding fetal movements by [Ms D] is not within the clinical notes pertaining to that visit but in the antenatal records, which [Ms D] has reported as 'fine'. If [Ms D] asked [Ms A] and ascertained that movements were normal at that time then it was appropriate not to perform a CTG and is in accordance with usual midwifery practice.

4. Availability of oxygen cylinder equipment.

Preliminary advice:

For term infants, air should be used for resuscitation at birth (Resuscitation Council: UK, 2006). Oxygen however should be available for babies who do not respond once adequate ventilation has been established (NICE, 2007).

The planned back-up midwife [Ms E] was not available for the birth. According to the statement provided by [Ms C] (27 June 2012) to [staff member] (HDC), [Ms D] and [Ms E] had specific arrangements for the provision of oxygen at a home birth — arrangements of which she herself had forgotten. This implies that [Ms D] usually did have oxygen available at home births which is contrary to her statement to [HDC staff member] (27 June 2012) which states that her reason for not carrying oxygen is because she had been influenced by research.

Home birth midwives still carry oxygen as part of their neonatal resuscitation equipment as oxygen needs to be available for those babies who do not respond to initial resuscitation. In this case, it is unlikely that the initial lack of oxygen available has altered the outcome as the ambulance attended very quickly and had oxygen available. Ambulances do not always respond so quickly however, therefore it is appropriate for home birth midwives to carry oxygen. The responsibility for the provision and coordination of home birth equipment lies with the LMC midwife.

The equipment was inadequate in this case. This is a moderate departure from an acceptable standard of care.

Further advice:

In accordance with the preliminary advice, it is the responsibility of the LMC ([Ms D]) to ensure the provision of all homebirth equipment. Homebirth midwives still carry oxygen as it needs to be available for those babies who do not respond to air in the initial resuscitation. Not to do so would be viewed with moderate disapproval by most midwives. In her letter to [Deputy Commissioner] (HDC) dated 4 June 2013, [Ms D] states that she has now rectified this and always carries her own oxygen cylinder.

5. Maternal and fetal monitoring.

Preliminary advice states*:*

The profound hypoxia evident at the time of [Baby A's] birth would indicate that the hypoxia had been continuing for some time. At the onset of hypoxia, muscle tone and fetal breathing movements alter to become deeper and more rapid — this is a period known as primary apnoea. If the hypoxic insult continues, the gasping will become weaker and eventually cease — this period is known as terminal apnoea (New Zealand Resuscitation Council, 2006). The clinical notes indicate that [Baby A] was not breathing and still required full ventilation 29 minutes after birth. She was therefore born in the stage of terminal apnoea. Fetal hypoxia

during labour is associated with fetal heart rate abnormalities (NICE, 2007) and would have been present in this case as the baby was profoundly hypoxic at birth.

During the first stage of labour the fetal heart should be auscultated every 15–30 minutes, towards the end of a contraction and for at least 30 seconds after the contraction (RANZCOG, 2006). It is important to ensure that auscultation takes place as recommended in the RANZCOG (2006) and NICE (2007) guidelines to identify the presence of late decelerations of the fetal heart as these are associated with a reduction in fetal oxygen availability (hypoxia).

The clinical records indicate that [Ms A] had been experiencing contractions 2–3 minutes apart since 01.50hrs on 3 [Month10]. [Ms D] arrived at [Ms A's] home at 03.15hrs. The fetal heart was first auscultated at 03.45hrs following a vaginal examination which found that the cervix was 8cm dilated. It is standard practice to listen to the fetal heart prior to vaginal examination and as [Ms A] had been contracting strongly for over 2 hours it would have been good practice to listen to the fetal heart soon after arrival. The fetal heart was auscultated again at 04.20hrs and found to be in the normal range.

There is a discrepancy between the clinical notes and the labour and birth summary as to the time of the onset of the second stage. The labour and birth summary records the onset of the second stage as 05.00hrs but the clinical records state that the cervix was not fully dilated at this time (an anterior rim of cervix was present). I am unable to determine therefore the exact time of the onset of the second stage. The fetal heart was auscultated at 05.45hrs when [Ms A] had a sudden urge to push. I assume that the cervix was fully dilated at this time as the labour and birth summary record states that effective pushing commenced at 05.50hrs.

During the first stage of labour [Ms D] auscultated the fetal heart almost every 30 minutes which is just acceptable to a minimum standard.

During the second stage of labour the fetal heart should be auscultated at least every 5 minutes in the absence of pushing and towards the end and for at least 30 seconds after each contraction during active pushing in the second stage of labour (RANZCOG, 2006; NICE, 2007). Vigilant monitoring of the fetal heart is required particularly during active pushing when fetal oxygenation is prone to change more rapidly (RANZCOG, 2006).

In this case, following commencement of active pushing, the fetal heart was auscultated at 06.00hrs, 06.10hrs, 06.30hrs, 06.40hrs, 07.00hrs, 07.10hrs, 07.15hrs and lastly at 07.20hrs. The baby was born at 07.31hrs. All of the documented fetal heart rates are in the normal range. There is a discrepancy between the time of birth in [Ms D's] Statement to the Coroner and her clinical notes. I refer to the birth time as stated in the clinical notes which is 07.31hrs. Therefore, the fetal heart was auscultated after a 5 minute interval on only two occasions, the rest of the time auscultation occurred every 10–20 minutes. For 12 minutes prior to the birth, the fetal heart was not auscultated at all. The fetus was

therefore not adequately monitored particularly during the second stage of labour.

In addition, the clinical records state that the fetal head began crowning at 07.00hrs. There is a discrepancy in the recorded time of crowning; in her Statement to the Coroner [Ms D] states that the fetal head began crowning at 07.15hrs. Crowning occurs when the biparietal diameter of the fetal head is born and the remainder of the head is usually born within the next one or two contractions. The fetal pH reduces significantly once the head is crowned (Nordstrom, Achanna, Naka & Arulkumaran, 2001) and midwives are aware that there should not be significant delay in the birth of the head following crowning. In this case the fetal head was not born for at least 16 minutes and possibly as long as 31 minutes following crowning. This combined with the tightening nuchal cord would have caused further hypoxia in the fetus and subsequent fetal heart rate abnormalities (NICE, 2007).

Vigilant monitoring as described in the RANZCOG (2006) and NICE (2007) guidelines is likely to have identified fetal heart rate abnormalities which would have alerted the midwife to the increasing fetal hypoxia. The appropriate course of action would have been to remove the mother from the water and strongly advise that an episiotomy be performed to expedite the birth for fetal well being.

Assessment of maternal temperature and blood pressure were never made. Maternal monitoring was inadequate therefore throughout the first and second stage of labour.

Fetal monitoring was inadequate particularly throughout the second stage of labour.

This departure from an acceptable standard of care is viewed as moderate.

Further advice:

The purpose of vigilant intermittent auscultation (IA) of the fetal heart during labour is to identify any problems which may be arising. During the first stage of labour, usual midwifery practice is to auscultate the fetal heart every 15–30 minutes, towards the end of a contraction and for at least 30 seconds after the contraction is finished as recommended in the RANZCOG (2006) guidelines. During the second stage of labour the fetal heart should be auscultated at least every 5 minutes in the absence of pushing and towards the end of, and for at least 30 seconds after each contraction during active pushing (RANZCOG, 2006). These guidelines for IA are recommended as a minimum for women who at the onset of labour are identified as having a low risk of developing fetal compromise (RANZCOG, 2006) and are presented during the Fetal Surveillance Education Programmes. [Ms D] attended a refresher course of one of these programmes in 2011.

During the first stage of labour [Ms D] auscultated the fetal heart almost every 30 minutes which is the minimum standard required. [Ms A] began active pushing at

05.45 hrs and the baby was born at 07.31hrs. Auscultation of the fetal heart occurred only 8 times in that 1 hour and 46 minute period, after 5 minute intervals on 2 occasions and every 10–20 minutes otherwise. This level of monitoring is significantly less than the recommended guideline and usual midwifery practice, and would be viewed by most midwives with moderate disapproval.

[Ms D] states in her letter to [Deputy Commissioner] (HDC) of 4 June 2013 that she believes her monitoring of the fetal heart was diligent and her care was reasonable. She also states that it is not common practice to auscultate the fetal heart as regularly as the guidelines suggest in low risk women. Most homebirth midwives are very vigilant in monitoring the fetal heart as they are aware of the need for early detection of a problem because of the transfer time to hospital. [Ms D] states that she has since altered her practice in accordance with the recommended guidelines.

Usual midwifery practice would be to monitor the maternal temperature, pulse and blood pressure at the first contact in labour as an assessment of maternal well-being. Temperature and blood pressure would then normally be recorded at 4 hourly intervals during labour unless there were clinical indications to monitor more frequently. Maternal pulse is usually checked more frequently and good practice is to palpate the maternal pulse during auscultation of the fetal heart. This ensures differentiation between the two and excludes the possibility that it is the maternal pulse and not the fetal heart that is being heard. In this case no assessment of the maternal temperature or blood pressure was made and the pulse rate was recorded once in labour. Most midwives would ensure at least the first baseline assessment was made and not to do so would be viewed with mild disapproval.

Re crowning of the fetal head and episiotomy: there was a significant delay between crowning and the birth of the head. Once the head is crowned (the bi-parietal diameter is born) most midwives would expect the whole head to be born shortly afterwards i.e. in the next one or two contractions. If this does not occur and the fetal head 'sits' on the perineum most midwives are aware that the fetal pH reduces significantly and the baby can be born in poor condition.

Following crowning, if the perineal tissues remain tight and prevent birth of the head, most midwives would advise an episiotomy for reasons of fetal well-being. If this is the case the perineum should be infiltrated with local anaesthetic and the episiotomy performed. It would be expected that all home birth midwives carry local anaesthetic for such purposes. If however the head continues to advance well with each episode of pushing and the midwife is confident that the head will be born very soon, or the perineum spontaneously tears, then an episiotomy is not required.

In her letter to [the Deputy Commissioner] (HDC) dated 4 June 2013 [Ms D] states that following crowning of the head the progress was slow and episiotomy was discussed but vehemently declined by [Ms A]. In her response to the preliminary advice, [Ms A] stated that she was advised to have an episiotomy but she refused because there was no access to anaesthetic at home.

[Ms D] states that she always carries local anaesthetic and this was available (letter to [the Deputy Commissioner] (HDC) dated 4 June 2013).

At all times, informed consent from the mother is required before performing such a procedure and this would not be undertaken without consent. Informed consent means ensuring that the woman is aware of the reasons for the episiotomy and the possible consequences for the baby if the fetal head remains in the 'crowned' position for a significant period of time. This would normally be documented in the clinical notes. If the mother is fully informed and still declines the procedure then it is entirely appropriate not to perform an episiotomy. If the woman is not fully informed of the possible consequences for the baby then this would be viewed by most midwives with moderate disapproval.

6. Transfer to hospital processes.

[Ms A's] transfer to hospital was organised by [Ms C], not [Ms D], so is not applicable.

7. Professional boundary issues.

Preliminary advice:

In her letter of 27 June 2012 [Ms D] states that she sought legal advice and permission from her client before forwarding her Statement for the Coroner to [Ms B]. It is clear from an email sent to [Ms B] from [the] (Legal Advisor for NZ College of Midwives) on 5 [Month11] that [Ms D] had not in fact sought legal advice from [the Legal Advisor] prior to sending the statement to [Ms B].

[Ms B] did not request the statement be sent to her and was clearly shocked when she received it. [Ms B] made [Ms D] aware that she was distressed by receiving the statement yet [Ms D] subsequently forwarded it to midwifery colleagues. The reason stated is that she 'felt it was important to communicate with local midwives who would have to confront the anxiety in their clients'. Her first priority for care and compassion should have been to the family concerned and to minimise the impact of the shock and grief they were already suffering. The matter could also have been dealt with in a much more sympathetic and compassionate manner such as a mediated discussion rather than public defence of her actions.

The level of personal attachment of [Ms D] to [Ms A] following the death of [Baby A] is of concern. I am disquieted by the documentation which alludes to the personal/emotional response of the midwife. For example, the documentation at the 6 week discharge visit on 17 [Month11] states:

> *'I will forever treasure these memories and [Baby A] will always remain in my heart. I will always be here for you. I give you my absolute biggest respect and love to you always. Sadness today but joy for the future. I will never forget the journey we have walked together. Stay in touch. Love always, [Ms D]'.*

This demonstrates a relationship that has transgressed professional boundaries and is not in the best interests of the family concerned. It may even have disrupted the family unit permanently. The clinical records should be objective and

appropriate. The midwife/client relationship should be caring and sympathetic, but professional. At all times the midwife should be respectful of the grief and suffering of all members of the family, including the extended family. This has not happened in this case.

This is a serious breach of professional standards and I recommend the matter be referred to the Professional Conduct Committee of the NZ Midwifery Council.

Further advice:

[Ms D] sent a copy of her Statement to the Coroner (unsigned and undated) to [Ms B]. [Ms B] had not requested a copy be sent to her and was very distressed by this. [Ms D] then sent copies of the statement to other health professionals. Circulation of the statement to other parties would be viewed with severe disapproval by most midwives. [Ms D] has reflected upon this and in her letter to [the Deputy Commissioner] (HDC) of 4 June 2013 she accepts this was not an appropriate course of action. She expresses her regret and apologises for her actions.

There was obvious dispute between [Ms D] and [Ms B]. If there are concerns by family members regarding the care a midwife has provided, most midwives would try to organise a mediated discussion and address those concerns directly. If the continuing presence or relationship between the client and the midwife was causing family disruption or further distress to grieving relatives, most midwives would consider whether it was appropriate to continue care and facilitate transfer of care to another LMC. If [Ms D] knowingly or deliberately caused disruption to the family by her actions, this would be viewed with severe disapproval by most midwives. [Ms D] has however apologised for her actions in this regard and states that she had no intention of causing distress to [Ms B] (letter of 4 June 2013 to [the Deputy Commissioner] (HDC)) and would now avoid providing care to someone who had a family member opposed to her doing so.

Following review of the documentation submitted by [Ms D] on 4 June 2013 (file N) it is clear that her typical style of documentation is very personal and emotional. As this could easily be misconstrued, she has since made some changes to her documentation style.

[Ms E]

2. Growth chart completion.

Preliminary advice:

The customised antenatal growth chart completed by [Ms D] and [Ms E] was inaccurately charted. The measurements are charted in completed weeks rather than the accurate gestation of the pregnancy by weeks and days, for example, the fundal height measurement plotted at 34 weeks should have been plotted at 34 weeks and 6 days according to the expected date of delivery. This causes a discrepancy in the perceived growth for gestational age. The area below the growth chart: date of visit, gestation, fundal height and for growth scan was not completed.

The fundal height measurement taken by [Ms E] on 29 [Month8] was 34cm. When [Ms A] was seen by [Ms D] two weeks later (12 [Month9]) the fundal height measurement was again 34cm. In her statement [Ms D] states that she acknowledged that there may have been a plateau in growth but that this may have been due to different practitioners performing the measurements. She also states that this had been discussed with [Ms A] and that no further action should be taken. [Ms D] checked the fundal height again five days later on 17 [Month9].

The customised growth chart was not documented or used correctly. It would be common midwifery practice that when a plateau in growth has been recorded, regardless of the possibility of practitioner difference, the findings would be acted upon and a growth scan advised at that time. There was however a follow up check within a five day period so this is viewed as a minor departure from an acceptable standard of care.

Further advice:

In accordance with the preliminary advice, the growth was charted inaccurately as it was documented in completed weeks rather than the accurate gestational age. The fundal height measurement plotted at 34 weeks by [Ms E] should have been plotted at 34 weeks and 6 days according to the expected date of delivery. This causes a discrepancy in the perceived growth for gestational age and would be viewed by most midwives with mild disapproval.

3. The latent phase and report of decreased fetal movements.

Preliminary advice:

There is some evidence to suggest that there is an association between a long latent phase (defined as >12 hours in nulliparous women) with lower APGAR scores and increased need for resuscitation (Chelmow, Kilpatrick & Laros, 1993; Maghoma & Buchmann, 2002) and commonly, experienced practitioners will voice their concerns regarding fetal outcome in such circumstances. The optimal management of prolonged latent phase is still uncertain however and there are no clear guidelines for practice available. Midwives individualise care in accordance with client needs in these circumstances.

The clinical records indicate that on 28 [Month9], [Ms A] had begun to experience painful contractions. On 29 [Month9] at 22.30hrs, the contractions were 8 minutes apart.

On 30 [Month9] the contractions were described as becoming 'stronger again' and a vaginal examination was performed at 12.15hrs that day. The cervix was found to be 2–3 centimetres dilated and fully effaced indicating that [Ms A] was in the latent phase of labour (NICE, 2007). On 31 [Month9] [Ms A] was still experiencing contractions. She was not reviewed on 1 [Month10]. An antenatal check was performed by [Ms E] on 2 [Month10] at 2pm at which time [Ms A] had been experiencing contractions for five days. At this visit, [Ms A] reported a reduction in fetal movements. [Ms E] palpated the abdomen felt fetal movements and advised [Ms A] to check movements by placing a hand on her abdomen. She

was reviewed by [Ms D] at 5pm that day and options for labour management discussed. There is no indication of fetal movements having been discussed during that visit.

Maternal perception of decreased fetal movements is an indicator for pregnancies at increased risk of adverse outcome including stillbirth and neonatal death even in pregnancies that are deemed low risk (Preston et al., 2010). It is recommended that to check movements the mother is advised to lie on her side and concentrate on fetal movements. The mother should report less than 10 movements in 2 hours (Preston et al., 2010). It is important that it is the mother's perception of fetal movements that is considered. In this case the midwife palpating the abdomen and stating that she could feel fetal movements may have falsely reassured [Ms A].

[Ms E] states in her letter to [staff member] (HDC) dated 28 June 2012 that the fetal heart baseline was 134bpm with accelerations of the fetal heart heard on the hand held Doppler. This is not the baseline rate but the fetal heart rate counted over a one minute period. The baseline heart rate can only be determined by using electronic fetal heart monitoring (EFM), not intermittent auscultation as happened in this case. It is therefore difficult to determine true accelerations of the fetal heart (which are reassuring) using a hand held Doppler.

Given the very prolonged latent phase of labour [Ms A] was experiencing and maternal report of decreased fetal movements, the appropriate course of action would have been to perform a Cardiotocograph (CTG) to exclude fetal compromise (Preston et al., 2010).

This departure from an acceptable standard would be viewed as moderate.

Further advice:

[Ms E] visited [Ms A] on 2 [Month10] at 2pm. During that visit she asked [Ms A] about fetal movements. [Ms A's] response was that she 'didn't think she had felt movements since the day before' (letter to [the Deputy Commissioner] (HDC) dated 22 April 2013). [Ms E] palpated the abdomen and felt 3 fetal movements which were validated by [Ms A] (letter to [the Deputy Commissioner] (HDC) dated 22 April 2013). She then advised [Ms A] to continue to monitor the fetal movements by placing a hand on her abdomen.

It would be usual midwifery practice that when a woman reports absent fetal movements for more than a 12 hour period ([Ms A] has been experiencing contractions so presumably would have been awake and aware of the movements) that a CTG would be advised particularly because there had been such a very prolonged latent phase — [Ms A] had been experiencing contractions for 5 days at that point. [Ms E] however was obviously reassured by the movements which the mother also felt. She appropriately asked her to continue to monitor them. She recorded this in the clinical notes for [Ms D] to read at the next visit (5pm). In contrast to preliminary advice, it appears that it was in fact maternal perception of fetal movements that was considered (letter to [the Deputy Commissioner] dated 22 April 2013), so care would be considered appropriate.

[Ms C]

6. Transfer to hospital process

Preliminary advice:

The clinical notes give no indication of method or time of transfer to [hospital] or the condition of the mother. In her letter of 27 June 2012 to [staff member] (HDC), [Ms C] states that she actively managed the third stage of labour and examined the perineum. A second degree laceration was identified and was not bleeding. The fundus was checked and bleeding was not excessive. [Ms A's] blood pressure was normal. [Ms C] states that [Ms A's partner] wanted to drive [Ms A] to [the hospital]. She firmly declined, offering to drive them [there] herself. From the information available, I am unable to ascertain whether the second ambulance was available for transfer of [Ms A] (not all ambulances are for transfer purposes) or whether the couple were declining ambulance transfer and wanting to travel in their own car.

[Ms A's] physical condition was satisfactory and given the exceptional circumstances, it would seem appropriate that [Ms C], rather than the distressed father, drive the couple to [hospital].

Further advice:

[Ms C] attended as the second midwife for a home birth in accordance with standard midwifery practice. Following assistance with the resuscitation of [Baby A] she provided postnatal care to [Ms A]. In her letter to [the Deputy Commissioner] (HDC) dated 28 April 2013 [Ms C] states that although they had asked one of the ambulances to return and transfer the parents to [hospital], it did not do so. The parents were tired and distressed. [Ms C] assessed [Ms A's] condition which was satisfactory and offered to drive the couple to [hospital] to be with their daughter. It is common practice for women to transfer between birthing units, home or hospital by car, usually 2 hours or more following the birth. Although it was not quite 2 hours following the birth, [Ms A] was physically stable. Most midwives would have acted in the same manner in these circumstances and it was the safest and compassionate course of action. In accordance with preliminary advice, the care provided by [Ms C] would be considered by her peers to be appropriate throughout.

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Lesley Ansell

Appendix B — Customised antenatal growth chart