HEALTH & DISABILITY COMMISSIONER
TE TOIHAU HAUORA, HAUĀTANGA

Insufficient antenatal monitoring of woman prior to stillbirth

1. On 11 July 2022, the Health and Disability Commissioner (HDC) received a complaint from Ms A (aged 25 years at the time of these events) about the care she received from her lead maternity carer (LMC) registered midwife (RM) B. Ms A raised concerns that RM B failed to provide her with an appropriate standard of care between mid 2021 and early 2022 when she was pregnant with her second child, Baby A. Sadly, Baby A was delivered stillborn in early 2022. I extend my sincere condolences to Ms A and her family for the loss of Baby A.

Information gathered

Initial booking appointment

2. RM B[1] had been Ms A's LMC for her first pregnancy (a normal vaginal birth at 40 weeks 4 days' gestation in 2019), and Ms A engaged her as LMC for her second pregnancy at 8 weeks' gestation in mid 2021 via email. RM B said that, at the time she was engaged as LMC for the second pregnancy, she discussed nutrition with Ms A and referred her for an ultrasound dating scan to confirm the pregnancy and establish the estimated due date and for initial antenatal blood tests.

3. In 2021 (at 10+4 weeks' gestation), Ms A had her initial appointment with RM B, where she was given an 'information folder' that included information about 'warning signs' in pregnancy, fetal movements, and common complaints during pregnancy, including morning sickness. At the time, Ms A weighed 54kg, had a normal body mass index (BMI)[2] of 19.6, and was still breastfeeding her first child. The dating scan showed an estimated due date of early 2022. RM B said that the antenatal blood test results were not available for review at this appointment.

4. RM B visited Ms A at her home eight times throughout her pregnancy (once a month in a seven-month period between 2021 and early 2022 but with two appointments in the last month, including an appointment the day prior to birth).

Antenatal care

<u>Weight management</u>

5. Ms A told HDC that she experienced persistent vomiting throughout her pregnancy, which resulted in her not gaining any weight (compared with a weight gain of 17kg during her first pregnancy). Ms A said that she could not keep any food down and was vomiting 'all day' every day, making it difficult for her to care for her other child. Ms A said that RM B did not weigh her throughout her pregnancy or refer her for further investigation of this issue.

[1] RM B said that she works with a group of midwives as part of a semi-rural practice and that she undertakes visits in different areas of the region. She has a clinic at a birth centre one day a week, a clinic at a community house one day a week, and a small clinic in another area of the region.

[2] This is a medical screening tool used to estimate body fat based on a person's height and weight. It helps to categorise a person into a weight category (underweight, normal weight, overweight, obese), providing a general indication of health status. A 'normal' BMI for a woman with a height of 166cm is 18.5–24.9 (47.2–61kg).

6. RM B accepts that she did not weigh Ms A throughout her pregnancy. RM B said she felt reassured that Ms A's abdomen was growing each visit, she had undergone scans that showed the baby was growing normally, and the fetal movements appeared to be normal. RM B acknowledged that Ms A had gained more weight during her first pregnancy and said that she discussed this with Ms A, although this discussion was not documented.

7. Regarding management of Ms A's ongoing vomiting, RM B told HDC that she did not believe that referral was necessary as Ms A did not clinically present with hyperemesis gravidarum (severe or prolonged vomiting during pregnancy that leads to weight loss and dehydration). RM B said that she was not of the understanding that vomiting was persistent or to the point that Ms A was unable to properly eat or drink. The clinical notes state that Ms A reported nausea/vomiting at her first home visit in 2021,[3] her third home visit in 2021,[4] and her last two home visits in 2022.[5] RM B said that the information she gave to Ms A about weight gain during pregnancy included healthy eating resources and that she discussed strategies for dealing with morning sickness, including ginger, herbal tea, acupressure points, and regular small snacks. These discussions were not documented.

Fetal monitoring

8. Ms A said that RM B did the 'bare minimum' of checks antenatally and that she only used a Doppler machine[6] once, aside from during labour. Ms A said that RM B would only offer to listen to the fetal heartrate at the end of her appointments but that RM B did not seem concerned so she thought it was unnecessary. In response to the provisional report, Ms A said that RM B presented any checks as 'extra and unnecessary', which made Ms A feel like it would be extra work for RM B if she were to request them. Ms A said that, on multiple occasions, she raised that she did not think her baby was moving very much and that RM B would just say that all babies are different. Ms A said that the entries in the clinical notes of reportedly normal fetal movements are inaccurate.

9. The clinical records show that on three occasions antenatally the fetal heartrate was auscultated and the abdomen was palpated.[7] The clinical notes also record reported fetal movements on three occasions[8] with no abnormal movements reported. The clinical records also contain a GROW chart,[9] but this includes only one entry for fundal height[10]

[3] RM B documented that Ms A was 'feeling tired and a bit nauseous – particularly in the mornings – she is physically being sick just in the morning but manages to eat regularly during the day.'
[4] RM B documented that Ms A was 'vomiting in the morning often still.'
[5] RM B documented that Ms A had a stomach bug the day prior but was 'all good.'
[6] An ultrasound device that uses high-frequency sound waves to measure the speed and direction of blood flow (the fetal heartrate).
[7] Auscultation is where a clinician listens to sounds from the heart, lungs, or other organs, typically using a stethoscope. Palpation is a physical examination where the clinician feels the abdomen with their hands to assess the baby's growth, size, position, and presentation. These examinations were conducted at the third home visit in 2021, fourth home visit in 2021, and the last two home visits in 2022.
[8] At her fifth home visit in 2022: 'baby is moving a lot.' At her sixth home visit: 'baby is really active all the tim[e].' At the eighth home visit appointment: '[Ms A] is happy with movements so did not want to listen.'
[9] GROW stands for Gestation-Related Optimal Weight and is the customised charts used in the Aotearoa Growth Assessment Programme to assess fetal growth. It is unclear whether the chart was generated contemporaneously or retrospectively.
[10] The distance, in centimetres, from a pregnant person's pubic bone to the top of the uterus, used to estimate fetal growth and gestational age.

(measured at 37 weeks' gestation) and two scan entries (at 33+3 weeks' and 36+1 weeks' gestation).

10. RM B said that she offered to listen to the fetal heartrate at every appointment but that Ms A would not always consent. However, there is only one reference to palpation being declined, at the eighth home visit appointment in 2022, because Ms A was 'happy with movements'. RM B accepts that she did not document the consenting discussions with Ms A.

11. In early 2022, Ms A had a scan to follow up on previously reported enlarged fetal kidneys. The scan showed that the enlarged kidneys had resolved but it also showed enlarged ventricles. RM B said that she discussed these findings with Maternal Fetal Medicine (MFM) before seeing Ms A the next day. MFM agreed to see Ms A early the following month . RM B said that during the sixth home visit, Ms A advised that she was happy with movements and, as she had had a normal scan the day before, she chose not to listen to the heartbeat. The clinical notes state: 'I did not feel baby today as [Ms A] had scan yesterday but will feel for position next visit.'

12. Regarding documentation of reported fetal movements, RM B said that she always correctly documented reported fetal movements and that at no point during her pregnancy did Ms A report abnormal movements. RM B said that if reduced fetal movements had been reported at any stage, she would have taken appropriate action. RM B said that her understanding is that, following the birth, Ms A's partner reported that movements may have been reduced.

Labour and birth

13. At 38+2 weeks' gestation at 8.05am, RM B was contacted and advised that labour was establishing (ie, the cervix has started to dilate and contractions were becoming more regular and intense) so she attended Ms A's home at around 11.50am because Ms A's initial birthing plan had included a home birth. She reviewed Ms A and was unable to find the fetal heartrate using a Doppler machine. RM B said that she did not obtain a set of maternal observations on review of Ms A at home. This is because she usually checks the fetal heartrate first, and when she was unable to locate the fetal heartrate, her immediate reaction was to move to the Birthing Unit for support.

14. On review at the Birthing Unit, RM B attached the cardiotocography (CTG)[11] to Ms A, but she did not attach the tocodynamometer (TOCO)[12] to the CTG to record Ms A's contractions. RM B said that she and another attending midwife, RM C, were 'reassured' after finding the fetal heartrate on the CTG. The CTG showed no accelerations and one to two decelerations[13] (abnormal); however, the CTG was removed after six minutes of monitoring, and the fetal heartrate was not recorded again after this reading. RM C told HDC that, in hindsight, Baby A's condition at birth means it was not possible that the fetal heartrate had been heard and that the CTG was probably doubling the maternal pulse, which can sometimes happen.

[11] A machine used to monitor the fetal heartrate and uterine contractions during pregnancy and labour.
[12] A pressure-sensing device used to monitor and record uterine contractions during labour.
[13] Accelerations are sudden, temporary increases in the fetal heart rate, defined as at least 15 beats per minute (bpm) for 15 seconds, and are a reassuring sign of fetal wellbeing. Decelerations are temporary drops in the fetal heartrate of more than 15bpm for more than 15 seconds.

15. RM B said that she did not take maternal observations at the birthing unit as she presumed RM C had done so and birth appeared to be imminent. There is no evidence that RM B palpated Ms A's abdomen at any stage on this day, nor is there any documentation of reported fetal movements or regularity of contractions in the lead up to, and during, labour. RM B said that she documented that Ms A was losing her mucous plug[14] at her second visit at (38+1 weeks' gestation), but she did not ask about regularity of contractions as Ms A had laboured quickly in her first pregnancy and she assumed this pregnancy would be the same.

16. Sadly, Baby A was delivered stillborn.[15] RM B told HDC that the umbilical cord was wrapped tightly around his neck and he had evidence of maceration[16] and no heartbeat.

Further information

17. RM B accepts that her documentation was insufficient during her care of Ms A. She said that this standard of documentation was not usual for her and has not occurred since. However, she also reported that her notes were sent to Ms A following each appointment, and she did not receive any feedback that they were incorrect.

Responses to provisional opinion

Ms A

18. Ms A was given the opportunity to comment on the 'information gathered' section of the provisional report. Ms A told HDC:

> 'The signs were all there, but [RM B] didn't see it. Everyone around me worried, and I told them my midwife wasn't worried as I felt reassured by her. For [RM B] to ever say that she wasn't worried [because] I wasn't worried is a huge oversight in her care. It was her job to properly care for me and Baby A, inform me and be aware of any risk factors that I was clearly unaware of. Looking back, they are clear as day to me'.

RM B

19. RM B was given the opportunity to respond to the provisional report. RM B accepted the findings and recommendation.

Changes made

20. RM B told HDC that she has made the following changes to her practice since these events.

Documentation

- Takes advice and feedback from colleagues on documentation standards.
- Uses her laptop for note-taking at all in-home antenatal appointments.
- Completed a documentation course to improve the standard of her documentation.
- Sends notes from appointments to pregnant clients so they can advise if anything is incorrect or missing.

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[14] A thick clump of mucous that forms in the cervical canal during pregnancy to block the entrance to the uterus and protect the baby from infection.

[15] No pathology was identified on assessment of the placenta to account for the stillbirth, and Baby A did not undergo an autopsy.

[16] The process of fetal decomposition that occurs inside the uterus after a fetus has died during pregnancy; it is caused by the body's own enzymes and can lead to significant tissue breakdown.

Weight management

- Takes a set of scales to in-home visits and will usually conduct initial appointments at a birth centre or clinic to measure height and weight.
- Has updated the information about healthy eating in pregnancy that she gives to women at the initial appointment and has specific and in-depth conversations with women around eating during pregnancy.
- Plans to book a diet and nutrition course to further her knowledge.

Fetal monitoring

- Completed the Fetal Surveillance Education Program (FSEP) and the Growth Assessment Protocol (GAP) training.
- Seeks input from other midwives or obstetricians when she requires support and will consider referral when necessary.
- Has a pulse oximeter, blood pressure measuring equipment, and a thermometer easily accessible.
- She no longer offers palpation and heart rate monitoring as optional and always proceeds to obtain consent to palpate and listen to the heart rate unless expressly declined.
- She now generates the GROW chart earlier in pregnancy and discusses the chart at booking for pregnant clients she has not cared for previously.

21. The Te Tatau o te Whare Kahu Midwifery Council (the Midwifery Council) undertook a review of RM B's competency and required her to complete further education on documentation and fetal surveillance, including interpretation of CTGs. RM B was also required to write a reflection of her learnings and advise of any further changes to her practice. On 24 June 2025, the Midwifery Council confirmed that RM B had satisfactorily completed the competence programme.

Opinion: RM B – breach

22. Given the circumstances of this case, it is understandable that Ms A has concerns about the care she received from RM B. As Ms A's LMC, RM B had a responsibility under the Code of Health and Disability Services Consumers' Rights (the Code) to provide care of an appropriate standard to Ms A. In her complaint to HDC, Ms A raised several concerns about RM B's management of her wellbeing during pregnancy, a lack of fetal monitoring, and the care she provided during labour.

23. The circumstances in the period leading up to Baby Baby A's stillbirth have been difficult to reconcile because of not only the discrepancies between Ms A's complaint and RM B's version of events but also the poor standard of RM B's documentation during her care of Ms A. I am cognisant of the advice of my in-house clinical advisor, RM Nicholette Emerson, that it is difficult to ascertain what discussions took place between RM B and Ms A regarding consent for routine midwifery practice and that the 'sparsity of detailed documentation and differing accounts of the antenatal period has hindered clarity.' I have taken careful note of RM Emerson's advice, alongside the other information gathered over the course of this investigation, and I have concluded that aspects of the care RM B provided to Ms A were deficient and did not meet the required standards. These deficiencies are set out below.

Documentation

24. The New Zealand College of Midwives (NZCOM)[17] and the Midwifery Council outline the documentation standards expected of midwives. NZCOM standards state that a midwife should comprehensively document all assessments, information, and advice shared and decisions made for the plan of care. In addition, the Midwifery Council publication 'Documentation and Record Keeping'[18] states that professional documentation should include detailed assessments and clinical findings, discussions of care and information provided to the woman, evidence of informed choice and consent, and care decisions with rationale.

25. RM B's clinical records are clearly deficient. RM B saw Ms A on eight occasions antenatally, but there are only three references to reported fetal movements, fetal heartrate, and palpation; no documentation of consenting discussions about standard midwifery assessments such as palpation or fetal heartrate auscultation or reference to Ms A being offered such assessments and declining them; only one fundal height measurement and an incomplete GROW chart; and a lack of documentation of advice provided about healthy weight gain in pregnancy or management of persistent vomiting. RM B has accepted that her documentation fell below an acceptable standard.

26. RM Emerson considered that the standard of RM B's documentation departed from an accepted standard to a moderate degree. I accept this advice and am extremely concerned at the paucity of information recorded by RM B. Fulsome contemporaneous documentation is essential for chronicling the provision of safe and effective care for women and is an important mechanism for monitoring the progression of the fetus over the course of the pregnancy. The failure to capture important information makes retrospective review of the care provided very difficult, as outlined by NZCOM and the Midwifery Council.

Antenatal monitoring

Management of maternal wellbeing

27. At the time, the Ministry of Health had published guidelines for healthy weight gain in pregnancy. The guidelines state that, for a woman with a BMI of 18.5–24.9, the recommended weight gain during pregnancy is 11–16kg. The 'NZCOM Assessment and Promotion of Fetal Wellbeing (2021) practice points' state that the midwife should share information about healthy nutrition and weight gain with the mother, identify the need for support in these areas, and offer the woman referral to other services if required.

28. The accounts of the nature and frequency of Ms A's vomiting are conflicting, and the clinical notes only contain three references to nausea/vomiting reported by Ms A. However, I note that Ms A was still reporting vomiting at her appointment with MFM at 36 weeks' gestation. Given that Ms A did not gain any weight during her pregnancy, I consider it more likely than not that she did experience persistent vomiting over the course of her pregnancy. I also consider that it should have been apparent to RM B that Ms A was not gaining the recommended 11–16kg.

[17] Standards of Practice - New Zealand College of Midwives -New Zealand College of Midwives
[18] Be Safe 4 Documentation and record keeping.pdf

29. RM Emerson advised that to gain 17kg in a previous pregnancy and none in a subsequent pregnancy warrants further investigation and that a referral to a general practitioner (GP) or dietitian to explore possible causes of the ongoing vomiting should have been considered. RM Emerson also advised that there is both a woman and a baby in pregnancy, and although the growth of the baby may have been reassuring, it should not have been considered in isolation from Ms A's wellbeing. In conclusion, RM Emerson advised that RM B's management of Ms A's persistent vomiting and lack of weight gain constitutes a moderate departure from accepted standards, and I agree with this finding. In my view, the extended period of poor nutrition is likely to have had some bearing on Ms A's maternal health. I am also critical that there is no evidence that RM B discussed healthy weight gain or nutrition with Ms A, aside from providing her with a written resource at her initial appointment.

GROW chart

30. The GROW chart that RM B gave to HDC contains only one entry for fundal height and two scan entries.[19] RM Emerson advised that if the chart was generated contemporaneously, it has not been used appropriately as 'it is the trajectory of fetal growth[20] (a combination of fundal height measurement and scans from 26 to 28 weeks' gestation to birth) that engenders reassurance regarding fetal growth.' RM Emerson advised that the lack of fundal height measurements makes it difficult to assess the fetal growth trajectory and that, combined with RM B's monitoring of Ms A's weight gain and lack of palpation, this constitutes a moderate departure from accepted standards. I accept this advice. As I have reflected earlier, in my opinion, customised growth charts are a valuable tool for monitoring the progression of the fetus over the course of a pregnancy.

Fetal monitoring

31. The lack of documentation and somewhat conflicting accounts about fetal monitoring has made it difficult to establish the facts. RM B's account is that she offered palpation and fetal heartrate auscultation but Ms A declined. Ms A's account is that RM B did not convey the importance of such checks. If any consenting discussions occurred, they are largely undocumented. There is only one reference to palpation being declined, in 2022 at 38+1 weeks' gestation, as Ms A was reportedly happy with the fetal movements, and one reference in the month prior to RM B not palpating as Ms A had received a scan the previous day, although it is unclear whose decision this was. Other than that, the clinical records show that palpation and fetal heartrate auscultation occurred only three times antenatally.[21] RM B accepts that she did not document the consenting discussions. Taking into account the limited evidence, I find it likely that, on at least some occasions, RM B offered to complete these checks. However, I also find it likely that RM B failed to appropriately educate Ms A

[19] The fundal height was measured at 37 weeks' gestation, and the scan entries are from 33+3 weeks' and 36+1 weeks' gestation.

[20] The middle line (50th centile) is the optimal growth curve, which goes through the 'Term Optimal Weight' point at 40 weeks. The upper and lower lines show the 97th and 3rd centile limits, respectively, for fetal weight. The curves can also be used to plot the slope of fundal height measurements. With any assessment of growth, the slope of serial measurements is more important than individual points. https://www.perinatal.org.uk/FAQ/CustomisedCharts/#UseOfCharts.

[21] At the third, fourth and last home visit appointments.

about the importance of completing these assessments, which RM Emerson advised are part of routine midwifery practice.[22]

32. In any event, RM Emerson advised that RM B's failure to document her discussions with Ms A about the assessments constitutes a moderate departure from accepted standards, and I agree.

Labour and birth

33. When RM B attended Ms A's home at 38+2 weeks' gestation, she was unable to locate the fetal heartrate, so she advised Ms A to attend the birthing unit for CTG monitoring.

34. The CTG at the birthing unit was abnormal with no accelerations and one to two decelerations; however, it was removed after six minutes, and no further fetal heartrate monitoring was documented. RM B also did not attach the TOCO (to record contractions) to the CTG and did not take a set of maternal observations, including maternal heartrate, which she assumed had been taken by RM C. There is also no evidence that RM B palpated Ms A's abdomen or that she recorded the regularity of contractions. RM B acknowledged that this was not acceptable midwifery care. RM B said that she documented that Ms A was losing her mucous plug at 38+1 weeks' gestation, but she did not ask about the regularity of contractions as Ms A laboured quickly in her first pregnancy so she assumed that would be the case with this pregnancy.

35. RM Emerson advised that, assuming the CTG was monitoring the fetal heart (which, retrospectively, is unlikely to be correct), there were CTG features that required further investigation and the CTG should have been left in place so that monitoring could continue. Further, RM Emerson advised that, combined with the lack of palpation antenatally, there was a moderate departure from accepted standards for RM B failing to palpate Ms A during labour. Overall, RM Emerson advised that the failures in the care provided to Ms A by RM B during labour, as outlined above, constitute a moderate to severe departure from accepted standards. I concur with my advisor's findings and consider there were stark omissions in the midwifery care RM B provided during Ms A's labour.

Conclusion

36. RM B had a responsibility to provide midwifery services to Ms A with reasonable care and skill. As discussed above, she failed to do so in a number of key respects. I am critical of the standard of RM B's antenatal care and her management of Ms A's labour, and therefore I find that she breached Right 4(1) of the Code.

37. Further, RM B's documentation of Ms A's antenatal care and labour did not meet the required standards, and therefore I find that she also breached Right 4(2) of the Code.

Fetal movements – educational comment

38. Ms A said that she told RM B on multiple occasions that she did not think her baby was moving very much; she told HDC that any documentation of reported normal fetal movements was incorrect. Conversely, RM B told HDC that she correctly documented all

[22] As per the NZCOM standards: https://www.midwife.org.nz/wp-content/uploads/2021/05/Assessment-and-promotion-of-fetal-wellbeing-during-pregnancy.pdf.

reported fetal movements and at no stage did Ms A report abnormal movements. The clinical records show reported fetal movements on several occasions, with none reported as abnormal.

39. The conflicting accounts from Ms A and RM B and the contemporaneous documentation reflecting normal fetal movements mean I am unable to make a finding on whether or not Ms A reported abnormal fetal movements to RM B. I note that RM Emerson also noted that she could not verify this retrospectively and was therefore unable to comment further on that aspect of the care provided to Ms A. However, if Ms A did report abnormal fetal movements at any stage during her pregnancy, I would be very critical that RM B failed to both document this and appropriately escalate Ms A's care.

Recommendations and follow-up actions

40. In my provisional report I recommended that RM B provide a written apology to Ms A for the failings identified in this report. The written apology was provided to HDC and has been forwarded to Ms A. Given the changes already made by RM B since these events, including her completion of the competence programme, I have no further recommendations to make.

41. A copy of the sections of the final report that relate to RM B will be sent to the Midwifery Council. I note the Midwifery Council has already reviewed RM B's competency and, in June 2025, confirmed that RM B had satisfactorily completed its 'competence programme'; however, I will ask that it consider whether any further action is called for on account of this investigation and my findings.

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

Rose Wall
Deputy Health and Disability Commissioner

Appendix A: In-house clinical advice to the Commissioner

The following in-house advice was obtained from registered midwife (RM) Nicholette Emerson:

'**CLINICAL ADVICE – MIDWIFERY**

CONSUMER: **[Ms A]**

PROVIDER: **LMC RM [B]**

FILE NUMBER: **C22HDC01686**

DATE: **13 March 2024**

1. Thank you for the request that I provide clinical advice in relation to the complaint from Ms [A] about the care provided by LMC midwife [RM B]. In preparing the advice on this case, to the best of my knowledge I have no personal or professional conflict of interest. I agree to follow the Commissioner's Guidelines for Independent Advisors.

2. **I have reviewed the documentation on file:**

   - Complaint from [Ms A] 11 July 2022
   - Complaint response from RM [B] 6 September 2022
   - […] Birthing Unit clinical notes 2 August 2022
   - Further correspondence from RM [C] 5 March 2024

3. **Background:** Ms [A] booked with RM [B] at 10 weeks' gestation. This was the second pregnancy with RM [B] as Ms [A]'s LMC. Ms [A] suffered from nausea and vomiting throughout the pregnancy and did not gain weight. She had gained 17kg in her previous pregnancy. Her labour commenced at 38 weeks' gestation, and her baby son [Baby A] was unexpectedly stillborn. Ms [A] complains that routine assessments regarding her weight gain, fetal heart auscultation, and abdominal palpation were not carried out by RM [B].

   Advice request

   Advice would be appreciated on:

   1. Antenatal consultations and checks, including measurements of blood pressure, weight gain, and fetal movements and whether these were appropriate.
   2. Any indications for further referrals or transfer of care to MFM.
   3. Care provided during labour, including any comments on mistakenly identifying a heart rate as the fetal heart rate.

1. Antenatal consultations and checks

Blood pressure and urinalysis
Blood pressure and urinalysis recordings and contemporaneous documentation is in keeping with accepted midwifery practice, with no departures identified.

Maternal history – thrombocytopenia
RM [B] states that Ms [A] had thrombocytopenia (low platelets) in her previous pregnancy but did not meet the local referral criteria in her current pregnancy. The local criteria could not be verified; however, with reference to *Guidelines for Consultation with Obstetric and Related Medical Services (Referral Guidelines 2007–2023)* **current pregnancy** (page 29- 8034), maternal thrombocytopenia requires an obstetric consultation. This would be particularly relevant in the context of previous pregnancy-related thrombocytopenia that required treatment.

[… 2021] 14+4/40

Discussed low platelets Referred for low platelets in first pregnancy but did not meet the referral criteria in this pregnancy.

Normal platelet range in pregnancy 150–450.

[…] 2021 platelets 127–

discussed platelets as they are low already so will send a list of foods to try and keep them up.

[…] 2022 platelets 142

There may be a local guideline regarding thrombocytopenia in pregnancy; however, there is no documentation of a consultation, including by phone, regarding an obstetric plan to monitor platelets. The platelets have been monitored, however, by RM [B] so I am unable to comment regarding whether the criteria for referral met local guidelines.

Weight gain
In her complaint, Ms [A] states that, at the end of her pregnancy, she weighed a kilo less than at the beginning of her pregnancy. In her previous pregnancy (when RM [B] was also Ms [A]'s LMC), she had gained 17kg.

Ms [A] states in her complaint that during her entire pregnancy she was exhausted and vomiting. She states she was hardly able to eat or keep food down. As a result, Ms [A] states that she didn't put on weight. Ms [A] says that RM [B] never weighed her or asked her what her weight was. She states that "*my midwife never discussed the importance of weight gain; she never asked for my weight or weighed me throughout the whole 9 months.*"

In her complaint response, RM [B] says that she did make a comment regarding the weight being different from the last pregnancy (not documented). The lesser wait gain

was put down to Ms [A] still feeding (breastfeeding) her son (2+ years old). RM [B] states that she could see that *Clinically as shown by her scans, her baby was growing normally and I could see that her tummy was growing, she did not appear to be losing weight and the scans and palpation showed baby was growing normally for her.* (Fetal growth is addressed under **GROWTH chart** further on in this question.) RM [B] states that she used the (then) MOH guidelines for weight gain in pregnancy. https://www.health.govt.nz/publication/guidance-healthy-weight-gain-pregnancy The (then) MOH guidelines state Match BMI in the table below to establish recommended weight gain.

BMI	Recommended weight gain (kg)
Underweight <18.5	13–18
Healthy weight 18.5–24.9	11–16
Overweight 25–29.9	7–11
Obese >30	5–9

Reference: Institute of Medicine. Weight Gain During Pregnancy: Re-examining the Guidelines. Washington, DC; 2009.

Ms [A]'s recommended weight gain in accordance with her BMI of 19.6 is highlighted on the chart above.

[…], 10 weeks + 4 days. Booking weight 54 kg. Clinical notes state *She's feeling tired and a bit nauseous – particularly in the mornings – she is physically being sick just in the morning but manages to eat regularly during the day.*

In her complaint response, RM [B] states, *we discussed basic strategies for dealing with morning sickness, including ginger, herbal tea, acupressure points.* Strategies and acupressure points are not documented.

[…], 14 weeks + 4 days. *Starting to feel a bit better.*

In her complaint response, RM [B] states, *[Ms A] did not report severe vomiting. I did not see weight loss. At the 14-week appointment, she reported that she was starting to feel better, which reaffirmed my clinical assessment that [it] did not meet the criteria for hyperemesis. [Ms A] never reported to me vomiting more than once in a day. I recommended regular small snacks to help combat any nausea.* Recommendations of regular small snacks are not documented.

[…], 20 weeks + 4 days. Feeling like she has more energy now, still vomiting occasionally but able to eat much better. *[Ms A] said she was still vomiting every 2–3 days but could eat more frequently without nausea and had more energy. Her blood pressure was lower at this appointment but again did not appear tachycardic. She did not report faintness or dizziness. Based on these symptoms, the clinical picture did not show hyperemesis gravidarum.*

[…], 26 weeks + 3 days. *Vomiting in the morning often still, script given for pyridoxine*. Complaint response: *[Ms A] reported that she was still vomiting in the morning. Not daily and not severely. Maintaining good hydration and able to eat small meals.* Frequency and severity are not documented. Hydration and meal size are not documented.

[…], 30 weeks + 2 days. *No concerns at this stage.* (Vomiting not documented at this appointment.)

[…], 33 weeks + 4 days. No documentation regarding vomiting at this appointment.

[…], 37 weeks + 2 days. *Had a tummy bug yesterday but all good.*

According to RM [B], *On booking, [Ms A] had a normal BMI. When [Ms A] was reporting sickness, she assured me she could eat two meals a day and drink plenty of fluids. If a woman puts on less weight in pregnancy our focus is that the growth of the baby is normal.*

In forming an opinion, the following has been considered.

- Weight gain in pregnancy is on a continuum. To gain 17kgs in a first pregnancy and not to gain weight in a subsequent pregnancy warrants investigation and might be considered pathological.
- It could be argued that sustaining a pregnancy whilst still breastfeeding is normal; however, it may require additional nutritional support and calorie intake.
- There is both a woman/birthing person and a baby in a pregnancy, and the growth and wellbeing of the baby may appear reassuring; however, this should not be considered as isolated from the mother/birthing person's wellbeing.

According to the NZCOM Assessment and promotion of Fetal Wellbeing (2021) Practice points page 2 (https://www.midwife.org.nz/wp-content/uploads/2021/05/Assessment-and-promotion-of-fetal-wellbeing-during-pregnancy.pdf):

> *Information to promote pregnancy wellbeing is shared, including healthy nutrition and activity, healthy weight gain, food safety and maternal immunisation to create the best circumstances for fetal growth and development. • Identification of the need for support in these areas and of maternal physical, mental, and cultural wellbeing forms an important component of assessment of fetal wellbeing. Offer the wahine referral to appropriate other providers who can assist her further.*

- Ms [A] was not weighed after her booking visit, so the assertion that she was gaining weight is not supported by clinical evidence.
- The persistent vomiting may not have constituted hyperemesis gravidarum, but a discussion regarding referral to the GP or a dietitian to explore possible causes and additional support does not appear to have been considered or documented.

- When assessed by MFM at 36 weeks' gestation, documentation states that Ms [A] was still vomiting.

There is a moderate departure from accepted midwifery practice in recognising the comparative lack of weight gain (from the previous pregnancy) and focusing on the growth of the baby in isolation from maternal wellbeing.

Customised Growth Chart
Ms [A] states that her baby was small for gestational age, and this was a contributing factor to his stillbirth. Growth is difficult to assess for the following reasons.

Whilst a GROW chart has been submitted with the clinical notes (page 20 of clinical notes submitted by RM [B]), there are aspects that warrant discussion:

- There is one entry on the chart for fundal height measurement at 37 weeks.
- There are two scan entries: 33 weeks + 3 days, 36 weeks and 1 day.
- There is one post-birth entry.

It is unclear whether this chart has been generated retrospectively. If the chart was generated contemporaneously, the chart has not been used in accordance with the guidelines as it is the trajectory of fetal growth (a combination of fundal height measurement and scans from 26 to 28 weeks' gestation until birth) that provides reassurance regarding fetal growth.

> *The middle line (50th centile) is the optimal growth curve, which goes through the 'Term Optimal Weight' (TOW) point at 40 weeks. The upper and lower lines show the 97th and 3rd centile limits, respectively, for fetal weight. The curves can also be used to plot the slope of fundal height measurements. With any assessment of growth, the slope of serial measurements is more important than individual points. https://www.perinatal.org.uk/FAQ/CustomisedCharts/#UseOfCharts*

The Growth Assessment Protocol (GAP) is used in Aotearoa New Zealand. The GAP programme has been commissioned nationally by ACC. The GROW chart is part of the GAP protocol, and multidisciplinary training is offered to both obstetricians and midwives. No abdominal palpations are recorded by RM [B] between 26 weeks and 37+1 weeks. There are three abdominal palpations recorded in eight antenatal appointments. During a home visit […] at 37 weeks and 1 day, the fundal height measurement is recorded as 36cm on RM [B]'s palpation. RM [B] states the following in her complaint response:

A small for gestational age baby is one that is below the 10th centile on a customised growth chart. This would involve 11 growth scans. [Ms A] had scans at 20 weeks, 33 weeks, and a follow-up at Maternal Fetal Medicine at 35 weeks. Growth was above the 10th centile, scans are attached. I was reassured that [Ms A] put on adequate weight by the growth scans.

Whilst it is understandable that RM [B] was reassured by the fetal medicine scan and report and the fundal height measurement at 37 weeks, it would appear that the

GROW chart has not been used as intended, and the lack of fundal height measurements makes it difficult to assess whether the growth trajectory altered or reached its potential.

Assessment and promotion of fetal wellbeing during pregnancy NZCOM (2021) (https://www.midwife.org.nz/wp-content/uploads/2021/05/Assessment-and-promotion-of-fetal-wellbeing-during-pregnancy.pdf):

> Recording and interpretation of measurements
>
> - Measurement and recording of findings needs to be consistently applied, whatever tool is used.
>
> - When using a customised fetal growth chart to plot fundal height, practitioners are required to be conversant with their conditions (for example, a condition for the use of the Perinatal Institute GROW© charts is that the Growth Assessment Programme (GAP) education has been undertaken prior to using them).

In her complaint response, RM [B] states that she has attended the GAP training (4).

RM [B] states:

Clinically as shown by her scans, her baby was growing normally, and I could see that her tummy was growing, she did not appear to be losing weight, and the scans and palpation showed baby was growing normally for her.

Clinical notes state:

[…] 30 weeks +2 days' gestation. *Tummy is growing - baby is moving a lot.*

[…] 33 weeks +4 days' gestation. *Growth of baby is normal, and I can visually see her tummy has popped out since our last visit too.*

It is impossible to determine retrospectively whether Ms [A]'s baby was growing as expected, and it cannot be determined whether this was a contributor to [Baby A]'s stillbirth. There were two scans and a fundal height measurement at 37 weeks, which have provided understandable reassurance to RM [B]. Overall, the care provided to Ms [A] regarding her weight gain, measurement of fundal height, and abdominal palpation moderately departs from accepted midwifery practice. RM [B] states that Ms [A] declined palpation and fundal height measurement; however, the clinical notes do not evidence any ongoing discussion regarding accepted midwifery practice, informed decisions regarding palpation and fundal height measurement.

Fetal movements

In her complaint, Ms [A] states that her baby hardly moved, and she considered him a "lazy" baby. *I noticed on receiving my notes, which I had to request from her, that she has only bothered to record what his movements are like half the appointments we had, and all are completely the opposite of what I have said to her.*

In her complaint response, RM [B] states:

[Ms A] has stated in her complaint that she told me her baby did not move much often throughout her pregnancy and that I have documented this incorrectly. [Ms A] did not report reduced movements at any point in her pregnancy. I documented "Normal" movements on our last visit as this is what was clinically presenting and what I was being informed. If at any point I had clinically believed there had been reduced movements, I would have actioned a CTG, a scan, and referral if needed.

The clinical notes record Ms [A]'s baby as active in six out of eight appointments. Neither version can be verified retrospectively, so I am unable to comment further.

Auscultation of the fetal heart

Ms [A] was seen eight times in the antenatal period. At seven of the appointments, the fetal heart would likely have been audible (excluding 10 weeks' gestation). Fetal heart is documented on three occasions. Ms [A] states:

At the end of my pregnancy, she would be packing up to leave and then quickly say "oh we can listen to the heart if you want but I'm not worried" and I naively would say I'm not worried if you're not worried. The way she worded this and presented it to me made me feel like I would be being over the top and a bother if I asked to listen and it was unnecessary.

According to NZCOM (https://www.midwife.org.nz/wp-content/uploads/2021/05/Assessment-and-promotion-of-fetal-wellbeing-during-pregnancy.pdf):

> Listening to the fetal heart rate is a routine component of antenatal fetal assessment. It provides an opportunity for examination and discussion with the wahine about her pēpi wellbeing. Many wāhine and their whānau expect the fetal heart rate to be assessed at each antenatal visit and can feel reassured when the fetal heart is heard. One off period of listening to the fetal heart rate confirms that the pēpi is alive but otherwise has little clinical or predictive value for fetal health.

Listening to the fetal heart is currently an accepted part of routine midwifery assessment.

> According to NZCOM (https://www.midwife.org.nz/wp-content/uploads/2021/05/Assessment-and-promotion-of-fetal-wellbeing-during-pregnancy.pdf):

> When auscultating a fetal heart, it is important to distinguish between the maternal and fetal heart rates. Measurement of the wahine pulse while listening to the fetal heart rate is the best way to achieve this. Both rates are then documented. 5 • The midwife and wahine decide together on which equipment to use to auscultate the fetal heart. The three most common options are: Pinard stethoscope (monaural stethoscope), fetoscope (Allen stethoscope) and hand-held Doppler. RM [B] comments in her complaint response As detailed in the Timeline above, I offered to listen to the baby's heart rate at every appointment as per my routine practice. This was not always consented to. (page 11 (44))

Outside of the three occasions when the fetal heart has been auscultated, there is one comment in the antenatal clinical notes at 38 weeks and 1 day: *no wee stick as [Ms A] is losing her mucous plug, she is happy with movements so did not want to listen. Having irregular tightenings – 2 or 3 together then a gap.*

In her complaint response, RM [B] states, *I requested and recommended to her three times throughout the visit that I be able to listen to the fetal heart as this is my normal practice. The last recommendation was as I was about to leave. [Ms A] did not take me up on the recommendation. I was reassured of the wellbeing of the baby due to the movements described by [Ms A].*

If auscultation of the fetal heart was offered and declined as stated, this has been documented on one occasion (above).

(A) If it is accepted that there has been an offer to listen to fetal heart rate at all antenatal appointments and in early labour and this has been declined, then there is a moderate departure from accepted midwifery documentation in not recording the non-consent of the recommendation and the discussion documenting reasons and recommendations.

(B) If it is accepted that fetal heart auscultation was not offered at each antenatal appointment and in early labour, and reassurance was based on fetal movements, then there is a moderate departure from accepted midwifery practice in not offering to listen to the fetal heart. There is a further moderate departure from accepted midwifery practice in not documenting a discussion outlining reasons for not listening and Ms [A]'s view regarding this departure from accepted practice.

2. Any indications for further referrals or transfer of care to MFM

At 8 weeks and 4 days' gestation, an ultrasound scan for unsure dates took place. A single live intrauterine gestation was confirmed.

- **[…] 13 weeks + 4 days' gestation**. *Difficult scan to perform*. Single live fetus at 13 weeks 4 days' gestation. MSS1 and MSS2 not completed as Ms [A] attended scan but has not attended to have bloods taken. The forms for the bloods to accompany the scan were documented as discussed (and given) by RM [B] at first and second home visit.

- **[…] 21 weeks +3 days gestation**. Anatomy scan (page 24 of RM [B]'s clinical notes). Report states, *Fetal kidneys appear a little prominent in size. There is incomplete assessment of the fetal spine and skin line. Review of fetal kidneys at the follow-up anatomy scan is recommended. The size of the fetal kidneys appears a little prominent. Fetal medicine opinion regarding the significance of this finding is suggested.*

There is no documentation recording a discussion with Ms [A] regarding the recommendation of MFM opinion. RM [B] states in her complaint response that follow-up occurred at 32 weeks with a repeat scan. It is unclear whether this follow-up was the result of a discussion with MFM or the result of Ms [A] enquiring about the previous scan (9 weeks later) as per below.

- **[…] 30 weeks' gestation** *[Ms A] asked about size of kidneys on last scan. We looked at scan today – they have not quite completed all anatomy and wanted to check out the spine and skin. Form given for a scan to check this and the kidneys out. She has been watching some antenatal class online that she found helpful last time. Will do bloods before I see her next time. No other concerns at this stage.*

- **[…] 33 weeks +3 days repeat scan** (page 26 of RM [B]'s clinical notes) *Scan report Conclusion: Normal interval growth. Normal amniotic fluid volume. Mild dilatation of the lateral cerebral ventricles. Obstetric referral recommended.*

- **[…] 33 weeks +4 days** *[Ms A] had a scan yesterday to look at the enlarged kidneys noted on 20-week scan. This seemed to have resolved but the sonographer mentioned a mild increase in size of the left ventricle. I spoke with Maternal Fetal Medicine this morning before seeing [Ms A] - who suggested it would be a good idea to get a second opinion and asked me to send a referral to them. I talked with [Ms A] about this – initially MFM will look at the scan pictures already done, if they feel it is necessary, they will contact [Ms A and her partner] to arrange a scan up in Auckland. [Ms A] was okay with this being done for peace of mind and I will send it through today.* The actions and documentation [at 33 weeks +4 days] are in keeping with accepted Midwifery practice.

- **[…]2022** Blood tests requested by MFM prior to being seen. Same done. Toxoplasmosis and cytomegalovirus (CMV). Negative results.

- **[…]2022** Seen by Dr […] at MFM in Auckland (page 34 of RM [B] clinical notes) Concluding comment: *No further action required. LMC to do baby check after birth and refer to paediatrics if concerns. No routine follow-up required.*

There are no departures from accepted midwifery practice identified in the referral to MFM. The care was clearly concluded by MFM and handover back to LMC as evidenced by the concluding comment that no routine follow-up was required.

3. **Care provided during labour, including any comments on mistakenly identifying maternal heart rate as fetal heart rate.**

Early labour
[38 weeks gestation] *Text from [Ms A]: Hey [RM B] I've just lost my bloody show just thought I'd let you know because I don't feel far off last couple days ive felt it looming haha, what did you say about the birth pools the other day are they being used at the moment? Reply: I have one at home and one about to be used today – fingers crossed you both don't go at the same time x I was planning to come and see you tomorrow afternoon so will bring one if your body waits until that time!* There is no text discussion regarding fetal movements, vaginal loss, or regularity of contractions.

38 weeks and 1 day gestation No urine dipstick taken as mucous plug has been lost. This is in keeping with accepted midwifery practice and documentation. BP 108/50. Movements are recorded as normal. *She is happy with movements so did not want to listen. Having irregular tightenings 2 or 3 together and then a gap.*

[38 weeks and 2 days gestation] Text to say that *"things have ramped up a bit"*
8.05am
There is no documented discussion enquiring about fetal movements or vaginal loss. At 11.40am, a text from RM [B] states that she will call in, in 10 minutes. Clinical notes at 11.50am record that RM [B] has arrived at Ms [A]'s house and could not auscultate the fetal heart rate with her doppler. 11.54 Ms [A] is on the CTG, the fetal heart rate is recorded as normal in the clinical notes.
12.15pm Ms [A] is recorded as in the pool. *Lots of pressure*
12.30 Spontaneous vaginal birth of a stillborn baby boy.

In forming an opinion regarding the mistaking of maternal heart rate for fetal heart rate, the following has been considered.

- Fetal heart rate auscultation by doppler was not able to be obtained at home despite attempts.
- The birthing unit was very close and on arrival a CTG was attached.
- The CTG was left on without attaching the toco (the toco records contractions). As a result, only the heart rate was being recorded (unclear retrospectively whether fetal or maternal). Without the Toco, a clinical picture of fetal heart rate in response to uterine contractions cannot be determined. It is not in keeping with accepted midwifery practice to attach a CTG without the Toco.
- A full set of maternal observations were not performed. It is reported that maternal pulse was taken to differentiate maternal from fetal heart rate. This is particularly important in the context of not hearing the fetal heart at home. The differentiation of maternal and fetal heart rates is accepted midwifery practice. Both RM [C] and RM [B] remember that maternal pulse was taken; however, this has not been recorded in the clinical notes.
- Palpation of fetal position is not recorded.
- The CTG was not normal but was removed after 6 minutes.
- The CTG is retrospectively diagnosed as maternal on the grounds that following the birth the baby showed signs of an earlier death (soft and fluid-filled skull, skin maceration)
- A postmortem was declined, so an earlier death is not confirmed; however, due to the condition of [Baby A], resuscitation was not initiated.

- Placental pathology did not determine a cause of death.

According to the 'Intrapartum Fetal Surveillance Clinical Guideline – Fourth Edition 2019 – current'

A normal CTG contains the following features.

- Baseline 110–150bpm
- Baseline variability 6–25bpm
- Accelerations 15bpm for 15 seconds
- No decelerations

According to the guideline, all other CTGs outside of the above category are by this definition abnormal and require further evaluation, taking into account the full clinical picture. The features of Ms [A]'s CTG are:

- Baseline 110–150bpm **(CTG baseline 120–125bpm – normal)**
- Baseline variability 6–25bpm **(CTG – normal)**
- Accelerations 15bpm for 15 seconds **(CTG – no accelerations – abnormal *)**
- No decelerations **(CTG-1 possibly 2 decelerations present – abnormal)**

A discussion (content anonymised) with […], who is a midwife and a clinical educator for the Fetal Surveillance Education programme (FSEP), concluded that:

- *The necessity of accelerations in an intrapartum CTG is debated; however, it is accepted that absence of fetal heart rate accelerations constitutes a reason for further investigation.
- The presence of fetal heart rate decelerations warranted further investigation.
- Because of the two abnormal features, by definition the CTG was abnormal.

Assuming that the CTG was monitoring fetal heart (which we only know retrospectively is unlikely to be correct), then there were CTG features that required further investigation and warranted leaving the CTG in place. There were no accelerations present and there were one to two decelerations.

Recommendation from 'Intrapartum Fetal Surveillance Clinical Guideline – Fourth Edition 2019' (recommendation 5 page 13):

Good practice point

Regardless of the method of intrapartum monitoring, it is essential that an accurate record of fetal wellbeing is obtained. Fetal and maternal heart rates should be differentiated whatever the mode of monitoring used, ideally with monitors capable of simultaneously recording maternal and fetal heart rates.

According to NZCOM assessment and promotion of fetal wellbeing during pregnancy (https://www.midwife.org.nz/wp-content/uploads/2021/05/Assessment-and-promotion-of-fetal-wellbeing-during-pregnancy.pdf):

When auscultating a fetal heart, it is important to distinguish between the maternal and fetal heart rates. Measurement of the wahine pulse while listening to the fetal heart rate is the best way to achieve this. Both rates are then documented

RM [B] states in her complaint response that a maternal heart rate was obtained by RM [C] but not recorded. RM [C]'s response (5 March 2024) does state that she obtained a maternal *heart rate however this is not recorded. I do know with certainty that the maternal pulse was within normal range and significantly lower than the CTG – both audible and print out recording of what we at the time thought was the fetal heart rate.*

Further to the discussion with RM […] (FSEP educator), it is clear that there is no documentation of further auscultation of fetal heart rate following Ms [A]'s removal from the CTG.
Recommendation from 'Intrapartum Fetal Surveillance Clinical Guideline – Fourth Edition':

> Method of auscultation intermittent auscultation (IA) is defined as the auscultation of the fetal heart using a handheld Doppler at regular intervals and for a pre-defined duration during labour. It is recommended that IA should be undertaken and documented:
> - Every 15–30 minutes in the active phase of the first stage of labour
> - With each contraction or at least every five minutes in the active second stage of labour.

There is no documentation of fetal heart rate following removal of the CTG. It is noted that this was an active second stage of labour, and documentation can be difficult for a sole midwife in the circumstances. The expectation, however, is that the retrospective documentation would reflect that the fetal heart had been listened to at five-minute intervals or after each contraction. The fetal heart rate is not documented following removal from the CTG.

A) If it is accepted that it was thought that the fetal heart was being recorded by the CTG, the birth was rapidly progressing in a primary unit, and the birth was imminent, then there is a moderate to severe departure from accepted midwifery practice in,
   - not completing a set of maternal observations (particularly in the context of an absent fetal heart at home)
   - removing the abnormal CTG
   - recording the fetal heart rate subsequently and not documenting the fetal heart rate retrospectively.

B) If it is accepted that it was thought that the fetal heart was being recorded by the CTG, the birth was rapidly progressing in a primary unit, and the birth was imminent, then there is a moderate to severe departure from accepted midwifery practice in,
   - not completing a set of maternal observations (particularly in the context of an absent fetal heart rate at home)
   - removing the CTG
   - not recording the fetal heart rate.

The birth was progressing rapidly, and there was no opportunity for transfer to a hospital; however, a reasonable expectation is that identification of an abnormal CTG on the background of no fetal heart at home would prompt close monitoring of fetal heart rate following the removal of the CTG.

Palpation antenatally and in labour

According to NZCOM (https://www.midwife.org.nz/wp-content/uploads/2021/05/Assessment-and-promotion-of-fetal-wellbeing-during-pregnancy.pdf):

- Physical identification and assessment of the lie, position, and growth of the fetus by palpation is an integral and highly valued part of midwifery practice. It also provides a time for the wahine and midwife to discuss the developmental milestones of pregnancy, including sharing information about the pēpi growth and activity.

In labour, palpation is particularly important in confirming the fetal presenting part as a malposition, for example, breech presentation will determine the course of the labour and choices made. Palpation antenatally and in labour are an accepted part of routine antenatal and labour care. Palpation is recorded on three occasions during the antenatal period. There is no documentation of palpation in labour.

RM [B] states in her complaint response that her recommendation to palpate and listen to the fetal heart was declined at 30 weeks' gestation ([…]). Not documented in clinical notes.

38 weeks, day before birth. *I have recorded that [Ms A] reported that she was happy with movements. I have not palpated her abdomen or listened to the baby.*

a) If it is accepted that palpation was offered and declined antenatally and in labour, then there is a moderate departure from accepted midwifery practice in not documenting the request and decline on each occasion and/or a discussion regarding recommendations, rationale, and reasons for declining.
b) If it is accepted that palpation was not offered at every antenatal appointment and in labour, then there is a moderate departure from accepted midwifery practice in not offering routine midwifery care. There is a moderate departure from accepted midwifery practice in not documenting the rationale for the departure in practice and consent from Ms [A].

Cord entanglement

Ms [A] states in her complaint that when [Baby A] was born his cord was wrapped around his neck and RM [B] said that it was not the cause of death and *extremely unlikely that's so rare and that it wasn't even wrapped tightly she's seen babies with tighter cords absolutely fine. Yet when she filled out notes of the birth later in retrospect she wrote "cord tightly wrapped around [baby's] neck" so why the discrepancy?*

Retrospective clinical notes state that cord was tightly around baby's neck and RM [C] had to double clamp and cut the cord in order for [Baby A]'s body to be born. The

notes state that RM [B] was then able to deliver [Baby A]'s body and take him to the resuscitaire.

RM [B] states in her complaint response, *as the baby was born, I could see there was a nuchal cord which was wrapped tightly four times around baby's neck. I asked for support from the staff midwife to cut the cord so that the baby could be fully delivered.*

RM [C] states, *I do recall [RM B] having to unwrap the cord from the baby to aid the birth. I don't recall this having to be done while the baby was on the perineum, I can't recall if this was done prior to or after I clamped and cut the cord. It is a fairly common occurrence to have the cord entangled around the baby's body or neck, in most cases the cord can be looped over rather than cut. It is less common to have the cord wrapped several times around the neck tightly. I cannot recall how tightly the cord was presenting or where it was wrapped as [RM B] was managing this aspect of the birth. I do not recall a conversation around the time of the stillbirth of [Baby A], thinking that the entanglement of the umbilical cord was responsible for his demise.*

UpToDate states:

> Umbilical cord entanglement is a frequent finding in deliveries. Its prevalence at birth varies between 15 and 25% and is considered a physiologic event. It has been reported that the presence of two or more loops around the fetal neck occurs in between 2.5 and 8.3% of pregnancies. Loop of umbilical cord around the fetal neck (nuchal cord) is a common finding at delivery. In most cases, it is not associated with a significant increase in the rate of any clinically important adverse fetal/neonatal events. In case reports and small case series, tight nuchal cords have been associated with adverse outcomes, including fetal asphyxia, demise, and long-term neurodevelopmental consequences, but causality via constriction of the umbilical vessels often cannot be proven. UpToDate 2024

- The retrospective documentation does not state how many times the cord was wrapped around [Baby A]'s neck,
- RM [B] complaint response states four times,
- RM [C] recalls unwrapping and clamping the cord but is unable to confirm whether this was to facilitate the birth of [Baby A]'s body.
- Contemporaneous documentation by RM [C] states *Cord clamped and cut by myself.*

Retrospectively, without a postmortem and with the conflicting accounts, it is not possible to determine whether the cord entanglement was a factor in [Baby A]'s stillbirth.

4. Documentation

The sparsity of detailed documentation and differing accounts of the antenatal period has hindered clarity in completing this report. The care provided falls outside accepted midwifery practice in areas of palpation, fetal heart auscultation, and the differentiation of maternal and fetal heart rate. The difficulty arises with the undocumented discussions regarding decline/consent to routine midwifery practice.

The documentation moderately departs from accepted midwifery standards on the whole.

NZCOM documentation:

- The midwife comprehensively documents all assessments, information and advice shared and decisions made for the plan of care in the wahine maternity record.

Midwifery Council Documentation and record keeping (2018) (https://www.midwiferycouncil.health.nz/common/Uploaded%20files/Be%20series/Be%20Safe%204%20Documentation%20and%20record%20keeping%20F.pdf):

> **Professional documentation includes**
>
> - Detailed assessments and clinical findings.
> - Discussions of care and information provided with the woman.
> - **Discussions and consultations with health professionals, including care plans.**
> - **Evidence of informed choice and consent.**
> - **Care decisions with rationale**.
> - Any medication or treatment prescribed.
> - All administrative requirements eg dates, time, identifying information.
> - Name and designation of health professionals consulted and/or referred to.
> - Any referrals. Documentation should occur at the time that care is provided. Notes written in retrospect should be identified as such.
>
> Midwifery Standard Five
> Midwifery care is planned with woman.
>
> - Sets out specific midwifery decisions and actions in an effort to meet the woman/birthing person's goal and expectations and documents these.

Informed Choice

RM [B] states that [Ms A] made informed choices to decline vaccination of newborn and COVID vaccine, whooping cough, and flu vaccine, vitamin k, and a glucose tolerance test. She further states that abdominal palpation and fetal heart auscultation have been declined.
I have not documented that recommendation to palpate, and listen was declined. This discussion is had in line with informed choice and consent with each woman.
Retrospectively, it is impossible to determine the content of any undocumented discussions and the effort to ensure informed choice.

Postnatal period

Following review of the antenatal notes, it appears that reasonable effort has been made in ensuring that Ms [A] received postnatal care (eight attempts). On recognising that Ms [A] was avoiding engagement in postnatal care, an offer of an alternative midwife was proposed. […] *I messaged [Ms A] saying I would not place any further pressure on her to see me. I advised her that she was entitled to midwifery care, offered care from another midwife, or suggested she see her GP. I explained that I would discharge her from my care unless I heard from her that this was not what she*

wanted. [Ms A] replied that she had got the message. No departure from accepted midwifery care is identified in the postnatal care provided.

Summary

Forming an opinion is hampered by insufficient documentation. There are areas that depart from accepted midwifery practice, and it is stated that these departures were compliant with Ms [A]'s wishes. Unfortunately, there is little documentation to support that the following was agreed to with informed consent.

- No FH auscultation antenatally
- No abdominal palpation between 26 and 37 weeks' gestation or in labour to confirm presenting part. The lack of palpation impacts on the functionality of the GROW chart (customised growth chart)
- No documented referral for thrombocytopenia
- Removal of the CTG with no subsequent recording of fetal heart auscultation by IA in labour
- No referral or discussion regarding maternal wellbeing in light of lack of weight gain and continuous vomiting
- Documentation.

Steps RM [B] has committed to undertake following this case as per her complaint response.

- I am using my laptop in all antenatal visits carried out at home
- I have bought a set of weighing scales that I keep in my car to keep track of weight gain during the antenatal period
- I have enrolled on a NZCOM Unexpected Outcomes course on 30 August and will research further bereavement training
- I have enrolled into a Documentation Course on 6 September to go over my documentation again
- I have added more detailed information to my information folder around healthy eating
- I am doing an updated FSEP course
- I am updating my GAP training
- I am reducing my caseload back to 30 or less from beginning of 2023
- I am reducing the geographical area I cover
- I will be palpating the uterus and listening to the baby heart rate of every woman and clearly documenting when they decline this recommendation.
- I am reviewing the information I share with women with colleagues to make sure this is as up to date as possible.
- I am asking women to check the notes I send them of our appointments and asking them to let me know if there is anything they do not agree with or feel I have missed.

Finally, I extend my heartfelt sympathy to Ms [A], […], and […] for the loss of their precious [Baby A]. I wish them the best in the ongoing care of their precious family.

Nicholette Emerson, BHSc, PG Dip-Midwifery

Midwifery Advisor
Health and Disability Commissioner ’

Further internal clinical advice was received from RM Emerson on 12 May 2025:

‘I have reviewed the above file and additional information provided as requested. I acknowledge the appropriate steps taken by RM [B] to address the practice issues identified by [the] Midwifery Council. Following referral, I note the Obstetric letter received by RM [B] regarding Ms [A]’s platelets in her previous pregnancy ([…]). I do not think that this mitigates the obligation to refer in the current pregnancy for low pregnancy platelets (thrombocytopenia). I do note, however, that the platelets were monitored by RM [B] and did increase.

Thank you for providing the file for review. Following review, I do not wish to change any aspects of my advice.

Let me know if you have further questions or require further clarification’.