HEALTH & DISABILITY COMMISSIONER
TE TOIHAU HAUORA, HAUĀTANGA

Failures in maternity care for wahine who experienced stillbirth after ruptured uterus

Introduction

1. For women with normal pregnancies, for the most part their labour and birth process can be safely managed in a primary birthing unit by a lead maternity carer (LMC) and appropriate support staff. However, there are circumstances where a woman birthing in a more remote rural setting without ready access to specialist expertise may not be appropriate.

2. This case is important as it highlights the unique challenges for a woman birthing in a more remote rural locality when there were identified issues that put them at greater risk of developing serious complications. Difficulties developed during the birthing process, and the service providers did not sufficiently recognise and react appropriately to the situation.

3. This Office received a complaint[1] from Mrs A about the maternity care provided to her daughter, Ms B, by multiple providers before and during the birth of her second child, Baby B. These providers were registered midwife (RM) C; the midwifery practice she was associated with (the Practice)[2]; the Health New Zealand | Te Whatu Ora region (Health NZ); Dr D, consultant obstetrician; and the ambulance service. Sadly, Baby B was stillborn on 17 July 2022.

4. The B and E whānau wanted this report to acknowledge Dr F and the Action to Improve Maternity support group for the expertise, advice, and aroha they provided throughout this experience and in bringing this complaint. I also want to thank the B and E whānau for sharing their mamae and bringing their concerns to the Health and Disability Commissioner (HDC).

5. At the outset, I extend my sincere condolences and acknowledge the tragic loss of Baby B for the B and E whānau, which I am aware has had a deep and profound impact on them. Ki ngā huia kaimanawa kua ngaro ki te pō, moe mai koutou. To our precious ones who have disappeared into the night, rest in peace.

6. Having considered the concerns raised in the complaint by Mrs A, for the reasons set out below I find RM C in breach of Rights 4(1), 6(2), 6(1)(a), and 7(1) of the Code of Health and Disability Services Consumers' Rights (the Code). I have also made adverse comments about the Practice and Health NZ and educational comments for Dr D and the ambulance service.

Information gathered and events leading up to birth

7. On 9 March 2022, Ms B, aged 27 at the time, had her first antenatal visit with RM G of the Practice after discovering that she was pregnant with her second child at 19+6 weeks' gestation. At the time, Ms B and Mr E's first child was around 9 months old. Ms B has confirmed, and the clinical records of Health NZ reflect, that she had been made aware of

[1] Prepared in collaboration with Dr F from Action to Improve Maternity.
[2] A midwifery practice of two junior and three senior midwives at the time the care was provided.

Names have been removed (except Health New Zealand | Te Whatu Ora and the clinical advisors on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

the need to wait at least 12 and preferably 18 months before becoming pregnant again because her first baby had been in a breech position and so delivered by emergency Caesarean section but that she was suitable for a vaginal birth after Caesarean (VBAC). Although Ms B mentioned it was a surprise pregnancy and that she was concerned about the time span between babies, it was happy and welcome news for them as a whānau.

8. On 14 March 2022, Ms B's LMC at the time, RM H (a caseloading midwife employed by the Practice) contacted her. To clarify Baby B's due date, RM H made an appointment for Ms B to have an ultrasound scan (USS) the following day. It was noted that Ms B ideally wanted a VBAC.

9. On 15 March 2022, Ms B had her first USS, which resulted in an estimated delivery date of 28 July 2022 '+/- 10 days.' However, Ms B's last menstrual period placed the delivery date around 4 July 2022. The estimated timeframe for delivery between the births of her first and second children was between 13 and 14 months.

10. On 21 March 2022, when Ms B was at 21+4 weeks' gestation, RM H sent a women's maternity assessment referral for her to be seen by an obstetrician at the Health NZ antenatal clinic (ANC) for pregnancy counselling related to a VBAC, noting that this was Ms B's preferred mode of delivery.

11. On 18 May 2022, Ms B (29+6 weeks' gestation at the time according to the USS results provided on 15 March 2022) attended an ANC appointment with Dr D, a consultant obstetrician. In Dr D's follow-up letter to RM H on the same date, she noted that Ms B was 'extremely keen' to have a vaginal birth for this pregnancy. Dr D also noted that she had given Ms B the Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG) Vaginal Birth after Caesarean Section (2018) Patient Information Leaflet (RANZCOG Patient Information Leaflet), and the form completed at the appointment had the 'Treatment Information Pamphlet' sticker from the RANZCOG Patient Information Leaflet attached to it. Dr D stated that Ms B was 'aware of the need for delivery in hospital with continuous monitoring.' Dr D noted that she was optimistic about Ms B having a normal delivery so long as the baby was not breech. Dr D made a plan for Ms B to have a USS to monitor growth and check the cervical length of the baby.

12. Dr D's handwritten clinical notes for this appointment reflected that Ms B 'understands risk of scar rupture' and 'need to deliver in [town]', which Dr D has since clarified was incorrectly written. However, the letter of the same date from Dr D to RM H referred to in paragraph 11 correctly stated Ms B's 'need to deliver in [the city]'.

13. Ms B acknowledged that Dr D provided clear advice at the appointment on 18 May 2022 that she was to immediately go to hospital at the onset of labour. However, she told HDC that Dr D did not explain the reasons for or the consequences of a potential uterine rupture[3] and that, if she had, she would have opted for an elective caesarean. Instead, Ms B stated that Dr D told her there was a 0.05% risk of uterus rupture. Ms B also told HDC that she strongly denies ever having received the VBAC information leaflet or discussing the contents

[3] A rare, life-threatening tear in the uterine wall during pregnancy or labour that results in the baby slipping into the abdomen. It is most common after a Caesarean section and can cause severe bleeding in the mother and suffocate the baby.

with Dr D. Ms B stated that she felt Dr D influenced her decision by telling her she was a good candidate for a natural birth.

14. On 23 May 2022, Ms B received a USS, and the clinical records reflect that 'Fetal measurements are large for dates with the [estimated fetal weight] EFW on the 91st percentile' (just under the 90th percentile on the customised growth chart), with normal growth since the previous scan at 23 weeks. On virtual review of the USS, Dr D noted that, at 30+4 weeks, there was 'good cervical length routine care to continue'.

15. On 26 May 2022, Ms B and Mr E attended a routine ANC appointment with RM C, who took over clinical care as Ms B's new LMC after RM H left the employment of the Practice suddenly.

16. On 15 June 2022, Ms B (33+6 weeks' gestation) had a further obstetric appointment with Dr D, and a follow-up letter was subsequently addressed to RM H.[4] In the letter, Dr D noted that it had been a pleasure to catch up with Ms B 'again' and Ms B was 'doing very well in the pregnancy' and that there had been a discussion regarding VBAC. Ms B was noted to still be "extremely keen" for this to happen. The letter also stated that Ms B was reminded 'to come through to [the city] if time allows and that she will be monitored continuously.' Dr D made plans to review Ms B if she had not delivered by 41 weeks. This was the last ANC appointment Ms B had with Dr D.

17. On 23 June 2022, Ms B attended another routine ANC appointment; she told HDC that RM C advised her that, once she was in labour, she should undergo a preliminary assessment at the [town maternity unit][5] first. In its response to the provisional opinion, the Practice stated it was standard practice of all LMCs operating in the town and nearby region for women to attend the town maternity unit for an initial assessment first (for 'safety-focused' reasons[6]) before heading to the city. RM C's records reflect that Ms B had discussed the VBAC at the 15 June 2022 appointment with Dr D and that she had informed Ms B she 'may need to assess in [town] first before heading to [the city] for birth.' RM C also noted that a scan request was sent to a radiology service for growth at 37 weeks because Ms B had contracted COVID-19 during pregnancy.

18. On 7 July 2022, at 37 weeks' gestation, Ms B attended a further routine ANC appointment with RM C. RM C's antenatal record notes reflect that she gave advice in relation to Ms B's 'birth planning'. Among other records of Ms B's condition at the time, RM C repeated her advice to Ms B that she may need to undergo a preliminary assessment at the town maternity unit once she was in labour and noted 'Birthing in [the city]' and 'For continuous monitoring' due to prev[ious] c[aesarean] sec[tion].'

19. On 8 July 2022, at 37+1 weeks' gestation, Ms B received a further USS, the results of which concluded that 'Large for dates fetus with EFW [at 3634g] on the 91st percentile' according

[4] Despite the letter being addressed to RM H, who had left the Practice, the letter was added to Ms B's notes and was accessible to RM C.

[5] A primary birthing unit for women with low-risk pregnancies (there is no provision for continuous electronic fetal monitoring during labour other than during normal births).

[6] '[T]o confirm that contractions have genuinely commenced and to assess the stage of labour, so as to avoid the serious risk of an unassisted roadside birth during the one-and-three-quarter-hour journey to [the city].'

to population-based charts (90th centile on customised growth chart) but stated there was 'normal growth since 30-week 4-day scan.'

20. On 14 July 2022, at 38 weeks' gestation, Ms B attended a routine ANC appointment, where RM C told her that the results from a vaginal swab she had arranged was positive for Group B Streptococcal (GBS), which is a type of bacterium that can harm babies before, during, and after birth. In her response to the complaint, RM C stated that antenatal GBS is considered a risk factor,[7] so she offered Ms B 'prophylactic antibiotics to be given to her intravenously once labour was established or earlier should her membranes have ruptured.' However, the antenatal record for this date notes only that Ms B was 'informed' of the positive GBS result.

21. On 16 July 2022, at approximately 5.00pm (as noted in RM C's antenatal visit record), at 38+2 weeks' gestation, Ms B called RM C and advised that she might be in labour and had been getting intermittent contractions since the morning. Ms B said she was feeling pain in her 'low groin and lower back' but was coping and reported good fetal movements, membranes intact, and no vaginal loss/discharge. RM C noted that they made a plan together for Ms B to try 'a hot shower/bath and to call if any further concerns or when support is needed'.

22. At approximately 6.30pm that same day, RM C's clinical records reflect that Ms B rang her again to advise that the contractions/pain had increased, with no relief from the shower. Ms B stated that RM C told her to 'labour as much as [she] could at [home] because that is where you make the most progress.' Ms B said that, because of her concerns about the advice from Dr D that she was at higher risk of uterus rupture, she asked to be assessed in the town maternity unit. A plan was made for Ms B and Mr E to meet RM C there.

23. At approximately 7.55pm, Ms B and Mr E arrived at the town maternity unit for early labour assessment by RM C. In their response to the provisional opinion, the B and E whānau noted that RM C was the only person present at the time who was aware of the need for Ms B to be monitored continuously and to go through to the city public hospital if time allowed, as outlined by Dr D in her 15 June 2022 letter. RM C's handwritten clinical records noted Ms B's previous obstetric history, gestation, and that the plan was for a 'VBAC' in the city hospital.

24. At approximately 8.15pm, RM C's records reflect that Ms B had started feeling sharp pains in her groin area that morning and reported difficulty walking, with intermittent pain and low central back pain. Cardiotocography (CTG)[8] monitoring was commenced. The clinical records note that Ms B reported normal fetal movements, no scar pain, and no vaginal loss/discharge.

25. At approximately 8.40pm, RM C noted that a vaginal examination found Ms B's cervix to be 2cm dilated but still 2–3cm long, indicating that she was in the early stages of labour. RM C also noted that Ms B was finding the contractions 'uncomfortable, breathing through them'.

[7] The result sheet noted: 'This organism is part of the normal vaginal flora but can cause neonatal or maternal sepsis when acquired during parturition [the biological term for childbirth].'

[8] Used to monitor a baby's heart rate and a mother's contractions during labour.

26. At approximately 8.50pm, RM C's notes reflect that she discussed her findings of the vaginal examination with Ms B and Mr E and that she 'Gave options but for [Ms B] to decide what's comfortable for her.' Ms B recalled that the options RM C gave her were to go back home (approximately one hour from town and one and three-quarter hours from the city), to find somewhere to stay in town, or to make their way to the city hospital. RM C stated that, as the findings indicated Ms B was in 'early labour/latent phase', she considered Ms B did not need to head to the city hospital immediately. RM C also stated that this was in line with the local district health board's Maternity Services Clinical Guideline for Vaginal Birth after Caesarean at the time, which said, 'continuous monitoring is required when in active labour.' Ms B stated that RM C 'was pushing' for them to stay in town as RM C and Mr E would need the rest to help her through labour.

27. RM C rang the city hospital's maternity unit, which advised that Ms B could go there 'when suitable' and that a room was reserved for them. Ms B and Mr E decided to go to a friend's house in town first before travelling to the city in their own car and left the hospital at approximately 9.25pm, which RM C confirmed she supported. RM C's records reflected this plan and for them to call her any time if there were any concerns. It was noted Ms B had a 'TENS machine to cope with labour for the meanwhile'[9] and that the CTG had been discontinued because Ms B had been finding it uncomfortable. RM C noted that the CTG showed that the baby was 'very clinically active' and in her antenatal records that the CTG was 'normal and reassuring.'

28. At approximately 11.35pm (as noted in RM C's clinical records) that evening, Mr E rang RM C from the friend's house in town to advise that Ms B was in severe pain with continuous contractions. RM C's notes reflect that she heard Ms B in the background, 'very vocal and in distress'. Ms B advised that RM C told her, 'sometimes this can happen' and to try to get to 'the [maternity unit]'. RM C's notes reflect that she discussed 'needing to hea[d] to [the city] immediately.' Ms B said she knew something was wrong and it was not normal and that she was in so much pain there was no way she could get to the car. Instead, RM C confirmed she would call at the friend's house in town.

29. RM C's notes also reflect that she contacted the town maternity unit at 11.40pm and spoke to the registered nurse (RN) on duty to update her on the situation and to ask whether the Patient Transfer Service ambulance[10] could transfer Ms B to the city hospital as RM C was unsure whether this was possible. As the RN was also unsure, the contact details for the ambulance service were provided to RM C for her to check.

30. At approximately midnight (as noted in RM C's online diary) on 17 July 2022, RM C arrived at Ms B's friend's house in town, and her clinical notes reflect that she found Ms B to be 'very distressed lying on bed'.

31. Between approximately 12.10am and 12.20am, RM C carried out a vaginal examination and noted that Ms B was 'uncomfortable and in pain'. RM C also noted during this time that the examination felt 'very different from previous examination' and that she was unable to

[9] A TENS (transcutaneous electrical nerve stimulation) machine sends small electrical currents through the skin to stimulate nerves and relieve pain.

[10] The Patient Transfer Service ambulance carries out inter-hospital transfer of patients and is staffed and driven by a patient transfer officer who is not medically trained.

identify the baby's precise position or heart rate. Ms B was stated to have been describing constant pain in her upper abdomen, was feeling faint and having sweats, and was managing small sips of fluids. Ms B said she could sense something was wrong as RM C looked worried. RM C has since acknowledged that there were signs a uterine rupture may have occurred but stated 'this is not a diagnosis I can make and can only be officially diagnosed during surgery by an obstetric doctor where the uterus is visualised.'

32. Because of Ms B's condition, RM C called the ambulance service at around 12.19am to arrange for an ambulance to transfer her to the town maternity unit rather than the city hospital. RM C explained that her rationale for this was 'because there were more resources … including doctors/[emergency department] (ED) staff to stabilise [Ms B] before transferring to [the city hospital]'. However, RM C acknowledged that Ms B's pain would not be reduced, although she considered they were able to 'properly check Ms B's observations with better equipment'.

33. HDC was provided with a copy of the call records, which reflect that, when asked whether the 'problem is immediately life threatening' RM C answered 'yes'. When the call handler asked what the diagnosis was, RM C explained that Ms B was in labour, described her as 'technically a first-time mum', stated that an examination had been carried out that Ms B had found a bit uncomfortable, that she could not find the baby's heartbeat with the machine she had, and that it would be 'nice to get to [town] to use the machine over there'. RM C makes no mention of the likelihood of a suspected uterine rupture during this call. When the call handler asked, 'based on the patient's condition, what priority would you like this', RM C stated 'priority one'. She also asked the ambulance service to bring some portable gas for Ms B, and the call handler confirmed with RM C that this was for portable 'oxygen', which was confirmed.[11]

34. At 12.23am, RM C called RM I, a more senior midwife at the Practice, and asked her to assist her at the town hospital. In response to the provisional decision, RM I told HDC that RM C told her that she was with a client, could not find a fetal heartbeat, and was heading to the town maternity unit, and RM I immediately agreed to meet her there. RM I also told HDC she should have paused and requested more detail about the clinical circumstances. At approximately 12.32am, RM C called the town maternity unit and spoke to a staff RN to arrange for a Patient Transfer Service ambulance to be booked in readiness for Ms B to be transferred from the town hospital to the city hospital. The call was made by the RN at 12.38am, and the ambulance service gave an estimated arrival time at the town hospital of 1.15am. Ms B stated that, during this time, she had noticed RM C left the room they were in and came back after a few minutes and asked whether she could make it to the car to get some pain relief, which she was unable to do. RM C made further attempts to hear the baby's heart and noted that she still could not do so.

[11] RM C told HDC she requested this 'in case things expedited and had an even more compromised mum or she ended up delivering baby who [she] knew would have been also compromised due to not being able to find a fetal heart rate.'

35. At approximately 12.35am, the ambulance arrived with two emergency medical technicians; however, because of the pain and distress Ms B was in and because she was feeling faint, the ambulance did not leave for the town hospital straight away.

36. At approximately 12.40pm, and to reduce delay once they arrived at the town maternity unit, RM C phoned the ambulance service and requested an emergency transfer for Ms B to travel from the town maternity unit to the city hospital; they advised that the Patient Transfer Service ambulance would arrive at the town maternity unit by 1.15am.

37. At approximately 12.40pm, the emergency medical technicians transferred Ms B to the ambulance in a stretcher, and the clinical records note that, at around 12.45am they checked Ms B's blood pressure, respiratory rate, temperature, and oxygen saturations. No pain relief was provided to Ms B, nor was the oxygen/gas that RM C had requested used. RM C told HDC that her reasoning for this was that Ms B's 'oxygen saturation levels remained normal at 99–100%, nor was she having any respiratory issues, and none of her observations warranted needing oxygen during the ambulance trip to [the town maternity unit], and she did not deliver.' RM C also stated that oxygen was not something she would give to her clients for pain unless there were other clinical concerns.

38. The clinical records reflect that, at approximately 1.10am, Ms B was admitted to the town maternity unit, and it was noted that she was in 'Early (latent) labour' and that RM C had been unable to hear the baby's heart at the home assessment. RM I was present when they arrived. It was also noted that Ms B had 'severe abdominal pain, tachycardia [heartbeat of less than 100 beats per minute] and hypotension [low blood pressure].' RM C has since stated that Entonox gas (nitrous oxide) was offered to Ms B on arrival at the town maternity unit, but she declined. RM C told HDC that, in hindsight, morphine was another option that could have been offered. RM I also carried out a 'CTG attempt' on their arrival and confirmed that she was also unable to hear the baby's heart. Ms B said she could tell something was seriously wrong as everyone had stopped asking her about the baby's movement.

39. At approximately 1.15am, RM C called Dr J, the on-call consultant obstetrician and gynaecologist at the city hospital, who suspected uterine rupture and advised that Ms B should be urgently transferred to the city hospital by helicopter because the transit time would be shorter and the helicopter is medically equipped and staffed with an intensive care paramedic. The RN therefore cancelled the Patient Transfer Service ambulance that RM C had ordered at 12.40am.

40. In response to the provisional opinion, RM I stated that she took full responsibility for the events at the town maternity unit. RM I acknowledged she was a senior midwife working with a junior midwife and an RN. RM I told HDC that, although she took over liaising with Dr J and the transfer team, there were 'still regrettable miscommunications.' RM I stated that attempts to engage the ED were unsuccessful and she took heed of Dr J's advice to expediate the transfer, given Ms B's need for urgent theatre admission. She acknowledged that she did not 'push for ED engagement', though an admission to ED would have enabled Ms B to have been offered stronger pain relief that was not available at the town maternity unit.

41. At around 1.20am, oxygen was commenced for Ms B, and her condition was still noted as 'hypotensive'.

42. At approximately 1.26am, the Patient Transfer Service ambulance arrived at the town maternity unit. They were asked to wait until a helicopter transfer was confirmed but were unable to do so because the job had already been cancelled. Shortly after this, the city birthing unit called to ask for an estimated time of arrival for Ms B; the RN advised them that she would call as soon as they had left.

43. At approximately 1.28am, the RN requested a helicopter from the ambulance service. The helicopter service questioned the request given that the Patient Transfer Service ambulance was already onsite and it would take at least 30 minutes for the helicopter to reach Ms B. The RN explained that the urgency was that Ms B's condition was 'unstable, with tachycardia and hypotension'. Ms B said that, during this time, staff stopped talking to her and were rushing around trying to arrange the urgent transfer to the city hospital and that she had still not been given any pain relief and was starting to struggle to breathe.

44. Unfortunately, weather conditions made it too dangerous for the helicopter to take off. At approximately 1.46am, a new request was made for the Patient Transfer Service ambulance, which arrived at approximately 1.52am.

45. Around this time, 'after many attempts' by the ED nurse since 1.35am, Ms B had an intravenous line (IV)[12] inserted. In her response to HDC, RM C stated that the IV may have been prioritised earlier if they had received more support initially, as only she, RM I, and the RN were there at the time.

46. At approximately 2.16am, Ms B was transferred from the town hospital to the city hospital via the Patient Transfer Service ambulance. During the journey, Ms B was in pain and was administered Entonox but no other pain medication. Ms B and Mr E said they felt the ambulance officer's manner was 'rude and obnoxious' and that he 'snapped at' Ms B. Mr E was very concerned about the 'rough and unsympathetic care' Ms B received from both the ambulance officer and RM C, especially given the extreme pain she was in. In subsequent discussions with the Practice, it was noted that Ms B stated that RM C 'was a comfort' for this ambulance transfer.

47. At approximately 3.14am, the Patient Transfer Service ambulance arrived at the city hospital. Ms B said she was in extreme pain, could not breathe properly, was disorientated, was extremely upset, and felt like she was 'dying'. The clinical records reflect that observations showed she was in constant abdominal pain, she looked pale, urine in the catheter bag was clear, and the baby's heart could not be found on scan. A vaginal examination was carried out, and it was only at this point that Ms B and Mr E were told of the 'possible diagnosis' that they had lost Baby B because of a ruptured uterus. Ms B was then told she required an urgent Caesarean section as her life was in danger because she was bleeding severely internally and filling up with fluid.

[12] A small flexible tube placed inside a vein to deliver fluid or medicine.

48. At approximately 4am, Dr J performed a Caesarean section on Ms B. During the surgery, it was found that the scar from Ms B's previous Caesarean section had come apart. The baby was located in the general peritoneal cavity. Sadly, Baby B was stillborn at 4.04am. Ms B required two units of red blood cells in theatre due to blood loss, and the scar tissue was repaired in two layers. Ms B was discharged from the city hospital on 20 July 2022.

49. Mrs A stated that they were extremely grateful for the empathy, care, and support that the maternity staff at the city hospital provided to Ms B, Mr E, and all the whānau on and after 17 July 2022. This included Dr J, who they felt saved Ms B's life.

Subsequent events and cultural safety

50. RM C had postnatal contact on multiple occasions with Ms B and Mr E while they were grieving Baby B, and her postnatal visits record documents these as follows:

a) At the city hospital on 19 July 2022 to give her condolences and offer a debrief. RM C told HDC that they also discussed the tangi arrangements for Baby B and that she commented she would like to attend to show her support if the whānau wished to have her there.

b) A phone call on 20 July 2022, during which both Ms B's postnatal condition and support was discussed. RM C noted 'Has opened an invitation to me to attend tangi for Baby B in 2 days' time.'

c) A phone call on 23 July 2022, after the tangi on 22 July 2022, which RM C and RM I had both attended. Ms B's postnatal wound was discussed. RM C offered a postnatal visit for the following day, but she noted that Ms B asked for this to be on 25 July 2022 instead.

d) A further phone call on 25 July 2022, where it was noted that she had whānau around for support, her contact details to call anytime, and that Ms B '[d]eclined any further support resources,' and so the planned visit did not occur.

51. The Practice advised that Ms B requested that an RM other than RM C conduct the final at-home midwifery visit because Ms B did not wish to receive postnatal care from her. On 26 July 2022, RM K (the Practice manager) carried out a final home-based midwifery visit to remove a dressing and check Ms B's wound. During the visit, she noted that Ms B was happy with that day's check but did not want regular visits and would call if she required anything further. The Practice told HDC that Ms B also provided feedback to RM K about concerns with the care she had received from RM C. This feedback included RM C's use of language during postnatal visits, which she felt was inappropriate and caused her distress, including asking 'Is it weird without Baby B?', though Ms B did also provide feedback that RM C was 'Good during AN[C], though not in an emergency'. The Practice confirmed that it had passed on this feedback to RM C.

52. In contrast to paragraph 50, Ms B has since told HDC that they had to contact the Practice to stop RM C from calling them. The B and E whānau felt RM C's comments lacked cultural and emotional awareness. In their response to the provisional decision, the B and E whānau strongly refuted the statement made by RM C that she was unaware she was not welcome at the tangi and that because they already had concerns about the care provided by RM C in the first days after the tragedy at the city hospital, she had been strongly advised by them

to 'stay away' from Ms B. The B and E whānau told HDC that, knowing how they felt, they struggled to understand why RM C continued to make contact with Ms B 'while she was in deep grief, recovering from a major operation and extremely vulnerable.'

Other information

From the B and E whānau

53. Mrs A told HDC that Ms B, Mr E, and the extended whānau placed a deep sense of trust in RM C to provide appropriate care and advice to them as their midwife, despite Ms B's instinct that something was wrong. They also told HDC that they felt:

- there was a lack of urgency in response to Ms B's condition, despite clear clinical risk factors;
- the maternity system does not work for Māori women, describing it as inadequate and unresponsive to Māori voices;
- that each Health NZ district followed different guidelines, 'implying that different advice is given out depending on where you live';
- a phone conversation with Health NZ where they were told obstetricians would not recommend an elective Caesarean to a mother who had previously had a Caesarean, went against the advice in the VBAC leaflet; and
- there is a disconnect between Health NZ and midwives.

54. Ms B also raised concern that Dr D had a poor attitude and made inappropriate jokes with her during her antenatal visits on 18 May 2022 and 15 June 2022.

55. In a hui ā-whānau[13] with HDC's Māori Directorate team on 14 February 2025, the B whānau talked through their complaint concerns, which have been incorporated into this decision, including their significant concerns about the maternity system's responsiveness to Māori, the adequacy of midwifery care, and systemic failures that resulted in ongoing distress for them. The B whānau expressed that they and the E whānau would like to see changes for other women because of the struggle they had encountered, including better education, training, and system improvements.

Response from RM C

56. In her response to HDC, RM C acknowledged the significance of the situation and the impact it had on Ms B and her whānau and extended her sincere empathy to them for what they experienced.

57. RM C told HDC that, after having undertaken a 'deep and honest reflection' on the care provided to Ms B and the systems she was working within, she has recognised that she could have done things differently or more effectively in some areas.

58. RM C told HDC that, since she started with the Practice on 17 March 2022, she had not received any formal job training or orientation as she was in an 'employed caseloading

[13] A meeting offered by HDC to consumers/complainants and their whānau during the complaint process as part of its commitment to equity, cultural safety, and meaningful engagement with Māori. The hui is an opportunity to discuss the complaint concerns and aims to help provide some healing.

setting',[14] though she was informed about rural midwifery processes and abiding by local guidelines.

59. RM C said she took on a second caseload (which included the care of Ms B) 'not by choice but rather a necessity' because RM H had left and because she had been her practice partner at the time (the Practice disputes that RM C had two caseloads; refer to paragraph 75). RM C also told HDC that she did not have any clinical handover and her caseload of four to six women a month increased to 10 after the transfer of RM H's caseload, with a total of 57 women in one year.[15] RM C said that, at the time, she did not fully understand the implications of this and how inappropriate it was. In her response to the provisional opinion, RM C emphasised that, particularly as a very junior midwife in new employment, she felt she should 'not have been placed in the position of having to take on extra caseload whatsoever' and that she has learnt from this experience and not taken on an unsafe caseload since.

60. RM C also told HDC that, although she did have access to and assessed what she thought were relevant clinical records[16] for Ms B as her LMC on the Practice's Expect maternity software system, she did not become aware of the earlier ANC appointment and letter from Dr D of 18 May 2022 until after the birth. RM C also confirmed she had 'no communication' with Dr D. In her response to the provisional opinion, RM C said that Dr D's 18 May 2022 letter was not uploaded to the Expect maternity software system and suggested this was due to an administrative error.

61. RM C stated that she did not feel it was clinically appropriate for her alone to determine Ms B's suitability for a VBAC, particularly given the short interpregnancy interval and that this was a decision to be made jointly between Dr D and Ms B and she thought the relevant risks had been discussed. RM C acknowledged that she did not comprehensively revisit all the risks involved but did discuss her birth plan during ANC appointments.

62. RM C stated that she felt that Dr D's comment that '[Ms B] will need to come through to [the city] if time allows and that she will be monitored continuously' did not mention timing or that there was a need for her to be admitted at the onset of contractions and felt the relaxed manner of the statement 'if time allows' and lack of documentation of the short-interval pregnancy implied there was never any urgency for admission during her labour and there were no clinical concerns from Dr D. However, RM C said it did not change her plan, which was to admit Ms B to the city hospital for continuous monitoring once in established labour.

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[14] A model of care where a midwife is allocated a certain number of women (the caseload) and arranges their working life around the needs of the caseload. This model aims to ensure there is consistent support and care provided throughout the entire pregnancy, labour, birth, and early postnatal period by the same caseloading midwife.

[15] The normal caseload for a rural LMC is stated as being 1:35–40 and for women with complex needs 1–40 per year (MERAS. (2014). *Midwifery Staffing Standards.* Christchurch: Midwifery Employee Representation & Advisory Service, p 21. https://meras.midwife.org.nz/wp-content/uploads/sites/4/2019/06/MERAS-Mid-Staff-Stds-2014.pdf).

[16] '[M]aternity notes, lab results, scan reports, virtual scan review outcome of [Ms B's] 30+4-week scan, and the Antenatal Clinic letter dated 15 Jun[e].'

63. RM C told HDC that, even though she suspected uterine rupture at Ms B's friend's house, she did not have the full picture to do a proper handover to the obstetrician in the city hospital. However, she has since acknowledged, 'in hindsight, it would have been beneficial to have let the obstetrician know, even if it wasn't a full picture so they could have prepared for her arrival'.

64. RM C acknowledged that she did not complete a full clinical assessment to formally diagnose obstetric shock at the scene and had left her full midwifery kit in the work vehicle outside as she anticipated a routine labour assessment. However, when it became apparent to her that this was not the case, RM C said she did not feel it was safe to leave Ms B. RM C also stated that, having stated in her call to the ambulance service that it was an 'obstetric emergency' and expecting the ambulance to arrive quickly, she did not think there was much time for anything else, including calling the obstetrician.

65. RM C also acknowledged that her communication with the ambulance service could have been 'clearer and more concise' and that it was a 'high-stress and time-sensitive situation.' RM C explained that it was the first time she had needed to initiate a transfer from a home setting and was unsure whether a transfer ambulance could collect Ms B directly from the friend's house.

66. RM C stated that, in retrospect, also offering Ms B sips of fluid during the home assessment was not aligned with best practice and accepted that 'more could have been done at the scene', which she had reflected deeply on.

67. In relation to pain relief, RM C told HDC that Ms B was offered Entonox on arrival at the town maternity unit, which she declined at the time. However, RM C stated that, in retrospect, she acknowledged that she should have re-offered Entonox and more proactively explored further options for pain relief, particularly in light of the prolonged transfer process and the high likelihood of a uterine rupture.

68. RM C said that what she struggled with most was the 'transfer process', how 'unsupported' she was as a rural midwife, and the lack of resources. RM C outlined that 'there were no thorough guidelines on the steps to take when an emergency transfer is indicated from [the town maternity unit], and there was limited understanding/support of the situation from [ambulance service] comms and staff members.'

69. With regard to the Practice, RM C stated that, although she was grateful for the opportunity to work with it, she acknowledged that she entered a 'challenging practice environment with limited orientation and minimal structured support.' RM C stated that when RM K returned from leave, she 'decided not to hire another midwife' and she continued with the increased workload. RM C described it as a 'high-risk working environment.' RM C acknowledged that being responsible for two full caseloads was 'unsustainable and unsafe' and that she should have 'spoken up more about the risks [she] was experiencing and advocated more strongly for support.'

70. In relation to attending the tangi of Baby B, RM C stated she assumed this had been okay with the whānau as the invitation was offered to her during the call on 20 July 2022. However, if she had known that her attendance made them feel uncomfortable, she would

not have attended. RM C said she was not aware of Ms B's request for her not to provide any further care until the visit by RM K on 26 July 2022.

Response from the Practice

71. The Practice stated, 'It is with great sadness that we acknowledge the passing of Baby B and the trauma and grief that [Ms B] and [Mr E] have gone through.'

72. The Practice confirmed it employs midwives on an autonomous basis and the company supplied 'administrative and financial support only.'

73. The Practice also told HDC that all midwives at the Practice were supplied with a car, fuel card, clinic space, and '[antenatal] and [postnatal] equipment and full birthing kits for each car, including [indwelling urinary catheters] and IV line/fluid equipment. Oxygen and full maternal and neonatal resus', which was 'kept full'.

74. In contrast to RM C's response, the Practice stated that RM C received orientation[17] from both the Practice and Health NZ[18] and confirmed that RM C was 'not a new graduate' but was a junior midwife in her 'second year of practice.' In response to the provisional opinion, the Practice stated that it considered the orientation was 'comprehensive, structured, and went considerably beyond what would ordinarily be expected for a midwife at [RM C's] stage of practice.'

75. The Practice also stated that RM C did not have two caseloads combined and that a contingency plan had been put in place from 20 June 2022 to cope with RM H's caseload until RM K returned from overseas in early August 2022. The Practice advised that a more senior midwife, RM I, took over the caseload and became RM C's practice partner. In response to the provisional decision, The Practice told HDC that the care of Ms B was allocated to RM C as a 'specific arrangement within that contingency, not as a consequence of RM C assuming an entire second caseload independently and without support.' This contingency plan involving RM I was in place until RM K returned from leave and took over RM H's caseload and became RM C's practice partner. RM I provided a statement dated 14 May 2025 to HDC to this effect, which stated that, when she did this, she did occasionally both require and provide back-up.[19] RM I told HDC that it was a 'challenging few weeks.' RM I also stated that, when RM K returned, caseloads were 'officially distributed appropriately.' In response to the provisional decision, the Practice told HDC that RM H's sudden and unexpected departure created significant and additional pressure and that this placed demands on RM C. The Practice stated that RM C requested a change to her roster to enable her to have weekends off, which commenced from 1 August 2022, although it

[17] Orientation entailed shadowing one of the other midwives on her first rota, orientation at the Practice by the practice manager, RM K, who also was stated to accompany her 'on antenatal and postnatal visits until she was comfortable', 15- to 30-minute gaps between each antenatal appointment were protected for the first 4 weeks to enable time to document/seek advice, and a senior was always available for questions, challenges, and peer support. RM K also provided orientation at Town and City birthing units; she accompanied RM C to each of her births at these facilities 'until [she was] comfortable in the surroundings.'

[18] Who 'required any new LMC to complete their unit orientation, including IT access and emergency procedures'.

[19] An example given by RM I was on 8 July 2022 when she asked for relief at a birth after being up for nearly 36 hours.

considered this was 'not fair to the other practice partners to work weekends, it was agreed to support RM C.'

76. The Practice also told HDC that it had 'good rostering and mechanisms in place to ensure rest and safety for the midwives, thus reducing risk to the women.' This included that all midwives always had access to at least one other RM for fatigue relief and weekly protected time off. They also stated that the 'roster adjustments, flexible leave and team support provided to RM C were exceptional' and 'above and beyond what an LMC in her [second] year of practice would normally receive' and disputed RM C's claims that she was not supported and was compelled to take over a second caseload. The Practice also said that RM C had not raised any issues with it about her workload or support at the time. The Practice said that RM C always had senior support available, including from RM I, who 'attended immediately to assist with the transfer' when RM C called her on 17 July 2022.

77. In a response to the provisional opinion, the Practice told HDC that while it could not confirm with certainty when Dr D's letter was uploaded to its Expect system, it was on Health NZ's hospital computer system. The Practice also stated that as a condition of LMCs practising in the region, that they maintain active access to Health NZ's hospital computer system where all hospital correspondence and obstetric letters are held. The Practice confirmed this was a requirement of RM C's role with it and to its knowledge, she had access to the system and therefore to Dr D's letter of 18 May 2022, which was on Health NZ's system.

78. The Practice stated that, as a group practice, it implements safeguards, including 'always having two midwives on transfer and carrying the emergency bag at all times', which it considered demonstrated a 'well-resourced, supported system.' The Practice further stated that 'any deficiencies in clinical decision-making on the night of Ms B's abruption cannot be attributed to the work environment at the Practice.'

79. In contrast to RM C's response, the Practice also stated that it did not decide against hiring another midwife, and extensive efforts were made to recruit. However, it said that the nationwide shortage of midwives meant recruitment was not feasible at that time, even for an employed role. In response to the provisional opinion, the Practice told HDC that the nationwide shortage of midwives 'affected rural practices disproportionately'.

80. In relation to its understanding of whether the ambulance service could make routine transfers directly from a residential address to the city hospital, the Practice stated that it understood that routine transfers should go to the town hospital utilising the 'rural ED [senior medical officer] service/transfer ambulance system and not a frontline'. However, it stated that on occasion, in consultation with the city hospital Obstetric team, transfers had been undertaken from a residential address to the city hospital direct, which RM K and RM I were aware of.

Response from Dr D

81. In her response to HDC, Dr D stated that she had discussed with Ms B that, if uterine rupture occurs outside of hospital, it is an emergency for both mother and baby and that the baby is unlikely to survive.

82. Dr D also told HDC that there had been no maternity care plan summary card in the notes she had available at the location where she saw Ms B, as they were not routinely used in the town or surrounding region.[20] Dr D also acknowledged the error in her handwritten notes of 18 May 2022 regarding the 'need to deliver in [town]' (correctly stated as '[city]' in her subsequent letter), which had been caused by some confusion around an urgent scan required in town.

83. Dr D also noted that Ms B made early contact with RM C as discussed in the appointments on 15 May and 18 June 2022 but unfortunately was not sent to the city hospital as had been discussed.

84. In relation to the comments from Ms B regarding her 'poor attitude' and 'inappropriate jokes', Dr D strongly refuted these and said making inappropriate jokes would have been completely out of character for her. However, Dr D said that if she had inadvertently said something that had upset Ms B, then she apologised that her communication was perceived as upsetting for her.

Response from Health NZ

85. Health NZ confirmed that, at the time of events, although the CTG machine was used on 16 and 17 July 2022, it was in the process of developing a fetal heart monitoring guideline (see the 'changes made' section below).

86. Health NZ also told HDC that there had been no documented process for staff to follow for communication with parents when a baby's heartbeat could not be detected. However, the expectation was that staff at the town maternity unit would communicate this to the parents, and immediate transfer to the city maternity unit is strongly advised so a USS can be performed by a suitably qualified and experienced obstetric registrar or senior medical officer.

Response from the ambulance service

87. The ambulance service responded to Ms B on 13 February 2023 and apologised for the 'manner of engagement that was displayed by the attending officer' and for the distress it had caused.

88. The ambulance service said that the ambulance officer recalled Ms B being distressed and in pain and that they had called out to RM C to ask whether assistance was required. The officer reported that this was declined, and he was told to continue with the urgent transfer. They also confirmed that a Patient Transfer Service vehicle 'does carry limited medications and equipment (such as IV cannulas), similar to a frontline ambulance', which RM C could have used if needed under her scope of practice and clinical care.

Health NZ Serious Event Review

89. After these events, Health NZ completed a Serious Event Review (SER) report, originally dated 17 July 2022 and amended on 3 December 2022 after meeting with the B whānau, that identified care delivery problems. Although I acknowledge that the B whānau were unhappy with some aspects of the SER, I have referred to relevant findings and contributory

[20] They had initially been introduced into the city hospital notes.

factors (**Appendix B**) from the SER for the purposes of informing my decision-making in relation to Health NZ and to demonstrate what changes (**Appendix C**) it has made. I have also outlined further information from the SER as follows:

a) There was no clearly documented procedure for unwell maternity patients transferring to the town hospital via frontline paramedic ambulance for reasons other than to give birth to be admitted and stabilised in the ED rather than being taken through to the primary birthing unit.

b) There had yet to be a formal introduction of Maternity Early Warning System (MEWS)[21] charts into the town maternity unit,[22] including training and an escalation plan specifically for the town maternity unit, although city charts were available for use there.

c) After a previous incident, Health NZ introduced a 'maternity care plan summary' card for insertion in the front section of clinical records to document the specific identified obstetric issues and instructions for antenatal, intrapartum, or postnatal care. This was not well utilised, and there was no such card in Ms B's notes.

d) When Ms B arrived in the town maternity unit instead of the town hospital ED, the emergency bell was not activated on Ms B's arrival as would have been in line with its policy given that she was 'haemodynamically unstable.'[23]

e) The regional Health NZ guideline for transferring between the town primary unit and a secondary care facility (in this case, the city hospital) did not include uterine rupture in the possible scenarios where transfer might be required.

f) The Entonox analgesia provided to Ms B was not sufficient for her pain, and additional analgesia could have been administered had a process been in place for more formal involvement of town hospital ED medical staff to provide care. The Transfer Record document was also still in trial format and did not include a prompt to consider analgesia or monitoring equipment for transfer, and the place to document 'in transfer notes' was not clear. The town maternity unit had no portable blood pressure monitor that could be taken and used on ambulance transfers.

g) The transfer phone numbers and process in the Transfer Folder at the main desk of the town maternity unit were not in sequence and included out-of-date information.

Relevant guidelines, policies, and procedures

90. Relevant guidelines, policies, and procedures, including those considered by HDC's independent experts, are:

- Ministry of Health's *Guidelines for Consultation with Obstetric and Related Medical Services* (2012) (Referral Guidelines);[24]

[21] This helps clinicians identify when a pregnant or recently pregnant woman's condition starts to get worse, so they can respond quickly.
[22] This had been rolled out in other regions in August 2019.
[23] Haemodynamically unstable means a patient's blood pressure, heart rate, or blood flow is abnormal and not supplying enough oxygen and blood to vital organs.
[24] Ministry of Health. (2012). *Guidelines for Consultation with Obstetric and Related Medical Services.*

- Midwifery Employee Representation & Advisory Service's *Safe Staffing Standards* (2014) (MERAS standards)[25] (see the relevant standards referred to in RM McDougal's expert advice in **Appendix A**);
- 2015 New Zealand GBS Consensus Guidelines;[26]
- Royal College of Obstetricians & Gynaecologists (RCOG) guideline *Birth after Previous Caesarean Birth* (2015)[27] (see the relevant section in **Appendix A**);
- New Zealand College of Midwives Health and Safety at Work Policy 2017[28] (see the relevant sections in **Appendix B**);
- RANZCOG Patient Information Leaflet (2018);[29]
- New Zealand College of Midwives (NZCOM) *Midwives Handbook for Practice* (2018)[30] (see the relevant guidelines referred to in RM McDougal's expert advice in **Appendix A**);
- Perinatal Institute's Growth Assessment Programme online workshop (2020); and
- *New Zealand National Maternity Early Warning System (MEWS) Maternity Vital Signs Chart User Guide* (2019).[31]

Accident Compensation Corporation information

91. HDC has been given the expert advice that the Accident Compensation Corporation obtained from a midwife expert and a consultant obstetrician expert. Both sets of advice identified that, given Ms B's previous Caesarean section and short inter-delivery interval, RM C should have recommended that Ms B transfer straight to the city hospital when contractions commenced, and not waited for labour to be established, so she could have continuous monitoring of the baby from the onset of contractions. The midwifery advice stated that, if this had happened, early signs of scar dehiscence/uterine rupture could have been identified before the full uterine rupture occurred. The advice also stated that it was not appropriate for RM C to give Ms B the option of waiting in the friend's house in town first.

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[25] MERAS. (2014). *Safe Staffing Standards*. Christchurch: Midwifery Employee Representation & Advisory Service. https://meras.midwife.org.nz/meras-documents

[26] The guidelines were published in the *New Zealand Medical Journal* (2015; 128: 69-76) after a multidisciplinary review by the New Zealand College of Midwives (NZCOM), Paediatric Society of NZ, RANZCOG NZ committee, Australasian Society of Infectious Diseases NZ subcommittee, RNZCGP, and Home Birth Aotearoa.

[27] Royal College of Obstetricians and Gynaecologists (RCOG). (2015). *Birth after Previous Caesarean Birth* (Green-top Guideline No. 45) https://www.rcog.org.uk/guidance/browse-all-guidance/green-top-guidelines/birth-after-previous-caesarean-birth-green-top-guideline-no-45 (accessed 3 April 2025)

[28] New Zealand College of Midwives. (2017). *New Zealand College of Midwives Health and Safety at Work Policy*. https://www.midwife.org.nz/wp-content/uploads/2019/06/Health-and-Safety-Policy-2017.pdf

[29] RANZCOG. (2018) *Birth after Caesarean* (pamphlet). Melbourne: Royal Australian and New Zealand College of Obstetricians and Gynaecologists.

[30] The NZCOM Standards (published in the Midwives Handbook for Practice) provide the framework for midwifery practice in New Zealand.

[31] Health Quality & Safety Commission New Zealand. (2019). *The New Zealand National Maternity Early Warning System (MEWS) Maternity Vital Signs Chart User Guide*. https://www.hqsc.govt.nz/our-work/improved-service-delivery/patient-deterioration/workstreams/maternity-early-warning-system

Referral to Health NZ's National Office

92. As this was the third serious complaint HDC had received about maternity care provided by this Health NZ region in the preceding nine months, on 16 May 2024 HDC sent a letter to Health NZ's National Office raising concerns about patient safety. The concerns related to deficiencies of care, including inadequate clinical guidelines, inadequate documentation, and staff training/orientation. The letter also noted the quality improvement projects that had not progressed because of the pressure on Health NZ's maternity unit.

93. In its response dated 19 June 2024, Health NZ (National Office) stated that it had communicated with Health NZ, which had 'identified a cluster of maternity concerns earlier in 2023[32] and already had in place a strong clinical governance process with actions and follow-up to address them.' Health NZ (National Office) confirmed that a panel had reviewed Health NZ's response and found it to be 'comprehensive' and outlined the process undertaken to review the cluster of cases and ensure the safety of maternity services at Health NZ for women and whānau. Health NZ (National Office) also confirmed that Health NZ would arrange an external review to 'confirm the effectiveness of their interventions', such as a systemic review of documentation, policies/procedures, and guidelines.

Independent advice considered by HDC

94. In considering the care provided to Ms B, I sought independent clinical advice from RM Robyn McDougal (**Appendix D**) and from consultant obstetrician Dr Judy Ormandy (**Appendix E**). The advice is summarised in my decision in relation to each provider where relevant.

Responses to provisional opinion

B and E whānau

95. The B and E whānau were given an opportunity to comment on relevant sections of the provisional opinion, and some of their comments have been incorporated into this opinion where relevant. The B and E whānau commented that they felt that the routine practices referred to in paragraphs 158–163 of this decision should have been part of RM C's knowledge and skill base from the day she graduated, noting they are considered acceptable practice in accordance with guidelines[33] for an LMC role. They also felt that, given the midwife is accountable to the woman, to herself, and to the midwifery profession in accordance with Standard seven of the NZCOM Standards of Practice,[34] despite her reports of careful reflection surrounding events, RM C was not 'taking accountability for this tragic outcome and the near death' of Ms B.

96. In their response to the provisional opinion, the B and E whānau also said they were surprised that RM C felt unsupported and under-resourced as outlined by her. They also commented on the references to Ms B being 'extremely keen' to have a VBAC, and wanted

[32] Another six on top of the three cases HDC had referred.

[33] NZCOM standards of practice (Standard three), the Referral Guidelines, and the Section 88 Notice governing the requirements and responsibilities of the LMC midwife role.

[34] 'Standard seven: The midwife is accountable to the woman, to herself, to the midwifery profession and to the wider community for her practice' (https://www.midwife.org.nz/midwives/professional-practice/standards-of-practice).

it noted that this was because of the advice she had received from both Dr D and RM C. In their final note, the B and E whānau shared thoughts for other 'babies and mamas' who have suffered loss or harm because of the 'inherent faults' in the maternity system until changes are made.

RM C

97. RM C was given an opportunity to comment on relevant sections of the provisional opinion. RM C acknowledged there were shortcomings in the care she provided to Ms B, and these matters warrant criticism and she accepted the findings and recommendations. In relation to other comments provided by RM C, these have been incorporated into this decision where relevant.

98. RM C wanted to acknowledge Ms B, Mr E, and their wider whānau. RM C stated she was profoundly saddened by this tragic and heartbreaking event and wished to express her deepest condolences to the family, with whom her thoughts and sympathies remain.

99. RM C also acknowledged the role of HDC in promoting and protecting the rights of people who use health and disability services.

The Practice

100. The Practice was given an opportunity to comment on relevant sections of the provisional opinion. RM K of the Practice said she wished to reiterate her profound and sincere condolences to Ms B, Mr E, and the entire B and E whānau for the loss of Baby B. RM K stated that she was deeply sorry for her role in the circumstances that contributed to this outcome, and the tragedy of it has weighed heavily on her. RM K acknowledged that the trust that Ms B and her whānau placed in the Practice was not adequately honoured, and she carried that knowledge with her. RM K also stated she remains deeply committed to learning from this case and contributing to improvements in rural maternity care in the local region.

101. The Practice confirmed it accepted the adverse comment made and a number of the Deputy Commissioner's findings. However, clarification in relation to some of the events in relation to the orientation provided to RM C, the characterisation of the caseload and staffing arrangements following RM H's sudden departure, and the role and actions of RM I on the night of 16/17 July 2022 have been incorporated into this decision where relevant.

102. The Practice also commented that it deeply regrets that the systemic shortage of rural midwifery workforce made it impossible to provide the additional desired resource. The Practice stated it supported the Deputy Commissioner's intention to write to the National Maternity Monitoring Group to highlight the unique challenges facing women birthing in remote rural localities.

103. RM H was also provided with an opportunity to comment on the relevant parts of the provisional opinion referencing her, and she wished to pass on her 'deepest heartfelt condolences to the mother and whānau involved'. RM H said she cannot begin to imagine the immensity of the hurt and grief, and it was sad for her to hear that a baby had lost its life and sent 'Much aroha to the whānau affected.'

104. RM I was also provided with an opportunity to comment on the relevant parts of the provisional opinion referencing her and said she extended her sincere condolences to Ms B and her whānau and acknowledged their devastating loss.

105. RM I's comments have been incorporated into this opinion where relevant, including improvements made since, which are outlined under the 'changes made' section and include work done to improve the relationship between the town maternity unit and the ED so that admissions to the ED are now much easier to facilitate. RM I also confirmed that she accepted the comment she should have advised RM C to transfer Ms B from her friend's house to the city hospital.

106. RM I stated: 'As midwives we endeavour to provide the best possible care to the whānau we meet and it [is] distressing to know that we have not met that standard; from each encounter we hopefully learn to do better.'

Dr D

107. Dr D was given an opportunity to comment on relevant sections of the provisional opinion and did not wish to respond.

Health NZ

108. Health NZ was given an opportunity to comment on relevant sections of the provisional opinion and confirmed it accepted the provisional findings and proposed course of action. Health NZ's other comments have been incorporated into this final opinion where relevant.

The ambulance service

109. The ambulance service was given an opportunity to comment on relevant sections of the provisional opinion and had no comment to make.

Opinion: RM C – breach

110. Right 4(1) of the Code states: 'Every consumer has the right to have services provided with reasonable care and skill.'

111. Right 6(2) of the Code 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.'

112. Right 7(1) of the Code states: 'Services may be provided to a consumer only if that consumer makes an informed choice and gives informed consent, except where any enactment, or the common law, or any other provision of this Code provides otherwise.'

113. I note that RM C had registered with the Midwifery Council in February 2021 and been an RM with the Practice since only 17 March 2022 (approximately two months before she became Ms B's LMC). As such, she was relatively new to the profession and to the midwifery practice itself. In her response, RM C has referred to the lack of formal job training or orientation when she joined the Practice. There is also conflicting information over whether RM C took over her former colleague RM H's caseload in addition to her own when RM H left suddenly. However, I note RM McDougal's advice to RM C around having the courage to speak up in a situation where her caseload felt unsafe and that she should be aware of

her limitations, and I agree with this. I also accept that, as the midwives employed by the Practice were working autonomously, it was RM C's responsibility to ensure she was competent and equipped to provide the necessary clinical care to Ms B, make certain she was familiar with local protocols and procedures, and be prepared to seek out assistance and escalate her concerns when warranted.

114. Ms B, Mr E, and their whānau trusted RM C to provide appropriate care and advice to them as their midwife. I consider that, as LMC for Ms B from 26 May 2022, RM C had overall responsibility for the aspects of care outlined in my decision below. I have considered the support provided to RM C by her employer, the Practice, separately in my decision regarding the organisation below.

Handover of care

115. RM C stated that she did not have a formal handover when she became the LMC for Ms B. I agree with RM McDougal's advice that, in the absence of a handover, accepted practice would have been for RM C to have read Ms B's clinical records or notes (including relevant laboratory results and scans, as well as Dr D's correspondence). This would have enabled RM C to familiarise herself with Ms B's pregnancy progress, and – as RM McDougal advised – this would also have assisted her with knowing whether additional information was needed from Ms B, the practice manager at the Practice, or Dr D. I acknowledge it is not clear whether Dr D's letter dated 18 May 2022 was uploaded on the Practice's Expect maternity software system at the time and therefore I cannot be certain that RM C was able to access it on Expect when she provided care to Ms B. However, I am of the view that, as RM C was assuming responsibility for Ms B's ongoing maternity care, it was essential that she ensured she had a comprehensive understanding of Ms B's clinical history up until that point, and this included her referencing Health NZ's hospital computer system, which included a copy of Dr D's 18 May 2022 letter. The advice from Dr D in her subsequent letter dated 15 June 2022 referenced VBAC and the need for Ms B to be monitored continuously. RM C was aware of this. I agree with RM McDougal's advice that the responsibility to have continued the ongoing discussion about VBAC was shared between Dr D and RM C, and, because of this, I consider a discussion with Dr D would have been beneficial for RM C to understand the needs of Ms B going forward and seek clarity on what advice had been given if she felt it was unclear. I am critical this did not happen. In my view, this has some bearing on the events that subsequently transpired.

Laboratory results (specifically in relation to the GBS result)

116. In her advice, RM McDougal highlighted the implications for women during pregnancy where a GBS result is positive, as was the case for Ms B. I note that RM McDougal said that there is potential intrapartum transmission to the foetus (with 'systemic risks and even mortality') and outlined that usual practice would be 'to administer intravenous antibiotics once labour has established' to minimise this risk.

117. I acknowledge RM McDougal's comments that Dr D would have been able to access Ms B's results; however, in my view, unless RM C had made her aware of the test, she would not have necessarily been alert to the positive GBS result. RM McDougal further advised that the positive GBS or swab result was not properly followed up with those involved in Ms B's birth. I agree, and – as the instigator of the test – RM C bore the responsibility for following up on the result. In response to RM McDougal's advice, RM C acknowledged that this was

best practice and, although she said she had discussions with Ms B in the antenatal period about minimising this risk, she could not recall whether the GBS result was specifically mentioned during any of the phone referrals she made while Ms B was in labour.

118. Given the implications and the risk of infection to Ms B's baby, I accept RM McDougal's advice that RM C omitted to alert other health professionals, such as Dr D and/or the delivery suite, of the positive GBS result before transfer when labour was imminent and that this was a mild departure from accepted standards of care (not best practice, as RM C suggested).

Information provided and decision-making on where to labour

119. The Practice told HDC that standard practice for LMCs operating in the town and surrounding region was for women to attend the town maternity unit for an initial assessment first before heading to the city for 'safety-focused' reasons. Consequently, RM C advised Ms B at two antenatal checks (23 June 2022 and 7 July 2022) of the need to undergo a preliminary assessment at the town maternity unit once she was in labour.

120. These directions arguably went against the advice of Dr D (provided in the letters of 18 May 2022 and 15 June 2022) to birth in the city hospital with continuous monitoring there because of the risks of scar rupture. Acknowledging that the letter of 18 May 2022 may not have been on the Practice's Expect system, the Practice has clarified that the letter would have been available on Health NZ's hospital computer system, which RM C would have had access to. I also consider that there was enough information in the letter of 15 June 2022 to identify that continuous monitoring beyond what could be provided at the town maternity unit was required. As outlined above, I am of the view that, had RM C completed due diligence and taken note of the advice previously given she would have been aware of the requirement to attend the city hospital at the onset of labour, and I am critical of this oversight.

121. I have also considered RM McDougal's advice in relation to what RM C discussed with Ms B about the risks and the need to go to the city hospital. I agree that, based on clinical records, these were not extensive. RM McDougal also stated:

> 'Furthermore, RM C did not consider the potential for an emergency, or the [one to two] hour […] Ambulance transfer (dependent on availability and wheels on the road) required once labour was established, nor were the implications of a time-sensitive or traumatic emergency transfer discussed with Ms B during her pregnancy or on the night in question.'

122. RM C stated that her reasoning for allowing Ms B to go to a friend's house while in the early stages of labour was because of capacity limitations at the city hospital. In contrast, the city hospital had offered for Ms B to be admitted for rest and observation in its delivery suite, but RM C did not accept this offer.

123. RM McDougal also advised that uterine scar rupture can occur in labour as early as at 4–5cm dilation and that established labour was not necessarily required for this emergency to arise. Based on this information, I agree with RM McDougal that the delay in transferring Ms B to secondary care increased her risk of uterine rupture. RM C had a responsibility to

ensure that Ms B was aware of the risks of staying at a friend's house rather than transferring to the city hospital so that her decision about where to continue her labour was fully informed. I am very concerned that RM C did not do so.

124. I note RM C's comments that, as Ms B was in early labour/latent phase, she did not need to head to the city as she was following the local guidance,[35] which suggested continuous monitoring was required only once in established labour. The fact that this local guideline conflicted with the RANZCOG guidelines did not help the situation, which has also been accepted by Health NZ. However, for the reasons I have outlined in paragraph 128, if RM C had taken heed of the advice Dr D had previously offered about Ms B needing to transfer to the city hospital at the commencement of her labour for continuous monitoring and had RM C had discussions with Dr D and/or with the on-call consultant obstetrician at the city hospital before and during the birth, she would have likely understood the implications of each of the options and therefore been in a better position to fully inform Ms B and Mr E of the risks, and I am critical of this. I am also of the view that RM C's actions went against section 8.1 of the RCOG guideline attached at **Appendix A**, which states that women should be advised that planned VBAC should be in a 'suitably staffed and equipped delivery suite with continuous intrapartum care and monitoring with resources available for immediate caesarean delivery and advanced neonatal resuscitation' and 'to have continuous electronic fetal monitoring for the duration of planned VBAC, commencing at the onset of regular uterine contractions.' Irrespective of her lack of engagement with the obstetricians, I am concerned that RM C did not apply critical thinking to the situation and recognise that it was inappropriate for Ms B to be assessed at the town hospital and this should not have been offered as an option in this context.

125. Even when it came to the decision to transfer Ms B from the friend's house to the town hospital instead of directly to the city hospital, RM C's reasoning for this was to have help with IV cannulation and to use the USS to assess the fetal heart. Again, I am concerned at the lack of critical thinking, and I agree with RM McDougal that, given the suspected uterine rupture because of Ms B's excruciating pain, this further delayed Ms B receiving the appropriate care and surgical intervention at the city hospital given the emergency and risks.

126. I also consider that, once RM C suspected uterine rupture, it would have been prudent and appropriate for her to have spoken to a consultant obstetrician at the city hospital from Ms B's friend's house, as the consultant could have provided specialist advice to inform interim management of the situation. I note that RM C has also since acknowledged that this would have been beneficial.

127. I agree with RM McDougal that, overall, RM C's 'actions and inactions, combined with the lack of discussion about these risks during pregnancy and on the night in question, contributed to a delay in expediting a surgical delivery despite signs of scar rupture' and was a severe departure from accepted practice.

[35] District health board's Maternity Services Clinical Guideline for VBAC.

Clinical assessments and care provided at Ms B's friend's house in town

128. I note that, in her advice, RM McDougal states that there is a lack of evidence of RM C having conducted a basic full clinical assessment[36] of Ms B at her friend's house in town. This is despite the Practice providing employed midwives with appropriate equipment for emergency care, which RM C confirmed she had with her, albeit in her car. RM McDougal advised that delay could have been avoided if RM C had carried out a full assessment,[37] commenced IV fluids with ambulance personnel if required, started Entonox analgesia (also known as gas and air) for pain relief, consulted with an obstetrician, and gone straight to the city. I note that RM McDougal also stated that, if RM C had carried out a clinical assessment at Ms B's friend's house and commenced IV fluids, Ms B's hypotensive state at the town hospital could have been alleviated.

129. I accept RM McDougal's advice and find it concerning that RM C failed to consider immediately taking the relevant equipment and maternity bag she had with her into the house on arrival, as she was aware of the clinical history and had already been made aware of the pain Ms B was in. I note that RM C has accepted that 'more could have been done at the scene'. I also note RM McDougal's advice that RM C's failure to carry out an appropriate assessment at Ms B's friend's house constituted a moderate departure from accepted practice.

130. RM C suspected Ms B's uterine rupture, had concerns regarding the baby's heartbeat, and should have known surgery was likely to have been required. I agree with RM McDougal that, in these circumstances, it is concerning that RM C also failed to keep Ms B nil by mouth while at her friend's house, against accepted practice, which RM C has since acknowledged.

131. RM McDougal also considered there was a mild departure from accepted practice by RM C for failing to monitor and offer pain relief as required for a woman in labour according to her needs and birth plan. It is clear from RM C's notes and the clinical records that Ms B could not walk easily and was in discomfort from as early as 8.15pm, then in extreme pain from the time of the first phone call from the friend's house in town (at approximately 11.45pm on 16 July 2022) until Ms B arrived at the city hospital (at approximately 3am on 17 July 2022). It is concerning that Ms B was offered pain relief by way of Entonox gas only on initial presentation at the town maternity unit, which RM C stated Ms B declined. However, RM C did not consider offering any pain relief at any other points throughout this period of care, but especially within the last few hours of Ms B being in severe pain. This is despite the equipment she was provided with and its availability at the town hospital and on the ambulance, and I am critical of this.

Communication

132. Right 6(1)(a) of the Code states: 'Every consumer has the right to the information that a reasonable consumer, in that consumer's circumstances, would expect to receive including … an explanation of his or her condition'.

[36] Described by RM McDougal in her advice as 'blood pressure, pulse, temperature, abdominal palpation, fetal heart assessment, and vaginal examination.'

[37] Noting that she carried out abdominal palpation, fetal heart assessment, and vaginal examination.

133. RM C had a responsibility to Ms B and Mr E to ensure she communicated effectively with them about what was happening during labour and about the condition of the baby and her suspected concerns of a uterine rupture. However, it is clear from Ms B that this did not happen at the friend's house in town or at the town hospital, particularly around concerns that baby's heartbeat could not be heard. Ms B described instinctively knowing something was seriously wrong, but RM C did not inform her about what those concerns were, and Ms B and Mr E were made aware of the baby's condition and of the uterine rupture only at the city hospital, and I am extremely critical of this.

Conclusion

134. Given the above information, overall, I am extremely critical of RM C's failure to:

- review Ms B's clinical records and notes when she took over her care as LMC;
- follow up and/or acknowledge the risk of GBS infection in relation to the positive laboratory results for GBS;
- apply critical thinking to the situation at the outset and recognise it was inappropriate for Ms B to go to a friend's house while in the early stages of labour and not head directly to the city hospital for continuous monitoring as advised by Dr D;
- subsequently recommend that Ms B be assessed at the town hospital; the option of an assessment at the town hospital should not have been offered in the context of Ms B's emerging symptoms at that point;
- carry out a basic full clinical assessment of Ms B at the friend's house in town and take appropriate action by commencing IV fluids and providing pain relief;
- consult and seek advice from the city hospital once aware of the urgency of the situation after suspecting uterine rupture;
- ensure Ms B was immediately transferred from her friend's house in town to the city hospital, given the emergency and risks;
- keep Ms B nil by mouth in anticipation of a surgical birth; and
- monitor and offer pain relief to Ms B during labour, according to her needs and birth plan.

135. As Ms B's LMC, RM C was responsible for ensuring that she provided services with reasonable care and skill. This investigation has identified multiple failures on the part of RM C. For the reasons outlined above, I find that RM C did not meet the expected standards of care outlined by RM McDougal in her advice and consequently breached Right 4(1) of the Code.

136. In addition, I also find that RM C breached Right 6(2) of the Code for failing to provide appropriate advice and outline the risks and the options available to Ms B, both during her pregnancy and when she went into labour on 16 July 2022, which is information Ms B needed to make an informed choice.

137. It follows that Ms B was unable to make an informed choice about where to labour without all the relevant information and risks being provided to her from RM C and, accordingly, I

find that RM C also breached Right 7(1) of the Code. I have dealt with the obstetrician's responsibilities regarding this element of care in my decision below.

138. As a result of RM C's failure to communicate effectively with Ms B and Mr E during labour, both at the friend's house and at the town hospital, and to update them about her concerns regarding the baby's condition and a possible uterine rupture, I also find RM C in breach of Right 6(1)(a) of the Code.

Postnatal care communication – adverse comment

139. After the loss of Baby B, Ms B, Mr E, and the rest of the whānau were understandably distressed and grieving and asked RM C to respect their needs and to not contact them during this time. I note that this request to RM K appears to be on 25 July 2022, and no further contact appears to have been made by RM C after this time.

140. RM C attended the tangihanga[38] of Baby B with another midwife from the Practice and told HDC that this was at the invitation of Ms B, which is noted in her clinical records. In contrast, Ms B advised that RM C contacted her and asked to be present. As I am unable to determine what exact discussions took place other than what RM C noted in her clinical records at the time, I am unable to make a finding regarding this.

141. I also note that Ms B advised that she felt some of the communication from RM C was inappropriate and deeply distressing. I am of a mind to agree; I consider that asking a mother who has lost her child whether it is weird without them seems innately insensitive, and I am critical of this and have made a recommendation about her manner of communication in the future.

Information in handover call with the ambulance service from Ms B's friend's house on 17 July 2022 – educational comment

142. I acknowledge that the situation at Ms B's friend's house was fraught because of the emergency given Ms B's condition, and RM C acknowledged that her communication with the ambulance service could have been 'clearer and concise'. I note that RM McDougal, who had access to the call audio recordings provided by the ambulance service, advised that the call made by RM C was 'stunted and confused at times', though the correct information was ultimately conveyed.[39]

143. RM McDougal also advised that RM C could have been more concise and clearer and used the SBAR tool[40] during the handover, especially given the emergency, and said that this 'typically improves with experience'. I accept RM McDougal's advice that RM C's standard of this aspect of care was adequate, but it concerns me that RM C described Ms B as 'technically, a first-time mum' and failed to raise her concerns during these calls about Ms B potentially having suffered a ruptured uterus. I therefore consider it appropriate for a recommendation to be made (see below).

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[38] A Māori ceremony for mourning someone who has died (and known as a tangi, which means to weep and to sing a dirge).

[39] That '[the ambulance service] had a clear understanding of the patient's condition, the Code One call priority, and the initial destination.'

[40] SBAR stands for Situation, Background, Assessment, and Recommendation.

144. I acknowledge the concern raised in the complaint about RM C not having the emergency contact details for transport purposes at this time and recommend that RM C ensures she has this information for the local area to hand in case such an emergency arises in the future.

Other care

145. I accept RM McDougal's advice that, in relation to the management of Ms B's care considering the fetal weight, this care was appropriate for the reasons outlined in her advice in **Appendix D** and am not critical of this element of care.

Opinion: The Practice – adverse comment

146. In contrast to RM C's claims, it is evident from information provided by the Practice, including RM C's diary records, that orientation was provided by it.

147. However, although information from RM C and the Practice around who managed RM H's full caseload is conflicting, it is evident to me that RM C took over Ms B's care during the later stage of her pregnancy on top of the full caseload she already had. This is also demonstrated by her continuing to provide care throughout the pregnancy, during birth, and in the postnatal period for a time. I note that RM McDougal's concern in her advice is around the risks to women, as well as midwives, when caseload numbers exceed the normal caseload as set out in the MERAS standards.

148. As referenced in paragraph 72, I accept that, as the midwives employed by the Practice were working autonomously of the practice they were ultimately responsible for ensuring they were competent to support the women under their care. However, as RM McDougal noted in her advice, even where midwives are employed as caseloading midwives and seen as autonomous practitioners, there are still guidelines for safe and sustainable caseload numbers for each midwife.

149. As I have outlined above, although RM C had overall clinical responsibility as LMC for Ms B, I agree with RM McDougal that the responsibility to step in and solve the staff deficit should not have been left to RM C. The Practice stated that risks to women were reduced because it had 'good rostering and mechanisms in place to ensure rest and safety for the midwives', but I am critical that it expected RM C to take on Ms B as an extra case, even for a short time, given her lack of experience and time in the role. I also note that RM I reflected that it was a challenging few weeks, and the Practice, in its response to the provisional opinion, acknowledged that RM H's departure had created significant additional pressure, which placed demands on RM C. I acknowledge that attempts were made to recruit another midwife but without success. However, I also agree with RM McDougal that this placed both RM C and the women she was managing in her caseload at risk and was a moderate departure of accepted safe staffing standards as recommended by MERAS and NZCOM.

150. I also note that the Practice confirmed that RM K and RM I, the latter supporting RM C on the evening of Ms B's labour, knew that there had been occasions where a direct transfer from a residential address upon phone advice of an obstetric specialist could take place in an emergency. I acknowledge RM I's comments on the provisional decision that she has reflected on the events of that evening and perhaps could have taken different actions and that she has made improvements to her practice since. I also note that RM C contacted RM I only after already having made the decision to arrange an urgent transfer for Ms B to the

town maternity unit. However, it concerns me that RM I, as the more senior midwife, did not request more detail from RM C about Ms B's clinical circumstances in the early hours of 17 July 2022. RM I has acknowledged that she should have paused and requested more detail about the clinical circumstances. This would have allowed RM I to be able to impart appropriate guidance and information about a possible direct transfer and recommend that she contact the obstetrician in the city hospital, who may well have advised for urgent transfer direct to the city hospital. While I am critical of this, I acknowledge that RM C had an element of responsibility for ensuring she had knowledge around this in case of an emergency.

Opinion: Health NZ – adverse comment

Care provided

151. I acknowledge that Health NZ's SER identified several factors that contributed to the care and service delivery problems in the care provided to Ms B on the evening of her labour. I have included some of the relevant findings in **Appendix B**, which I have referred to as part of this decision. Health NZ has made substantive recommendations because of these system errors and ensured they have been implemented (see **Appendix C**). I acknowledge the work done by Health NZ, which will hopefully go some way to preventing another whānau from experiencing the pain and distress such as that of the B and E whānau.

152. However, I am critical that Health NZ failed to ensure there was a template for ANC letters to prompt the relevant issues in Ms B's pregnancy for those providing care, failing to have a VBAC guideline that was in line with the latest RANZCOG advice around when close monitoring should take place from the onset of uterine contractions, and failing to have the MEWS total and town-specific escalation plan for staff.

Opinion: Dr D – educational comment

Standard of care

153. Having reviewed the advice and care provided by Dr D on 18 May 2022 and 15 June 2022, my independent clinical advisor considered that, overall, this was an appropriate standard of care by Dr D. I accept this advice, save for my other comments about her care below.

Record keeping and documentation

154. Although Ms B is unable to remember being given a copy of the VBAC leaflet, I note that indications from the Treatment Information pamphlet sticker suggest it is likely to have been provided.

155. Dr D's clinical letters lack detail about the extent or specifics of the pregnancy counselling she provided to Ms B relating to VBAC. Ms B has acknowledged that some conversations took place with Dr D about the risks, and Dr D has since in her response to HDC outlined the specifics of what these were; however, it is apparent from Ms B's feedback that she did not register the significance of the information given to her at the time. For this reason, I recommend that Dr D checks in with patients regarding their understanding of the information conveyed and she considers elaborating in future correspondence to LMCs the extent of discussions had with patients.

156. In relation to the error in Dr D's written clinical notes about stating the need to deliver in the town instead of the city, although this was unfortunate, I note that she corrected and

clarified this in the letter dated 18 May 2022, and her letter dated 15 June 2022 further clarifies the point, so I am not critical of this.

Opinion: Ambulance service – educational comment

157. I note Ms B's comments that she felt the ambulance officer's care and manner caused distress during the transfer from the town hospital to the city hospital. The distress Ms B experienced as a result of this encounter is concerning. Unfortunately, I am unable to determine the nature or tone of the conversation that transpired at the time, nor what was said; however, ultimately, Ms B perceived the manner of the ambulance officer as 'rude and obnoxious' and 'rough and unsympathetic'. While I acknowledge that the ambulance service has apologised for the manner of engagement displayed by its officer at the time, I will be recommending that the service take this opportunity to remind its frontline staff of the need to be alert to the situation they are dealing with and ensure they engage with their patients in a manner commensurate with the situation.

Changes made

RM C

158. RM C told HDC that she had made meaningful changes to her practice to reduce the likelihood of a similar event occurring. RM C confirmed that she was deeply committed to continuous improvement, collaborative practice, and safe, informed maternity care.

159. RM C stated that, in future, she will prioritise the proactive offering of pain relief and ensure that options are clearly explained and re-offered throughout care, especially in evolving or emergency situations.

160. RM C is committed to ongoing education and to continually improving her emergency response practices in alignment with best practice and local service availability. In her response, RM C told HDC that working in an under-resourced, unsupported rural environment was why she chose to leave rural midwifery. However, now she is 'not working in a high stress, high-caseload rural environment', she finds she has the time and capacity to provide better care for her clients. RM C stated that she is now much more aware of her own limitations and more proactive in seeking help when needed.

161. RM C also stated that, if a face-to-face handover is not possible when taking over midwifery care from a colleague, she ensures a phone call handover is arranged so that any concerns can be clarified with the previous midwife. RM C also stated that she makes it a priority to review all available records in full when assuming care and that this experience has reinforced the critical importance of this when multiple providers have had prior input.

162. RM C also told HDC that she does not just rely on the obstetric team to inform clients of the risk associated with a VBAC; she makes sure that she relays all the information herself, including providing clients with up-to-date, evidence-based resources, including 'Te Whatu Ora Health New Zealand Health Info document on Birth after Caesarean Section'. RM C stated that she highlights 'key risks, including uterine rupture and potential neonatal mortality, supported by statistical evidence, to ensure clients are making fully informed choices. RM C told HDC that this experience has also highlighted for her:

a) the importance of flagging intrapartum and postnatal risks in documentation and through direct communication with relevant team members, particularly in shared or multidisciplinary care settings;

b) the importance of structured and focused communication in emergency situations, and she will incorporate the SBAR framework into her practice to support more effective handovers; and

c) the importance of advocating for patient comfort in high-stress and unfamiliar settings.

She states that she has made the following changes to her practice:

a. Full maternal observations are taken during any urgent callout, regardless of the presentation, and she recognises the importance of being fully prepared for the unexpected and that the situation can change rapidly.

b. She has made it a priority to better understand the protocols and pharmacological capabilities of ambulance services and EDs, and the scope of pain relief available within emergency transfer pathways.

163. RM C was also subject to recommendations from the Midwifery Council that she carry out education, including Practical Obstetric Multi Professional Training (PROMPT) and education on documentation and record keeping, to strengthen her competence. However, it did not find that RM C was practising below the required level of competence when it assessed this in November/December 2024. In her response to the provisional opinion, RM C confirmed that she had completed the PROMPT course and education as recommended and had attended ongoing education, including the RANZCOG Fetal Surveillance Education Program, health and safety, student precepting, and abortion law reform.

The Practice

164. The Practice stated that both RM K and RM I had done 'considerable reflecting on the processes and outcome'. In response to the concerns raised, the Practice confirmed it no longer runs a caseloading model of midwifery care. It stated that all midwives are now acting as independent practitioners, with no salaried positions. However, the Practice stated that, as a result of this, pregnant people in the town and surrounding regions now have limited choices for midwifery care.

RM I

165. RM I confirmed that she had reviewed and improved her communication leadership skills, worked to improve her level of cultural safety, and used tools such as a PROMPT course and reflection to recognise that leadership happens daily, not just in stressful situations, and believes her practice is safer because of this work.

166. RM I further said she considered the provisional report relayed events involving her care on 17 July 2022 chronologically and clearly and had found it a helpful reflection tool.

167. RM I also told HDC that general improvements were made as a result of this case, which included feedback being given to the town maternity unit and noted the changes highlighted

by Health NZ (**Appendix C**) around the changes to the MEWS chart and VBAC Caesarean Guideline. RM I also stated the NZCOM handover sheet is used by them at the Practice.

168. Health NZ proposed, and completed, changes in relation to its SER findings. These are attached to this decision as **Appendix B**.

169. In February 2023, Health NZ also implemented a fetal heart monitoring guideline that clarifies the use of electronic fetal monitoring in the town maternity unit. This includes, 'where there are concerns or risks to fetal wellbeing, time is not spent monitoring the fetal heart rate in Town, but these women/people are to be urgently transferred to the city hospital where birth can be rapidly expedited if required.'

The ambulance service

170. The ambulance service confirmed to Ms B that it has identified the following quality improvements:

a) 'Reminder to be provided to ambulance personnel of the need to display sensitivity, empathy, and compassion to the patient and whānau when attending an incident.

b) Debrief with the attending patient transfer officer to convey your concerns and the impact on yourself and your whānau as a result of this engagement.

c) Review [our] complaint investigation process to include and facilitate contact with patients and whānau to enable an opportunity for patients to express their concerns and for [us] to listen and include them in the investigation.'

Recommendations

171. Noting the changes made to her practice, and that RM C is due to be on leave for a number of months from September 2026, I recommend that RM C:

a) provide a written apology to Ms B, Mr E, and their whānau for the deficiencies in care outlined above resulting in the breaches of the Code identified, with the apology being sent to HDC within three weeks of the date of this report for forwarding to Ms B, Mr E, and their whānau;

b) within 18 months of the date of this report, undertake training on safe clinical handover with evidence of completion of the training provided to HDC within three months of the training taking place;

c) within 18 months of the date of this report, undertake training on assessment and emergency skills with evidence of completion of the training provided to HDC within three months of the training taking place;

d) within 18 months of the date of this report, undertake training in and/or provide evidence of increased exposure to IV cannulation with evidence of completion of the training provided to HDC within three months of the training taking place;

e) within 18 months of the date of this report, undertake training on confidence and standing up for yourself in an employee situation//learning limitations on caseload with evidence of completion of the training provided to HDC within three months of the training taking place;

f) complete the HDC online learning modules for providers,[41] providing with evidence of the completion of the modules provided to HDC within three months of the date of this report; and

g) should RM C return to rural midwifery practice on a caseloading basis, consider seeking a 'midwifery mentor'.

172. Having considered that peer support and direction is more appropriate in the circumstances, I recommend NZCOM carry out a special midwifery standards review for RM C as part of a professional development plan. This plan is to include PROMPT on the issues raised and recommendations outlined at b) to e) above (noting RM C is already subject to education on documentation and record keeping by the Midwifery Council as part of PROMPT) and accessing a local opportunity to practise and improve IV cannulation. The outcome of and evidence of adherence to the review is to be provided to HDC within 18 months of the date of this report.

173. Acknowledging that the Practice no longer operates a caseloading service and RM K is the sole practitioner operating under the Practice's name, I recommend that the Practice:

a) provide a written apology to Ms B, Mr E, and their whānau on behalf of the Practice for its involvement as RM C's employer in placing her in the position she was in that impacted on the care provided to Ms B, with the apology being sent to HDC within three weeks of the date of this report for forwarding to Ms B, Mr E, and their whānau;

b) provide confirmation that, where LMC care is transferred between registered midwives, the NZCOM transfer guidelines are followed and its handover sheet used to ensure detailed and relevant information is included and any missing information and planned care is outlined with this information and the template used provided to HDC within three weeks of the date of this report; and

c) use an anonymised version of this report as a basis for education and ongoing professional development and for training/induction should the Practice change its status on employing midwives in the future with evidence of this commitment provided to HDC within three months of the date of this report.

174. I recommend Health NZ:

a) provide an update to HDC on the outcome of the external review carried out to ensure the effectiveness of the interventions for the safety of maternity services at Health NZ for women and whānau with this information provided to HDC within three months of the date of this report.

Follow-up actions

175. I have given serious consideration to RM C being a relatively junior midwife when deciding whether to make this referral; however, in light of the significant concerns about and breaches in RM C's care, she will be referred to the Director of Proceedings in accordance

[41] HDC. (2023). Online learning. https://www.hdc.org.nz/education/online-learning.

with section 45(2)(f) of the Health and Disability Commissioner Act 1994 for the purpose of deciding whether any proceedings should be taken.

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

177. A copy of this report with details identifying the parties removed, except for the advisors on this case, will be sent to Health New Zealand | Te Whatu Ora, the Perinatal and Maternal Mortality Review Committee, and the National Maternity Monitoring Group and placed on the HDC website, www.hdc.org.nz, for educational purposes.

178. I will be writing to the National Maternity Monitoring Group to highlight the unique challenges for women birthing in more remote localities without ready access to specialist equipment and expertise as demonstrated by the circumstances of this case and will request the group consider whether further action is required as a result of this referral.

Rose Wall
Deputy Health and Disability Commissioner

Appendix A: Relevant sections from RCOG's Birth after Previous Caesarean Birth Green-top Guidelines No. 45 (October 2015)

8. Intrapartum management of planned VBAC

8.1 What delivery setting is appropriate for conducting planned VBAC?

Women should be advised that planned VBAC should be conducted in a suitably staffed and equipped delivery suite with continuous intrapartum care and monitoring with resources available for immediate caesarean delivery and advanced neonatal resuscitation. ✓

Women with an unplanned labour and a history of previous caesarean delivery should have a discussion with an experienced obstetrician to determine feasibility of VBAC. ✓

Epidural analgesia is not contraindicated in a planned VBAC, although an increasing requirement for pain relief in labour should raise awareness of the possibility of an impending uterine rupture. D

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Women should be advised to have continuous electronic fetal monitoring for the duration of planned VBAC, commencing at the onset of regular uterine contractions. D

There should be continuous monitoring of the labour to ensure prompt identification of maternal or fetal compromise, labour dystocia or uterine scar rupture. Consequently, all women in established VBAC labour should receive:

- supportive one-to-one care
- intravenous access with full blood count and blood group and save
- continuous electronic fetal monitoring
- regular monitoring of maternal symptoms and signs
- regular (no less than 4-hourly) assessment of their cervicometric progress in labour.

Appendix B: Health NZ's SER relevant findings originally dated 17 July 2022 (and amended on 3 December 2022) after a meeting with the B whānau

'FINDINGS

- Although the intention for labour and birth to occur in hospital with continuous monitoring was clearly stated in the ANC letters, and copies of these were in the [town maternity unit] clinical notes, the letters had no problem list to clearly communicate the short inter-delivery interval and USS estimated large for dates risks for this pregnancy

- The [Health NZ region's] Vaginal Birth After Caesarean Section Guideline implied that close monitoring was required only when a woman was in active labour and this may have impacted on the decision to offer location options and to Ms [B]'s decision to stay at her friend's house in [town] while labour established.

- Although Ms [B] was being transported by frontline paramedic ambulance due to being unwell, she was admitted to the [town primary maternity unit] instead of [town hospital] ED, which meant that ED staff did not take over responsibility for her care on arrival.

- Ms [B] presented with a number of classic signs of uterine rupture prior to transfer back to [the town maternity unit] and, while the emergency bell was not activated on her arrival, additional support was requested and given by ED staff.

- Staff recognised the deterioration in Ms [B]'s condition, but the absence of the MEWS total and [town]-specific escalation plan meant there was no clear trigger for further communication about her condition or handover to ED staff to stabilise her and manage the transfer.

- Entonox analgesia provided to Ms [B] was not sufficient to address her pain, and additional analgesia could have been administered had a process for more formal involvement of [town] ED medical staff in providing care been in place.

Contributory Factors

The Te Whatu Ora [region's] Vaginal Birth After Caesarean Section Clinical Guideline did not contain the latest RANZCOG advice for women with a previous caesarean section to present to a secondary facility for close monitoring from the onset of uterine contractions. This contributed to Ms [B] being provided with the option to remain in the community until labour was established. This contributed to Ms [B] not being closely monitored at the time her uterus ruptured and meant there was no opportunity to perform an immediate caesarean section and attempt resuscitation of Baby [B].

There was no template for Antenatal Clinic letters and therefore no prompt to include a list of problems/diagnoses/issues relevant to the current pregnancy. This prevented the clear communication that short inter-delivery interval and USS estimated large for dates fetus were relevant issues in Ms [B]'s pregnancy. This may

have contributed to the reduced sense of urgency for Ms [B] to present to [the city maternity unit] soon after uterine contractions began. This contributed to Ms [B] not being closely monitored, or in a facility where immediate caesarean section could be performed, at the time her uterus ruptured.'

Appendix C: Health NZ's implementation of recommendations as at 17 May 2024

Te Whatu Ora

Implementation of Recommendations
Health NZ Event Reference 147078 ([Ms B]) – as at 17th May 2024

No.	Recommendation	Progress To Date	Status
1	The [Health NZ region] Vaginal Birth After Caesarean Guideline is reviewed and with RANZCOG Guidelines to particularly include; • additional risk factors for uterine rupture • for women to present to a secondary facility for close monitoring from the onset of uterine contractions. This updated guideline is renamed 'Birth After Caesarean' and communicated to all [Health NZ region] hospital staff and LMCs.	Amended guideline published in Oct 2022. Audit completed in 2023 showed 63% of cases met standard around documenting discussion of risks and benefits of both birth options. Audit presented to Maternity CQI on 18th Jan 2024 & findings discussed. Recommendation to attach 'consultation aid' to all notes of those with previous caesarean section attending first specialist appointment agreed and implemented.	Completed
2	The [Health NZ region] Obstetricians consider creating a standard Antenatal Clinic Letter template to include a problems/diagnoses/issues list where information, relevant to the current pregnancy, can be highlighted. If agreed, this change is implemented for all [Health NZ region] Antenatal Clinic letters.	Discussed at Maternity CQI 2nd Feb 2023. Letter template already has a background section for previous and current issues. Decision not to change template, but Medical staff now instruct transcriptionists to carry the background section over from previous letters to the current one.	Completed
3	Consideration is given to the development and implementation of a 'Birth After Caesarean Section Consent Form' that outlines the specific risks and benefits of the birth options and on which women can indicate their understanding and give written consent to proceeding with a trial of vaginal birth. Consider offering the opportunity to develop this in conjunction with Ms [B]. and her whānau and/or other consumer representatives.	Discussed at Maternity CQI on 2nd Feb 2023. Decision to obtain [a nearby city hospital's] 'VBAC Consultation Aid', rather than create a consent form. 18th May 2023 – contacted patient and invited her to assist with the development of this document – no reply. Piloted [Health NZ region] version of this document in 2023. Document discussed at Maternity CQI 18th Jan 2024 – further amendments. CQI on 29th Feb 2024. Published and distributed to clinical areas – Feb/Mar 2024.	Completed
4	An admission to [town] Maternity Unit Procedure document is created which includes the process for unwell pregnant women, requiring transfer to [town] Hospital by frontline paramedic ambulance, to be admitted to ED.	Admission to Primary Birthing Unit – [town] 2742448 was amended and published in Jan 2023.	Completed
5	MEWS is fully implemented into [town] Maternity Unit; including training of [town] Maternity Staff, and a [town] specific MEWS chart and escalation plan developed in consultation with and including staff in [town] Hospital ED.	[Town] chart and escalation agreed at Maternity CQI on 29th Sept 2022. Still needing resus group sign off. Staff were using [city]a Chart. Implementation delayed by departure of MW Educator. Implemented in March 2023 with [town] specific MEWS charts. Audit in June/July 2023 showed this was generally being well done.	Completed
6	The [Health NZ region] guideline on Transfer from [town hospital] to Secondary/Tertiary Unit is updated with the most current information as well as inclusion of uterine rupture as a possible scenario. The updated guidance is communicated to all relevant staff.	Updated guideline published in Jan 2023. Needs further amendments (logged as an action from another Datix).	Completed
7	The trial Transfer Record Form is updated and aligned with the Transfer Guideline, analgesia is added to the checklist and clarification is given to the 'in transfer notes' section. The form is made into a finalised document and communicated to relevant staff.	Updated and published in September 2022.	Completed
8	Clarification is obtained about ambulance and crew options available to the [town] Maternity Unit and these options are communicated to all [town] Maternity Staff, LMC's and Obstetricians.	Information was obtained, included in updated transfer guideline and communicated to Obstetric and senior midwifery staff at CQI meeting.	Completed
9	The transfer phoning process on the front of the Transfer Folder at the main desk of [town] Maternity is updated and simplified to reflect each step of the process and only the required phone numbers.	Completed in September 2022.	Completed
10	[Town] Maternity Unit purchase a portable electronic blood pressure monitor that can be taken on ambulance transfers to monitor maternal blood pressure enroute. [Town] Maternity Unit staff and LMC's are notified of its availability and trained how to use it.	Ordered in September 2022 and staff were made aware that they could use one from the emergency department in the meantime. The Maternity monitor was in place by the end of 2022.	Completed

Appendix D: Independent clinical advice to the Commissioner

The following independent advice was obtained from RM Robyn McDougal:

'Independent clinical advice to Health and Disability Commissioner

Complaint:	**Ms [B] / RM [C]**
Our ref:	**23HDC03346**
Independent advisor:	**Mrs Robyn McDougal**

I have been asked to provide clinical advice to HDC on case number 23HDC03346. I have read and agree to follow HDC's Guidelines for Independent Advisors.

I am not aware of any personal or professional conflicts of interest with any of the parties involved in this complaint.

I am aware that my report should use simple and clear language and explain complex or technical medical terms.

Qualifications, training and experience relevant to the area of expertise involved:	I am currently working as a Midwifery Manager in a Primary Maternity Unit. I have been a midwife for over 30 years, and I have worked predominantly in a remote rural setting in the Central North Island in the Whanganui Region as well as across the whole of the Central North Island. I have had experience working in secondary maternity services; in Alice Springs, Australia and North Shore Auckland 2003, as well as 7 years' experience in Whanganui. In 2007, I attained a Masters of Midwifery degree writing a research project looking at the comparison of pethidine and fentanyl opiates in labour related to neonatal outcomes. I am an active member of the New Zealand College of Midwives (NZCOM) and have held various regional Chairperson positions for the College of Midwives for 16 years from 2003. I am currently a Midwifery Standards Reviewer for NZCOM, and I am also a competency reviewer for the Midwifery Council of NZ.
Documents provided by HDC:	1. RM [C]'s response sent direct to the [B] family, 30 November 2022 2. Letter of complaint dated 7 December 2023 2a. Clinical records provided as part of complaint from [B] family 3. RM [C]'s response dated 4 July 2024 and enclosures 3a. Clinical records 3b. ANC letters 4. [The Practice] response 29 August 2024. 5. Recording of call from RM [C] to [the ambulance service]

Referral instructions from HDC:	Clinical advice requested Please review the enclosed bundle of documents that relate to the care provided to Ms [B] by RM [C] and advise: 1. Whether RM [C] should have reviewed Ms [B]'s health/obstetric history and communicated with Dr [D], Obstetrician, when she took over her colleague's caseload and identified the short interpregnancy interval and the risk of uterine rupture. 2. What is a normal caseload considered to be for a rural case loading midwife of RM [C]'s experience? 3. Whether Ms [B] was managed appropriately considering the fetal weight was measuring large? 4. Whether any of the Lab Results ordered by RM [C] should have been copied to Dr [D]? 5. Whether the information provided by RM [C] to [the ambulance service] whilst at Ms [B]'s friend's home was appropriate? 6. Whether there is any other information RM [C] should have made Ms [B] aware of during the pregnancy and/or on the evening when a decision was made about where to continue her labour? 7. Whether you consider RM [C] should have utilised any equipment provided by [the Practice] at Ms [B]'s friend's home in [town]? 8. Whether there was any other pain relief that RM [C] could have considered other than morphine to provide to Ms [B] on the evening prior to, and during her transfer to [the city hospital]? 9. Any comments you have on the support given to RM [C] by [the Practice]. 10. Any other matters that you consider amount to a departure from accepted standards or warrant comment.

Factual summary of clinical care provided complaint

Brief summary of clinical events:	RM [C] was employed in January 2022 as a case loading midwife for [the Practice] in the [town and surrounding area]. RM [C] was compelled to take over her practice partner's caseload when this midwife left suddenly, which meant assuming care for Ms [B] and Mr [E], starting with an antenatal visit on 26 May 2022. Ms [B] was referred according to the Referral Guidelines by her colleague for a previous Caesarean section to facilitate pregnancy counselling for vaginal birth after caesarean (VBAC). The plan was always to birth in [the city hospital] where the option for a surgical birth was quickly accessible if necessary but to have continuous cardiotocographic (CTG) monitoring when labour commenced. Ms [B] commenced early labour on 16 July, awaited labour to establish at a friend's house [in town] and then called the midwife when the pain was excruciating, initiating a transfer to [the city], stopping at [the town] hospital on the way. RM [C] was unable to detect a fetal heart rate at the friend's house and sought help with assessment at [the town] hospital. Ms [B] presented to [the city hospital] with a ruptured uterus and fetal demise, subsequently birthed surgically on 17 July in [the city hospital] at 0404hrs. **The complainant's** concerns regarding the care provided by RM [C], which were believed to be suboptimal in several areas: 1. Ms [B] stated she was not fully informed about the risks associated with a shortened pregnancy interval and VBAC, both by RM [C] and the obstetrician, during both the antenatal and intrapartum periods. 2. Ms [B] felt that RM [C] did not follow the obstetrician's antenatal advice regarding her planned care during labour and delivery. 3. There was a failure to recognize the signs of uterine rupture, including signs of shock. 4. Ms [B] felt she was not adequately monitored by RM [C] at her friend's house in [town]. 5. Ms [B] reported that there were limited pain relief options made available to her. 6. Ms [B] was allowed to continue drinking fluids despite an imminent surgical birth, when she should have been kept nil per mouth. 7. Ms [B] felt there was a lack of knowledge regarding the local ambulance service, and she questioned RM [C]'s

	communication with the call centre during the emergency transfer request. 8. Ms [B] felt that the transfer to [the town hospital] further delayed her transfer to [the city hospital]. 9. RM [C] visited the family at the tangi when the family felt she wasn't welcome there. **RM [C], the provider,** responded to the above complaints in the following way: 1. RM [C] felt she was not responsible for continuing the advice regarding risks of shortened pregnancy interval as the due diligence for this matter was covered by her colleague's referral to the obstetrician. 2. RM [C] felt that [the city] hospital doesn't usually comply with a request to admit women in early unestablished labour so was happy to condone Ms [B]'s intention to await events at her friend's house in [town]. 3. RM [C] hasn't responded to the accusation that she didn't recognise the signs of obstetric shock. 4. RM [C] felt she had offered Entonox, but Ms [B] had declined. 5. RM [C] hasn't responded to the complaints about the lack of pain relief options nor the sips of fluid prior to transfer. 6. RM [C] is confident in her handling of the emergency call and ambulance use, citing advice from her manager about regional restrictions on calling from a private dwelling to avoid overuse of the service. 7. RM [C] felt she needed to be assessed in the [town hospital] and have ultrasound assistance to find the fetal heart with the help of her colleagues. 8. RM [C] was on the understanding she was invited to the tangi. The clinical notes do not provide enough information to demonstrate evidence for RM [C]'s responses to the complaint. The responses to the complaints have served as the primary source of evidence for this report.
Question 1: Whether RM [C] should have reviewed Ms [B]'s health/obstetric history and communicated with Dr [D] when she took over her colleague's case load and identified the short interpregnancy interval and the risk of uterine rupture.	
List any sources of information reviewed other than the documents provided by HDC.	Health NZ (2023). Guidelines for Consultation with Obstetric and Related Medical Services (Referral Guidelines). New Zealand College of Midwives (2015). Midwives' handbook for practice (5th ed.). Christchurch.
Advisor's opinion:	RM [C] accepted the responsibility for an increased caseload when her colleague had to leave the practice unexpectedly. Although her

	employer was away on leave at the time, my understanding is that RM [C] was expected to carry on. In the absence of a formal handover, the accepted practice would have been to review Ms [B]'s notes and consider whether additional information was needed from Ms [B], the practice manager, or the involved obstetrician. While communicating the change of LMC to all professionals involved in Ms [B]'s care would have been appropriate, it is not always done due to team complexities. The previous LMC's referral to the obstetrician for pregnancy counselling related to VBAC, which is a requirement of Referral Guidelines. The short pregnancy interval was only noted in the letter back to the LMC from a visit on 18/05/2022 in [the town where the obstetrician saw Ms [B], where there was implication of discussion between the obstetrician and Ms [B] regarding short interpregnancy interval, "she was aware that she was asked to leave it at least 12 months between the last pregnancy and this one, but this was unplanned". RM [C] did not read this letter. There is a note made by Dr [D] in handwritten notes: "understands the risk of scar rupture". However, the obstetrician's formal lettered responses lack detail about the extent or specifics of the pregnancy counselling provided to Ms [B], so it is not clear whether the risk of uterine rupture was explicitly discussed, despite that being the expectation from such a referral. The responsibility to have continued the ongoing discussion about VBAC with Ms [B] related to the risks should have remained shared between the obstetrician and RM [C]. RM [C] is very clear in her response to Ms [B]'s complaint that "the due diligence and responsibility of the LMC was achieved" ([response document RM C], p 2) when her colleague referred her to the obstetric team, which she believed absolved her of any responsibility to continue the discussion or plan care for Ms [B]. The expectation of the regulatory body: Midwifery Council and the New Zealand College of Midwives (NZCOM) Standards of Midwifery Practice as seen in Competency Two: "the midwife applies comprehensive theoretical and scientific knowledge with the affective and technical skills needed to provide effective and safe midwifery care", Standards Two: "The midwife upholds each women's right to free and informed choice and consent throughout the childbirth experience" and Standard Six: "Midwifery actions are prioritised and implemented appropriately with no midwifery action or omission placing the woman at risk." (2018, NZCOM).

What was the standard of care/accepted practice at the time of events? Please refer to relevant standards/material.	It is acceptable practice to have a handover of care from your colleague, but in the absence of a handover RM [C] should have read Ms [B]'s clinical records or notes, looked at all relevant laboratory results and scans as well as the obstetrician's letters to familiarise herself with Ms [B]'s pregnancy progress.
Was there a departure from the standard of care or accepted practice? • No departure; • Mild departure • Moderate departure; or • Severe departure.	Mild departure
How would the care provided be viewed by your peers? Please reference the views of any peers who were consulted.	My peers would have viewed this as an omission of care.
Please outline any factors that may limit your assessment of the events.	None noted.
Recommendations for improvement that may help to prevent a similar occurrence in future.	Handover of care is crucial to ongoing safe continuity of care for the woman, whether it is face to face or written. A written handover is a common strategy for handover in the absence of a face-to-face meeting and a practical solution.
Question 2: What is a normal caseload considered to be for a rural caseloading midwife of RM [C]'s experience?	
List any sources of information reviewed other than the documents provided by HDC.	MERAS (2014). Safe Staffing Standards. Christchurch.

Advisor's opinion	The normal caseload for a rural LMC is stated in the MERAS Safe staff Standards as being rural 1:35-40 women and women with complex needs 1:-40 per year. (Meras, Midwifery Staffing Standards, 2014, pp 21). There is a concern about the expectation of [the Practice] for RM [C] to take on an additional full caseload, especially when RM [C] already has a full workload. I believe this puts both the women and the midwives at risk.
What was the standard of care/accepted practice at the time of events? Please refer to relevant standards/material.	No this was not standard practice; however, it was difficult for RM [C] to step away from the provision of care for these women in the absence of her employer. There is a responsibility to manage caseloads so that the women are aware of the absence of a practice partner and the impacts on service provision as it would essentially affect the women. As an employed midwife, the responsibility to step in and solve this staffing deficit was not RM [C]'s. Therefore, taking over the caseload was an understandable action for the present time, short term. However, the practice did not demonstrate any resolution in the short term or long term for recruitment or respite to the workload for RM [C].
Was there a departure from the standard of care or accepted practice? • No departure; • Mild departure • Moderate departure; or • Severe departure.	Not on behalf of RM [C].
How would the care provided be viewed by your peers? Please reference the views of any peers who were consulted.	This would be viewed unfavourably by peers as the employer had poor mechanisms in place to reduce the risk to midwives and women within her service delivery and therefore put RM [C] at risk in employment settings.
Please outline any factors that may limit your assessment of the events.	The clinical notes from all professionals involved have not been clear when trying to calculate the caseload numbers.

Recommendations for improvement that may help to prevent a similar occurrence in future.	When taking over care, there should be documentation in the woman's clinical records to show that, as a new LMC, the planned care has been read and understood.
Question 3: Whether Ms [B] was managed appropriately considering the fetal weight was measuring large?	
List any sources of information reviewed other than the documents provided by HDC.	Perinatal Institute (2020). Growth Assessment Programme (GAP NZ) Online Workshop. Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG) (2024). Birth after Caesarean Section. Retrieved online 01/03/2025.
Advisor's opinion	RM [C]'s approach to Ms [B]'s pregnancy, specifically concerning the fetal weight, was appropriate. It's important to consider the variability of fetal weight estimates via ultrasound, which can be +/- 500g. The baby was born at 4040g. RM [C] demonstrated a solid understanding of current research and guidelines related to managing macrosomia in this case. Furthermore, the 2024 RANZCOG guidelines on VBAC do list macrosomia as a risk factor but at the very bottom of the list of 10 risks, meaning its priority as a risk was lower. Given that Dr [D]'s correspondence didn't see Ms [B]'s baby as a macrocosmic baby after the last scan report, the management of this pregnancy concerning the baby's size was within reasonable practice. While Ms [B]'s grow chart puts her baby above the 90th centile, the population-based growth chart that records all measurements for this baby: • head circumference: HC • biparietal circumference: BPD • abdominal circumference: AC • femur length: FL • & weight puts baby's size between the 90th and 50th centile. This was not a macrosomic baby.
What was the standard of care/accepted practice at the time of events? Please	Yes, this was accepted standard of care.

refer to relevant standards/material.	
Was there a departure from the standard of care or accepted practice? • No departure; • Mild departure • Moderate departure; or • Severe departure.	No Rm [C]'s conduct in this regard would be seen as acceptable practice.
Please outline any factors that may limit your assessment of the events.	None
Recommendations for improvement that may help to prevent a similar occurrence in future.	None
Question 4: Whether any of the Lab Results ordered by RM [C] should have been copied to Dr [D]?	
List any sources of information reviewed other than the documents provided by HDC.	None
Advisor's opinion	All practitioners in the region can access laboratory results through the established laboratory systems or HealthLink in electronic records. So, it stands to reason that Dr [D] could access these results, and it is generally considered acceptable for the obstetrician to access routine results without needing a specific prompt. However, a positive Group B Streptococcal (GBS) urine or swab result was not properly followed up for those involved in Ms [B]'s birth. While asymptomatic GBS may not always require treatment during pregnancy, it does have implications for potential intrapartum transmission to the foetus, which can lead to systemic risks and even mortality. The usual practice is to administer IV

	antibiotics once labour has established to minimise the risk of GBS infection to the foetus. RM [C] did discuss this at the time with Ms [B] in the antenatal period. The plan for a VBAC was evident, but it's unclear whether there were discussions with Dr [D] or the delivery suite before the transfer when labour was imminent regarding this added component of care regarding GBS. Ms [B]'s initial pregnancy care included a rubella screening that indicated she was non-immune. Consequently, she should have been informed and reminded about the option to receive rubella immunisation during her postnatal care.
What was the standard of care/accepted practice at the time of events? Please refer to relevant standards/material.	The accepted standard of practice is to alert the professionals taking over care of any other risks that may impact the intrapartum period, especially regarding GBS, but also to have the conversation with Ms [B] regarding her rubella non-immune status in the postnatal period.
Was there a departure from the standard of care or accepted practice? • No departure; • Mild departure • Moderate departure; or • Severe departure.	Mild
How would the care provided be viewed by your peers? Please reference the views of any peers who were consulted.	This would have been viewed as an omission as other professionals included in this care needed to be aware of the additional risk to the intrapartum period with GBS and inform Ms [B] about her rubella status.
Please outline any factors that may limit your assessment of the events.	None

Recommendations for improvement that may help to prevent a similar occurrence in future.	Have strategies in your documentation that highlight any pregnancy, intrapartum, and postnatal risk so they are not overlooked.
Question 5: Whether the information provided by RM [C] to [the ambulance service] whilst at Ms [B]'s friend's home was appropriate?	
List any sources of information reviewed other than the documents provided by HDC.	SBAR (Situation | Background | Assessment | Recommendation) retrieved online 03/04/2025.
Advisor's opinion	The information passed onto [the] Ambulance call centre on the night at Ms [B]'s friend's house was adequate although stunted and confused at times. RM [C] seemed to have either not heard the questions or needed to have them repeated so she could answer directly and clearly. There was a request for gas at the end of the conversation that was unusual as [the] Ambulance always carry oxygen. The correct information was ultimately conveyed, ensuring [the] Ambulance had a clear understanding of the patient's condition, the Code One call priority, and the initial destination. There was some initial confusion regarding whether the baby had been born and had a cardiac arrest, but RM [C] clarified that baby was still in utero and that she was having difficulty locating the fetal heart. While RM [C] could have been more concise and clearer during the handover, especially given the emergency, this is an area that typically improves with experience, and [the] Ambulance call centre have guidelines around clarity of information seeking clear concise information in an emergency. However, RM [C] should revise her technique for emergency handover of care and perhaps consider using the situation, background, assessment and referral (SBAR) Tool.
What was the standard of care/accepted practice at the time of events? Please refer to relevant standards/material.	The standard of care in this instance was adequate.

Was there a departure from the standard of care or accepted practice? • No departure; • Mild departure • Moderate departure; or Severe departure.	No
How would the care provided be viewed by your peers? Please reference the views of any peers who were consulted.	The conversation provided to [the] Ambulance call centre was slightly confusing; it would be seen as acceptable by peers only because the prompts from [the] Ambulance call centre provided clarity. These conversations are always easy to be critical of in hindsight; however, there are tools that colleagues use called the SBAR tool to have clear and concise messaging in these situations.
Please outline any factors that may limit your assessment of the events.	The audio was hard to hear for a very short period where RM [C] was advising [the] Ambulance where she wanted to go – to [the town] hospital – otherwise the audio was easily understood.
Recommendations for improvement that may help to prevent a similar occurrence in future.	RM [C] could avail herself of the SBAR tool so she has a clearer process to communicate in an emergency: **SBAR (Situation | Background | Assessment | Recommendation)**
Question 6: Whether there is any other information RM [C] should have made Ms [B] aware of during the pregnancy and/or on the evening when a decision was made about where to continue her labour?	
List any sources of information reviewed other than the documents provided by HDC.	Green Top guideline # 45, "Birth after previous Caesarean Birth," retrieved online 03/04/2025.
Advisor's opinion	RM [C]'s decision to condone Ms [B]'s choice to go to her friend's house and wait for labour to establish was reportedly due to [the city hospital]'s capacity limitations for women in early labour. However, [city hospital] staff offered to admit Ms [B] to the delivery suite that night for rest and observation, but RM [C] did not accept this offer. The discussion with Ms [B] about going to [the city] was not extensive when looking at the clinical record.

	Furthermore, RM [C] did not consider the potential for an emergency, or the 1- to 2-hour […] Ambulance transfer (dependant on availability and wheels on the road) required once labour was established, nor were the implications of a time-sensitive or traumatic emergency transfer discussed with Ms [B] during her pregnancy or on the night in question. Guideline #45 clearly outlines clinical features associated with scar rupture, emphasizing abnormal cardiotocography (CTG) and severe abdominal pain (especially between contractions) as key symptoms, particularly in early labour (4–5cm dilation). Given that uterine scar rupture can occur within the first 4–5 cm of cervical dilation, established labour was not necessarily required for this emergency to arise. The delay in transferring Ms [B] to secondary care increased her risk of uterine rupture. RM [C]'s admission that this information was not the responsibility of the LMC further compounded the risk, as she appeared to support Ms [B]'s decision to delay transfer and await events at her friend's house. When called to the [town] location, RM [C] suspected uterine rupture due to Ms [B]'s excruciating pain but did not consult with secondary care, instead taking Ms [B] to a primary unit for assessment. The clinical notes and RM [C]'s response lack evidence of a full clinical assessment at the initial meeting, and the subsequent transfer to [the city] was delayed. Knowing that [the Practice] are completely kitted out for emergency care in the community, doing a full assessment at the friend's house in [town], commencing IV fluids at home (which [the] Ambulance can assist with also), and starting Entonox for pain relief, consulting and then setting out to [the city] would have avoided delay. RM [C] states the reason she wanted to go to [the town] was to have help with IV cannulation and use the ultrasound to assess the fetal heart. RM [C] also neglected to keep Ms [B] nil per mouth in anticipation of a surgical birth. There is no discussion about this in the clinical record other than the written complaint from Ms [B] and her partner. In conclusion, RM [C]'s actions and inactions, combined with the lack of discussion about these risks during pregnancy and on the night in question, contributed to a delay in expediting a surgical delivery despite signs of scar rupture, which RM [C] acknowledged suspecting at the friend's house in [town].
What was the standard of care/accepted	No, this was not standard care or accepted practice.

practice at the time of events? Please refer to relevant standards/material.	
Was there a departure from the standard of care or accepted practice? • No departure; • Mild departure • Moderate departure; or • Severe departure.	Severe
How would the care provided be viewed by your peers? Please reference the views of any peers who were consulted.	There is an omission of care related to Standard Six: "Midwifery actions are prioritised and implemented appropriately with no midwifery action or omission placing the woman at risk." (2018, NZCOM).
Please outline any factors that may limit your assessment of the events.	There is no evidence of RM [C]'s current skills with IV cannulation. Was this a reason (novice practitioner with possibly limited cannulation experience) for her to take Ms [B] to [town] also besides using an ultrasound procedure to assess for fetal viability?
Recommendations for improvement that may help to prevent a similar occurrence in future.	Updating assessment skills, emergency skills, and increased exposure to IV cannulation.
Question 7: Whether you consider RM [C] should have utilised any equipment provided by [the Practice] at Ms [B]'s friend's home in [town]?	
List any sources of information reviewed other than the documents provided by HDC.	New Zealand College of Midwives (2018). Midwives' handbook for practice (5th ed.). Christchurch.
Advisor's opinion	RM [C] had discussed in her report to HDC regarding her supplies and equipment that she carries in her vehicle for births and emergencies. Although not itemised, the very implication of being equipment ready for not only her routine midwifery care but also

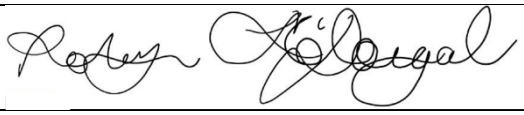
	emergencies would imply there was oxygen and IV equipment for emergencies that RM [C] would have been qualified to use in the home. The omission of a basic full assessment for Ms [B] at home contributed to a further unfortunate delay in providing adequate care and consulting with the obstetrician in [the city] prior to transfer. A full assessment would have been blood pressure, pulse, temperature, abdominal palpation, fetal heart assessment, and vaginal examination. The latter three were done. Ms B was noted to be hypotensive at [the town hospital], and this could have been alleviated if the assessment was completed at first contact in the friend's home, especially with IV fluids. The care provided at [the town] hospital didn't provide anything more than RM [C] could have done in the [town] residence, especially when the ultrasound performed in [the town hospital] did not enable any further treatment but also delayed the transfer further.
What was the standard of care/accepted practice at the time of events? Please refer to relevant standards/material.	To provide an appropriate assessment at first contact in any emergency.
Was there a departure from the standard of care or accepted practice? • No departure; • Mild departure • Moderate departure; or • Severe departure.	Moderate
How would the care provided be viewed by your peers? Please reference the views of any peers who were consulted.	An omission of appropriate care as stated in Standard Six: "Midwifery actions are prioritised and implemented appropriately with no midwifery action or omission placing the woman at risk." (2018, NZCOM).

Please outline any factors that may limit your assessment of the events.	There is no evidence of RM [C]'s current skills with IV cannulation.
Recommendations for improvement that may help to prevent a similar occurrence in future.	Updating assessment skills, emergency skills, and increased exposure to IV cannulation.
Question 8: Whether there was any other pain relief that RM [C] could have considered other than morphine to provide to Ms [B] on the evening prior to and during her transfer to [the city hospital]?	
List any sources of information reviewed other than the documents provided by HDC.	None
Advisor's opinion	[The] Ambulance carries Penthrox which is the equivalent to Entonox. Penthrox is an inhalant pain relief that contains methoxyflurane. Contraindications for Penthrox in pregnancy is preeclampsia, which Ms [B] did not have. RM [C] was noted to have offered Entonox at the [town] facility, but Ms [B] declined. I cannot see that this was offered again, but there was no evidenced discussion regarding further pain relief, nor was advice sought from the obstetrician before leaving the [town] facility about possible pain relief options in this scenario. There were more options available for pain relief in the emergency department in [town], especially when the ED doctor was already engaged in care for Ms [B]. [The] Ambulance could have assisted with pain relief before taking Ms [B] to the [town] facility also.
What was the standard of care/accepted practice at the time of events? Please refer to relevant standards/material.	The usual accepted midwifery practice in labour is to monitor and offer pain relief as required for a woman in labour according to her needs and birth plan. RM [C] did not.
Was there a departure from the standard of care or accepted practice?	Mild

• No departure; • Mild departure • Moderate departure; or • Severe departure.	
How would the care provided be viewed by your peers? Please reference the views of any peers who were consulted.	This situation would have been viewed as an omission of care; however, at 2 years post graduate, inexperience and only just being employed in the region may have been significant in RM [C]'s decision making.
Please outline any factors that may limit your assessment of the events.	What was the qualification of the […] Ambulance staff at the time, and do they carry other pain relief on board their vehicle? Not all […] Ambulance carry opioids according to the qualification of the […] Ambulance staff.
Recommendations for improvement that may help to prevent a similar occurrence in future.	Improve local knowledge regarding […] Ambulance services and what they can offer in terms of pain relief.
Question 9: Any comments you have on the support given to RM [C] by [the Practice].	
List any sources of information reviewed other than the documents provided by HDC.	Meras. (2014). Safe Staffing Standards. Christchurch. New Zealand College of Midwives. (2018). Midwives' handbook for practice (5th ed.). Christchurch.
Advisor's opinion	RM [C] was employed in January 2022 without receiving any formal job orientation. In May of the same year, RM [C] was required to manage a second caseload after her practice partner had to urgently leave the position due to personal reasons. Although I don't have exact figures for each employee's caseload, combining two caseloads suggests that RM [C]'s workload was significantly increased from the outset. Additionally, when the practice manager returned from leave, there was no attempt made to recruit another midwife. While the work setting was well resourced with midwifery equipment, computers for Expect IT Maternity Record program, phones, and car, there was an expectation for RM [C] to carry on

	with an increased caseload and no additional respite regarding midwifery recruitment. Although this business is built upon on a model of self-employed midwifery, where midwives are seen as autonomous practitioners, there are still guidelines for caseload numbers to ensure the individual caseloads are safe and sustainable for each midwife. I don't believe that this practice manager worked within the safe staffing standards recommended by the Meras Midwifery Union as well as the NZCOM.
What was the standard of care/accepted practice at the time of events? Please refer to relevant standards/material.	[The Practice's] Senior team have not supported RM [C] adequately as a midwife, 2 years postgraduate, and the expectations of taking over two caseloads was a risk for the women and for RM [C]. RM [C] needs to keep herself safe as well and have the courage to speak up. Standard 7 of the handbook for practice states "The midwife is accountable to the woman, to herself, to the midwifery profession and to the wider community for her practice". Within this standard, "identifies processes for ensuring midwife backup, access and support to other colleagues as necessary". [The Practice] did not fulfil their obligations to their employees in this regard.
Was there a departure from the standard of care or accepted practice? • No departure; • Mild departure • Moderate departure; or • Severe departure.	Moderate departure in terms of [the Practice].
How would the care provided be viewed by your peers? Please reference the views of any peers who were consulted.	This would be seen as unsustainable caseload with a lack of support for colleagues in their midwifery practice, especially as an employer.
Please outline any factors that may limit your assessment of the events.	The complaint isn't solely focused on [the Practice] but has context to add to the complexity of this event.

Recommendations for improvement that may help to prevent a similar occurrence in future.	RM [C] needs to learn her limitations with her caseload and work on her work–life balance in the aim of sustainability.
Question 10: Any other matters that you consider amount to a departure from accepted standards or warrant comment.	
List any sources of information reviewed other than the documents provided by HDC.	Ke Xu, Wen Sun, Shuangshuang Yang, et al. (2024). The impact of COVID-19 infections on pregnancy outcomes in women. BMC Pregnancy and Childbirth New Zealand College of Midwives. (2018). Midwives' handbook for practice (5th ed.). Christchurch.
Advisor's opinion	**Covid 19:** The practice manager, RM [K], had received notice of a positive COVID result for Ms [B] in the 2nd trimester of her pregnancy. While this may have been a mild illness, management prescribed was ultrasound monitoring of fetal growth, and general observations. The scan request at this time was for cervical length due to a previous cervical large loop excision of the transformation zone (LLETZ) procedure. The scan was not performed for a previous COVID infection. RM [C] did not seem aware of the link to increased incidence of PET, clotting disorders, heavy bleeding, preterm birth, low birth weight, fetal growth restriction, stillbirth. Although of low incidence (1%) and more common in the third trimester, RM [C] hadn't appeared to have considered COVID as a risk factor. Some studies have shown inflammatory markers on placental histology where COVID is experienced in pregnancy. The obstetrician notified RM [K] and recommended a scan at the time. **GBS:** RM [C] didn't acknowledge the risk of GBS infection when calling [the city hospital] during the transfer process. **Rubella:** Ms [B]'s initial pregnancy care included a rubella screening that indicated she was non-immune. Consequently, she should have been informed and reminded about the option to receive rubella immunisation during her postnatal care. I have not seen any documented conversations in the antenatal period regarding immunisation in the postnatal period.

What was the standard of care/accepted practice at the time of events? Please refer to relevant standards/material.	The accepted practice is to make sure that midwifery actions are prioritised and implemented appropriately with no midwifery action or omission placing the woman at risk: Standard 6 of the Handbook for Midwifery Practice.
Was there a departure from the standard of care or accepted practice? • No departure; • Mild departure • Moderate departure; or • Severe departure.	Mild
How would the care provided be viewed by your peers? Please reference the views of any peers who were consulted.	While COVID is now seeming a distant reality, at the time there were risks that we were all mindful of; colleagues would have seen this as an omission. Especially when thinking about the omission to discuss GBS or Rubella non-immune status with her colleagues.
Please outline any factors that may limit your assessment of the events.	Limited intrapartum notes, especially about the consultation with City hospital regarding transfer and passing on the GBS status.
Recommendations for improvement that may help to prevent a similar occurrence in future.	Update knowledge base around previous history of women in their pregnancies. Be mindful of the added risks that emerge throughout pregnancy and have a process or strategy to be reminded about their significance in any trimester with respect to midwifery care.
By signing this report, I agree to HDC correcting any formatting, spelling, or grammar issues on the proviso that the substance of the report and any quoted material remains unchanged.	
Signature	
Name: Mrs Robyn McDougal	
Date of Advice: 9 April 2025’	

'From: Robyn McDougal

Sent: Wednesday, 27 August 2025

[…]

I hope this email finds you well.

Apologies for the delay in my response.

My comments to your last request are:

1. Advise whether [the Practice] and RM [C]'s comments change any aspects of your initial advice.

I don't have any changes to make to my initial advice.

2. Provide clarification as requested by RM [C] on page 7 of her response around the 4-5cm dilation query.

My point was that women do not necessarily reach the end of their labour (10cm) to experience a uterine rupture: so the wording should have read "in labour as early as 4-5cm"

3. Advise whether there are any other matters in this case that you consider warrants comment

No other matters

4. Confirm whether there are any [re]commendations that you could think of for future improvements at [the Practice] or for RM [C]

- That [the Practice] seriously consider rural caseload numbers as recommended by NZCOM or the midwifery MERAS UNION as a strategy for safe caseloading practice.
- That RM [C] should consider a midwifery mentor as well as a well-supported midwifery team if rural midwifery practice was to be her consideration again.

Kind regards

Robyn McDougal'

Appendix E: Independent clinical advice to the Commissioner

The following independent advice was obtained from Dr Judy Ormandy, Consultant Obstetrician:

'Independent clinical advice to Health and Disability Commissioner.

Complaint:	**Ms [B] / Dr [D]**
Our ref:	**23HDC03346**
Independent advisor:	**Dr Judy Ormandy**

I have been asked to provide clinical advice to HDC on case number 23HDC03346. I have read and agree to follow HDC's Guidelines for Independent Advisors.

I am not aware of any personal or professional conflicts of interest with any of the parties involved in this complaint.

I am aware that my report should use simple and clear language and explain complex or technical medical terms.

Qualifications, training and experience relevant to the area of expertise involved:	I am a Senior Lecturer in Obstetrics, Gynaecology & Women's Health at the University of Otago, Wellington, and a consultant obstetrician and gynaecologist at Te Whatu Ora Capital, Coast and Hutt Valley. I have worked as a specialist obstetrician and gynaecologist since 2012. My qualifications are MBChB (2001, Otago), Dip Obs (Dist) (2003, Otago), FRANZCOG (2012) and MClinEd (Hons) (Auckland 2017).
Documents provided by HDC:	1. Relevant part of letter of complaint dated 7 December 2023. 2. Dr [D]'s response dated 28 May 2024 3. Clinical records provided as part of the complaint from the [B] family (enclosing letters dated 18 May 2022 and 15 June 2022 referred to in the request letter)
Referral instructions from HDC:	Dr [D] 1. Whether the care provided to Ms [B] in the antenatal clinic appointment of 18 May 2022 was appropriate? Please comment on whether the advice provided by Dr [D] in her clinic letter dated 18 May 2022 to the LMC at the time (RM [H]) was appropriate and the error acknowledged by Dr [D] around Ms [B] needing to deliver in [town]. 2. Whether the care provided to Ms [B] in the antenatal clinic appointment of 15 June 2022 was appropriate? Please comment on whether the information provided in the letter to [the Practice] dated 15 June 2022 was appropriate.

	3. Whether you would expect Dr [D] to have been notified of scan or other results during the pregnancy. 4. Whether any further follow-up should have occurred with Dr [D] and Ms [B]. *5.* Any other matters that you consider amount to a departure from accepted standards or warrant comment.

Factual summary of clinical care provided complaint:

Brief summary of clinical events:	Ms [B] has complained about the antenatal care she received from Dr [D], obstetrician. Ms [B] was in her second pregnancy, having had a caesarean section in her first pregnancy for a breech presentation in labour. She had two antenatal appointments with Dr [D]. During those appointments, a plan was made that Ms [B] would attempt a vaginal birth. While I do not have any hospital records, I understand that Ms [B] suffered a uterine rupture in labour and that her daughter [Baby B] was stillborn. I extend my condolences to Ms [B] and her whanau.
Question 1: Whether the care provided to Ms [B] in the antenatal clinic appointment of 18 May 2022 was appropriate? Please comment on whether the advice provided by Dr [D] in her clinic letter dated 18 May 2022 to the LMC at the time (RM [H]) was appropriate, and the error acknowledged by Dr [D] around Ms [B] needing to deliver in [town].	
List any sources of information reviewed other than the documents provided by HDC	
Advisor's opinion	Ms [B] was reviewed by Dr [D] in antenatal clinic in … on 18 May. The clinic letter is clearly set out with Ms [B]'s past history, including a late preterm labour, previous caesarean for breech presentation, and a LLETZ. Because of the history of LLETZ and previous early labour, Dr [D] has assessed the cervical length clinically and, when not reassured by this, arranged an ultrasound to check the cervical length. The short interpregnancy interval (another risk factor) is also documented in Dr [D]'s letter. VBAC is discussed with Ms [B], and she was provided with a RANZCOG information leaflet. Dr [D] has documented risk of uterine rupture was also discussed. The typed clinic letter clearly states that Dr [D] recommends that Ms [B] births in hospital. The comment in the written notes about needing to deliver in [town] was erroneous, as stated in Dr [D]'s response to the HDC. I

	accept Dr [D]'s assertion that the comment was written in error. It clearly states in her clinic letter to the LMC that she advises Ms [B] deliver in hospital. It was clearly a busy clinic appointment with a lot covered. In my own practice, I will often 'jot' notes on the paper notes, but it is my dictated letter that forms the formal documentation that I carefully check. A typed clinic letter 'overrides' jotted paper notes, and I wouldn't have thought that the LMC would routinely have had access to these jotted notes. It is evident from the clinic letter that a thorough review occurred, and risk factors were identified.
What was the standard of care/accepted practice at the time of events? Please refer to relevant standards/material.	The standard of care was appropriate.
Was there a departure from the standard of care or accepted practice? • No departure; • Mild departure • Moderate departure; or • Severe departure.	There was no departure from the standard of care.
How would the care provided be viewed by your peers? Please reference the views of any peers who were consulted.	My peers would regard the care as appropriate.
Please outline any factors that may limit your assessment of the events.	

Recommendations for improvement that may help to prevent a similar occurrence in future.	
Question 2: Whether the care provided to Ms [B] in the antenatal clinic appointment of 15 June 2022 was appropriate? Please comment on whether the information provided in the letter to [the Practice] dated 15 June 2022 was appropriate.	
List any sources of information reviewed other than the documents provided by HDC	
Advisor's opinion	Ms [B] was reviewed again by Dr [D] on 15 June. Dr [D] notes that Ms [B] remains keen for a VBAC. The letter specifies that Ms [B] will "need to come to [the city] if time allows". Again, I think this is clear advice that Dr [D] anticipates that Ms [B will labour in [the city] hospital. The 'if time allows' is a very reasonable and appropriate comment. If Ms [B had been assessed in [town] and had been close to delivery, it may have been safer for her to deliver there (despite the advice to birth in hospital) rather than risking birthing 'on the road'. This is an issue that we face regularly in Aotearoa for pregnant people who live a distance from hospital, and I regard that Dr [D] has appropriately adapted that standard advice.
What was the standard of care/accepted practice at the time of events? Please refer to relevant standards/material.	The standard of care was acceptable.
Was there a departure from the standard of care or accepted practice? • No departure; • Mild departure • Moderate departure; or	There was no departure from accepted practice.

• Severe departure.	
How would the care provided be viewed by your peers? Please reference the views of any peers who were consulted.	My peers would agree with me.
Please outline any factors that may limit your assessment of the events.	
Recommendations for improvement that may help to prevent a similar occurrence in future.	
Question 3: Whether you would expect Dr [D] to have been notified of scan or other results during the pregnancy.	
List any sources of information reviewed other than the documents provided by HDC:	
Advisor's opinion:	I think you are referring to the scan on 8 July, with an estimated fetal weight of 3634g. This plots normally on the GROW chart, and the growth trajectory is normal. As this is a normal scan, I would not have expected Dr [D] to have been notified of the scan result. Had she been notified of the scan result, I would not have expected it to have changed her earlier antenatal clinic advice or the management plan.
What was the standard of care/accepted practice at the time of events? Please refer to relevant standards/material.	The standard of care – midwife not informing Dr [D] of the scan report – was appropriate.
Was there a departure from the	There was no departure from accepted practice.

standard of care or accepted practice? • No departure; • Mild departure • Moderate departure; or • Severe departure.	
How would the care provided be viewed by your peers? Please reference the views of any peers who were consulted.	I believe that my peers would agree with me.
Please outline any factors that may limit your assessment of the events.	
Recommendations for improvement that may help to prevent a similar occurrence in future.	
Question 4: Whether any further follow-up should have occurred with Dr [D] and Ms [B].	
List any sources of information reviewed other than the documents provided by HDC.	
Advisor's opinion	If this question is asking whether there should have been any follow-up with Dr [D] between 15 June and birth, then my response is that there did not need to be any further follow-up. A clear plan was documented in the clinic letter, and this included that if Ms [B] had not laboured by 41 weeks, there would be a discussion regarding induction of labour. Dr [D] is also explicit in her letter that the LMC midwives could contact her if any concerns developed.
What was the standard of care/accepted practice at the time	The standard of care was appropriate.

of events? Please refer to relevant standards/material.	
Was there a departure from the standard of care or accepted practice? • No departure; • Mild departure • Moderate departure; or • Severe departure.	There was no departure from standard of care.
How would the care provided be viewed by your peers? Please reference the views of any peers who were consulted.	My peers would agree.
Please outline any factors that may limit your assessment of the events.	If this question is asking whether there should have been any follow-up following the stillbirth of [Baby B], then I would anticipate that Ms [B] would have been offered a postnatal review and debrief. This could have been with Dr [D], or alternatively another obstetrician. I don't have the hospital records to know if this was offered or occurred.
Recommendations for improvement that may help to prevent a similar occurrence in future.	
Question 5: Any other matters that you consider amount to a departure from accepted standards or warrant comment.	
List any sources of information reviewed other than the documents provided by HDC.	
Advisor's opinion	
What was the standard of	

care/accepted practice at the time of events? Please refer to relevant standards/material.	
Was there a departure from the standard of care or accepted practice? • No departure; • Mild departure • Moderate departure; or • Severe departure.	
How would the care provided be viewed by your peers? Please reference the views of any peers who were consulted.	
Please outline any factors that may limit your assessment of the events.	
Recommendations for improvement that may help to prevent a similar occurrence in future.	
By signing this report, I agree to HDC correcting any formatting, spelling, or grammar issues on the proviso that the substance of the report and any quoted material remains unchanged.	
Signature 	
Name: Dr Judy Ormandy	
Date of advice: 16 March 2025	