HEALTH & DISABILITY COMMISSIONER
TE TOIHAU HAUORA, HAUĀTANGA

Care provided by Lead Maternity Carer

Introduction

1. HDC received a complaint from Miss A raising concerns about the care provided to her by Registered Midwife (RM) B. The complaint relates to RM B's antenatal care of Miss A and management of the prolonged latent phase[1] of labour.

2. RM B was the Lead Maternity Carer (LMC) for Miss A during her first pregnancy from mid-2020 to early 2021. Miss A's pregnancy was described as 'normal'.

3. In early 2021 (at 40 weeks' gestation) Miss A informed RM B that her contractions were occurring more frequently. Miss A was identified as not being in active labour and advised to monitor her progress at home.

4. In the evening the next day, RM B assessed Miss A at home and was unable to locate a fetal heartbeat. At the hospital, it was confirmed that intrauterine fetal death (IUFD)[2] had occurred. Sadly, Baby A was stillborn the following day.

5. I express my sincere condolences to Miss A, her partner Mr C, and their family for their loss.

Antenatal care

6. Miss A told HDC that RM B failed to undertake numerous antenatal screening and monitoring tests[3] and did not monitor[4] her pregnancy adequately.

7. RM B advised that all standard antenatal screening and monitoring tests were completed for Miss A, as documented in the clinical notes. RM B said that when clinical concerns arose, she referred Miss A for obstetric review[5] or additional investigations.[6] RM B stated that the referrals and investigations were reported as normal, and no further follow-up or care was indicated prior to 40 weeks' gestation.

[1] The stage of labour when the cervix begins to soften and open so that the baby can be born. This stage can last on average 12–24 hours, but it can stop and start over several days or weeks. Active labour is considered to have begun once the cervix is over 4cm dilated.
[2] Death of a fetus at or after the 20th week of gestation.
[3] Miss A alleged that she was not tested for gestational diabetes and did not receive antenatal screening tests for Down syndrome and other rare genetic conditions.
[4] Miss A alleged that only one growth scan was performed, no urine tests were conducted in the last five weeks of the pregnancy, and she was prescribed iron supplement despite not having low iron levels.
[5] Miss A was referred for obstetric review regarding abdominal pain and diarrhoea at 22+4 weeks' gestation, and for decreased fetal movements at 28+9 weeks' and at 33+6 weeks' gestation.
[6] Miss A was referred for additional growth scans at 34 weeks' and at 37+6 weeks' gestation.

8. Health New Zealand | Te Whatu Ora (Health NZ) completed a Serious Incident Review (SER). The SER found that Miss A experienced two incidences of decreased fetal movements[7] and an episode of abdominal pain and diarrhoea during her pregnancy (prior to 40 weeks' gestation) and that adequate investigation and follow-up were completed.

Latent phase of labour

9. Miss A told HDC that RM B did not provide adequate assistance and management of her care while she was in early labour. Miss A advised that RM B offered no pain relief and instead offered her a homeopathy tablet to help bring on active labour. Miss A also requested an induction or caesarean section, but these were declined.

10. RM B received a text message from Miss A on the morning of 40 weeks' gestation advising that her contractions were four minutes apart. RM B met Miss A at the local public hospital. RM B examined Miss A[8] and considered that she was not in established labour.[9] RM B told HDC that hospital policy would not accommodate admission and pain-relief options for latent labour. Miss A was encouraged to keep hydrated and mobile, and to continue exercises to encourage active labour, at home.

11. At approximately 3pm on the day of 40 weeks' gestation RM B received a text message from Miss A advising that her contractions were now three minutes apart and lasting around 45 seconds. RM B assessed Miss A at home and documented that there was no change on vaginal examination. Fetal movements were documented.

12. At approximately 5am the next day, Miss A sent a text message to RM B advising that her contractions were becoming more frequent and stronger. RM B met Miss A at the local public hospital and performed a full set of observations and reported these as 'normal'. RM B advised that her findings were discussed with core midwifery staff and the on-call obstetric registrar, who all agreed that Miss A was not in established labour. RM B said that she encouraged Miss A to try to get some sleep, mobilise, and keep hydrated, and offered paracetamol to manage her pain at home. RM B also offered Miss A a homeopathic tablet[10] to help encourage active labour.

13. At approximately 2.15pm RM B received a phone call from Miss A's partner raising concerns about whether the long labour could be harmful to the baby. RM B said that she was reassured by Miss A's earlier observations that she was not in established labour. RM B planned to do a home visit and reassess Miss A at 6.30pm and to discuss Miss A with the obstetrician the following morning if labour had not established.

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[7] RM B referred Miss A for obstetric review regarding decreased fetal movements at 28 weeks' and 33 weeks' gestation.

[8] RM B undertook a full set of observations, auscultated the fetal heart rate, and completed a vaginal examination, which indicated that Miss A was in the latent phase of labour. Miss A was noted to be 2cm dilated with 50% cervical effacement.

[9] The phase of labour during which the cervix has become fully effaced, and the woman has dilated to around 4cm. The contractions become more regular, frequent, intense, and longer.

[10] RM B said that the homeopathic tablet was a 'caulophyllum homeopathic preparation' used by midwives to help augment tightenings to become contractions and progress into labour. RM B said that she had studied homeopathy but did not complete her studies.

14. At 6.30pm, RM B assessed Miss A at home. RM B was unable to hear the baby's heartbeat on auscultation. RM B said that she asked Miss A and her partner when they had last felt the baby move, and they reported that it had been 'mid-morning'. RM B advised Miss A and her partner to present to the hospital immediately.

15. Health NZ advised that Miss A arrived at the hospital at approximately 6.55pm. The core midwife was unable to locate a fetal heartbeat. Two obstetricians attempted to locate the heartbeat, and both verified that a fetal heartbeat could not be located, including with a bedside ultrasound, and IUFD was confirmed.

16. Health NZ advised that initially it was reported[11] that Baby A had lethal acalvaria.[12] However, after a full investigation it was concluded that the head findings were secondary to post-mortem changes. The overall impression was 'unexplained stillbirth'.

17. The SER found that Miss A had experienced a prolonged latent phase[13] of labour.

Midwifery clinical advice (Appendix A)

18. HDC's in-house midwifery advisor, RM Nicholette Emerson, provided advice on the care provided by RM B.

Antenatal care

19. RM Emerson advised that all appropriate referrals, consultations, and escalations of care were completed by RM B until the day prior to 40 weeks' gestation and were in keeping with accepted midwifery practice. RM Emerson noted that RM B had had concerns about fetal growth and had referred Miss A for additional growth scans at 34 weeks' and at 37 weeks' gestation. On both occasions, the ultrasound scans did not identify or report any abnormalities, including growth concerns.

20. RM Emerson said that she is unable to comment on whether RM B was qualified to supply a homeopathy remedy[14] to Miss A. RM B had studied homeopathy but did not complete her studies. RM B advised that she worked closely with a registered homeopath. The clinical notes contain no documentation about any discussions with Miss A regarding the use of alternative therapies.

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[11] An MRI, X-ray scan, and clinical examination were completed after birth.

[12] A rare congenital malformation characterised by the absence of the flat bones at the top of the skull, and absence of the dura mater (the membrane under the skull bone) and associated muscles in the presence of normal cranial content and facial bones.

[13] RM Emerson advised that there is no uniform definition of the prolonged latent phase. However, it can be defined as a nullipara (a woman who has not given birth previously) who has not entered the active phase by 20 hours after the onset of the latent phase, or a multipara (a woman who has given birth previously) who has not entered the active phase by 14 hours after the onset of the latent phase.

[14] The New Zealand College of Midwives (NZCOM) consensus statement (2018) indicates that 'midwives incorporating complementary and alternative therapies into their practice should have either undertaken a recognised education programme or have referred their clients to the appropriately qualified practitioners'. The midwife is required to document the use of complementary alternative therapies in the woman's notes and identify the information shared and decisions made regarding the use of complementary therapies during the pregnancy, birth and postnatal period.

Clinical management of latent phase of labour

21. RM Emerson advised that many women having their first baby will go beyond a period of 20 hours in a latent phase. If prolonged latent phase is suspected, the case should be discussed with the on-call registrar. The overall condition of the woman must be considered, including her hydration and ability to cope with pain. RM Emerson is of the opinion that Miss A had a prolonged latent phase of labour.

22. RM Emerson is critical that the following factors were not considered by RM B in her management of Miss A during the latent phase:

- Miss A described her pain as being 'unbearable'. It is documented that Miss A requested pain relief and midwifery support four times in the preceding two days and had not slept overnight on the day of 40 weeks' gestation. RM B stated that Miss A did not appear to be in labour or pain. RM B advised that between day one of 40 weeks' gestation and the next day, Miss A did not report experiencing any tightenings or contractions when she was examined.
- Miss A had had two previous assessments for reduced fetal movements.
- Two days prior to 40 weeks' gestation Miss A was palpating small for gestational age.
- Earlier discussion with the obstetrician in light of the above factors and in the context of a prolonged latent phase of labour after 24 hours.

23. RM Emerson noted that RM B stated that she had spoken to the obstetrics team on the morning of the day after 40 weeks' gestation when Miss A was assessed at the hospital. RM Emerson also noted that RM B planned to consult the obstetric team the following morning if the latent labour continued.

24. However, RM Emerson is of the opinion that there was a moderate departure from accepted midwifery practice in not considering earlier consultation with the obstetrician given that Miss A had been assessed four times in the prolonged latent stage and had a history of two previous episodes of reduced fetal movement.

Documentation

25. RM Emerson advised that RM B did not document her discussion with the senior house officer on the day after 40 weeks' gestation, and that this was a moderate departure from accepted midwifery practice. RM B accepts RM Emerson's criticism in this regard.

26. In addition, RM Emerson is critical that fetal movements were not discussed or documented during the phone call at 2.15pm on the day after 40 weeks' gestation, as this is part of accepted midwifery practice. RM B documented that 'baby appeared happy and active'. RM B advised that she had reminded Miss A's partner about 'being reassured' by the baby's movements, but this was not documented in the clinical notes.

Response to provisional opinion

27. RM B responded to the provisional opinion. She acknowledged that pain is subjective but said that Miss A did not report experiencing any tightenings, contractions or pain. RM B said that when Miss A asked about pain relief, she was provided with this to help manage any pain symptoms at home during the latent phase of labour. RM B acknowledged that she

should have documented all discussions regarding fetal movements. She said that Miss A's recollection of events as described in her complaint does not align with the documented care that was provided.

28. Miss A was given an opportunity to respond to the provisional findings. No further comments were received from Miss A in response to the provisional findings.

Decision: RM B — Breach

29. Having reviewed all the information in this case, I find RM B in breach of Right 4(1) of the Code of Health and Disability Services Consumers' Right (the Code). Right 4(1) of the Code states that '[e]very consumer has the right to have services provided with reasonable care and skill'.

30. I acknowledge that RM B would have been reassured by her examination of Miss A from the day of 40 weeks' gestation and the following day, and that no abnormalities were identified during the antenatal period.

31. However, in my opinion, RM B failed to manage Miss A's prolonged latent phase of labour appropriately. As guided by RM Emerson's midwifery advice, I consider that there was earlier opportunity to discuss the management of Miss A's labour with the obstetrics team. RM Emerson advised that the overall condition of the woman must be considered when managing the latent phase. I consider that RM B did not fully take into account Miss A's history of two episodes of reduced fetal movements, the ongoing concerns about fetal growth, and maternal perception of pain, as part of her management of Miss A in the context of a prolonged latent phase of labour.

32. In addition, I accept RM Emerson's criticism that RM B's failure to document key discussions was a moderate departure from accepted midwifery practice.

Changes made since events

33. RM B is no longer a practising midwife.

Recommendation

34. I recommend that RM B provide a written apology to Miss A and her partner for the failings identified in this report. The apology is to be provided to HDC, for forwarding to Miss A, within three weeks of the date of this report.

Follow-up actions

35. A copy of this report will be provided to RM B and the Midwifery Council. The Midwifery Council will be made aware of my findings in the event that RM B decides to re-register as a midwife in New Zealand.

36. An anonymised copy of this decision will be sent to Health NZ.

37. An anonymised copy of this decision will be placed on the HDC website (www.hdc.org.nz) for educational purposes.

Nāku iti noa, nā

Rose Wall
Deputy Health and Disability Commissioner

Appendix A: In-house clinical advice to Commissioner

CLINICAL ADVICE — MIDWIFERY

CONSUMER : Miss A

PROVIDER : LMC RM B

FILE NUMBER : C21HDC00954

DATE : 28 February 2022

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

1. **I have reviewed the documentation on file:**
   Documents provided
   1. Letter of complaint dated 2021
   2. Further information from consumer dated 2021
   3. RM B's response received 2021
   4. Clinical records from RM B covering the period mid-2020 to early 2021 (bookmarked)
   5. Health NZ's response dated 2021
   6. Clinical records from Health NZ covering the period late 2020 to early 2021
   7. Health NZ's Serious Incident Review Report (redacted)

2. **Background:** RM B was the LMC midwife for Miss A in her first ongoing pregnancy at 31 years old. Medical history included polycystic ovarian syndrome. There is no surgical or obstetric history of note. BMI was normal at 22.9 at booking. During the pregnancy Miss A was referred to and seen by secondary services on three occasions, once for abdominal pain and diarrhoea and twice for reduced fetal movements. Latent labour commenced at 40+0 weeks' gestation. The latent phase continued, and Miss A was either assessed in hospital or seen at home by RM B on four occasions. On the fourth occasion Miss A was seen at her request (the day after 40 weeks' gestation at 6.30pm); no fetal heart was heard. Miss A and RM B drove to the local public hospital, where intrauterine fetal death was sadly confirmed. Miss A states that in the afternoon of that same day, she called RM B to raise concerns about prolonged labour and to request an induction of labour or caesarean section, but this was declined. RM B does not recall this request being made.

3. **Advice Request:** The Commissioner is seeking your opinion on the care provided by RM B to Miss A during her pregnancy and labour.
   1. Whether all appropriate antenatal tests and assessments were offered and undertaken; in particular, please comment on:

2. Whether all appropriate referrals, consultations and escalation of care were made.
3. The concern regarding Miss A's iron levels being mixed up with those of another patient.
4. The concern regarding RM B's provision of a homeopathic tablet used to encourage the onset of labour.
5. Clinical management of the latent phase of labour.
6. The concern that Miss A was not provided with adequate information to make a decision regarding autopsy for her baby.
7. Concerns regarding inappropriate communication.
8. Any other matters in this case that you consider warrant comment.

1. Whether all appropriate antenatal tests and assessments were offered and undertaken.
2. Whether all appropriate referrals, consultations and escalation of care were made.

Following review of RM B's midwifery clinical notes, in my opinion the care provided to Miss A prior to the latent phase of labour was in keeping with accepted midwifery standards with no departures.

All routine midwifery assessments were undertaken. In addition

- Miss A was assessed for pregnancy diabetes and returned normal results. The HbA1c in June was 35mmol/mol (normal range below 41) and the polycose in the second trimester was 3.6 (negative screen for gestational diabetes). Both results warranted no further action.
- Miss A was swabbed for a vaginal discharge at 21 weeks and five days.
- Miss A was referred to and seen by the obstetrician in September for abdominal pain and diarrhoea, follow-up stool sample reported Cryptosporidium. Obstetric advice stated follow-up antibiotics were not required.
- RM B was concerned regarding fetal growth, and growth scans were ordered at 34 weeks and at 37 weeks and six days. On both occasions, the results plotted Baby A's estimated weight on the 50th centile according to RM B and Health NZ's SAC report.
- On two occasions, at 28 weeks and nine days and at 33 weeks and six days, Miss A was referred and seen for an obstetric consultation regarding decreased fetal movements.

In my opinion, there are no departures from accepted midwifery practice up until the day prior to 40 weeks' gestation. In my opinion, all appropriate referrals, consultations and escalations of care were in keeping with accepted midwifery practice until the day prior to 40 weeks' gestation.

Of note, I am basing my opinion on the SAC report and RM B's notes. I have not obtained a copy of the scan reports, and it is possible that my opinion may be altered following review of the scan reports.

3. The concern regarding Miss A's iron levels being mixed up with those of another patient.

- Iron ferritin levels were below normal range at 14 (normal range of Ferritin is 20–200ug/L) and oral iron supplementation was appropriately ordered in November. This is in keeping with accepted midwifery practice.

4. The concern regarding RM B's provision of a homeopathic tablet used to encourage the onset of labour.

RM B gave Miss A a homeopathic remedy (Caulophyllum) on the day after 40 weeks' gestation. Miss A took the remedy and is concerned.

New Zealand College of Midwives (NZCOM) consensus statement on complementary and alternative therapies states the following (last update 2018)

- *Midwives incorporating complementary and alternative therapies into their practice should have either undertaken a recognized education programme or have referred their clients to the appropriately qualified practitioners [1, 3].*

- *Each therapy has its own underpinning theory, and it is essential to understand the mechanism of action, indications, contraindications and precautions, side-effects and complications relating to each therapy or remedy used by, or advised on, within midwifery practice*

I cannot comment on whether RM B was qualified to supply the homeopathic remedy; however, she states in her complaint response that she works closely with a homeopath. RM B studied homeopathy but did not complete her studies. I am not qualified to comment on the homeopathic remedy supplied to Miss A.

5. Clinical management of the latent phase of labour.

40 weeks' gestation, 7am - midwifery clinical notes document irregular tightenings since previous day lasting 10 seconds. Good fetal movements reported.

10.40am - Miss A requested to be seen on ward. Same done. 11am clinical documentation states that Miss A is not in established labour. Vaginal examination is undertaken at Miss A's request. The findings are 2cm dilated and 50% cervical effacement. Plan to return to a family home 20 minutes away as opposed to own home, one hour away.

3.30pm - home visit with no change on vaginal examination. Active baby recorded.

<u>Following day</u>

5am - message.

6am - Miss A seen in hospital. Still no change in dilation. Neither Miss A nor her partner had slept the previous night. On discussion with the clinical charge midwife, RM B states it was agreed that Miss A did not present as being in labour and home was the best place to establish in labour. It is stated that Miss A requested to be admitted and questioned how

she would manage the pain. RM B states that hospital policy would not accommodate admission and pain relief options for latent labour. Miss A was given two oral Panadol.

2.15pm - phone call from Miss A's partner Mr C. No change but concerned long labour may be harmful to baby. Fetal movements not specifically discussed in this phone call but documented as happy and active. Plan to reassess at 6.30pm and discuss with obstetrician the following morning if labour not established.

6.30pm - visit at home. Fetal heart not found. Last movements felt earlier in day. Immediate transfer to hospital.

1. Latent phase of labour

This phase of labour up to 4cm dilation is considered the latent phase of labour. In this period the cervix is effacing, and dilation is beginning.

1. *NICE (2007) recommend the following definition of latent phase — a period of time, not necessarily continuous, when there are painful contractions and there is some cervical change, including cervical effacement and dilatation up to 4cm and the onset of active labour when there are regular painful contractions and there is progressive cervical dilatation from 4cm.*
2. ***DIAGNOSIS OF PROLONGED LATENT PHASE*** *— There is no uniformly accepted definition for a prolonged latent phase. It had been defined by Friedman as a nullipara (woman who has not previously given birth) who has not entered the active phase by 20 hours after the onset of the latent phase and a multipara (woman who has previously given birth) who has not entered the active phase by 14 hours after the onset of the latent phase (up to date Literature* ***review current through:*** *Jun 2018.)*
3. Further definitions include prolonged latent labour as defined by a period of two to three days or, a phase longer than eight hours. The latter definition is taken following admission to hospital and does not take into account latent labour at home.
4. *Diagnosis of the latent phase is not an exact science. The overall condition of the woman must be considered including her hydration and ability to cope with pain. If prolonged latent phase is suspected, the case should be discussed with the on-call registrar. In some cases, particularly if the gestation is post mature, it may be appropriate to induce labour. (Middle Essex Hospital NHS; reference to NICE Guidelines)*

Accepting that many women having their first baby will go beyond a period of 20 hours in a latent phase, I consider that Miss A had a prolonged latent phase of labour. In forming an opinion, I have considered the following:

- Many women will have a prolonged latent phase of labour and progress to normal birth; however, there are risks associated with prolonged latent labour. Reviewed research is not conclusive regarding whether the risks for the neonate were previously present or whether they are associated with intervention such as induction of labour; so subjectively an expectant management approach could be argued equally with a management (induction of labour) approach (Sagunam 2019).

- Pain is subjective and, although Miss A did not appear to be in labour or in pain according to RM B's response, Miss A had requested midwifery support four times in the previous two days and had not slept overnight on the day of 40 weeks' gestation. RM B states in her complaint response that tightenings were irregular and Miss A didn't appear to be in pain. RM B further states if she had rung an obstetrician requesting an induction of labour, she would have been '*outrightly declined*'. Miss A states in her complaint that the pain was unbearable.
- A plan to discuss the prolonged latent phase of labour with the obstetrician on the morning of 40+2 weeks' gestation has been outlined in the complaint response; however, on arrival for home assessment the day before, no fetal heart was heard. It was later reported that the last time fetal movements were felt that day was late morning. I am critical that fetal movements were not discussed or documented during the phone call at 2.15 as this is part of accepted midwifery assessment.
- In forming an opinion, I have considered that Miss A had two previous assessments for reduced fetal movements, so this was worthy of consideration in the management of the long latent phase. Whilst these episodes were at 28 and 33 weeks, they warranted consideration in my opinion. *Perception of altered or decreased fetal movements is associated with stillbirth. (Bradford 2019) Clinical practice guidelines emphasise the importance of acknowledging women's subjective concerns about a change in fetal movements rather than fetal count per se.*
- Another consideration was that, at two days before 40 weeks' gestation, Miss A was still not measuring to dates but plotting on the 50th centile for estimated weight according to RM B and Health NZ's SAC report.

Summary

In forming an opinion regarding the latent phase of labour, reviewed literature is not clear regarding what is considered a prolonged latent phase of labour or whether it is better to proceed with an induction of labour (obstetric decision) or to await the establishment of labour. For Miss A, there had been no appreciable change in labour establishment in well over 24 hours, and she had requested support and pain relief on four occasions, and neither she nor Mr C had slept the night of 40 weeks' gestation. There was a history of two occasions of reduced fetal movements and ongoing concern regarding fetal growth.

A reasonable midwife might consider that the episodes of reduced movements had not been recent and the referral for growth scans had been reassuring, plotting Baby A's estimated weight on the 50th centile.

It is impossible to say whether the outcome would have been different if RM B had formally consulted with an obstetrician earlier on 40+1 weeks' gestation; however, considering the history of reduced movements, persistent concern regarding growth and maternal perception of pain, I am critical that these considerations were not made and an earlier conversation with the obstetrician undertaken. I am also critical fetal movements were not recorded in the phone conversation at 2.15pm at 40+1 weeks' gestation. In my opinion, there is a moderate departure from accepted midwifery practice in not applying the pregnancy history of two episodes of reduced movements, ongoing concerns regarding fetal

growth and Miss A's request for pain relief and discussing these concerns with an obstetrician in the context of a prolonged latent phase of labour after 24 hours.

6. The concern that Miss A was not provided with adequate information to make a decision regarding autopsy for her baby.

Day of stillbirth, 7.39pm - post mortem discussed briefly, to rediscuss later (Obstetrician, Dr Shaw).

Following Baby A's stillbirth, the following documentation is found in Health NZ's clinical notes.

2.30pm - Paediatrician at Health NZ discussed post mortem, options, process and post mortem alternatives. Family need time to consider. Laboratory examination of placenta consented.

3.10pm - post mortem declined. (RM B)

7.20pm - discussed options again. Yes X-ray, No Autopsy (post mortem) (RMat Health NZ)

Two days later - post mortem asked twice and declined (annotated on Stillbirth and Neonatal Death Checklist and Handover Tool)

Miss A states that inadequate information was provided to her regarding a post mortem for Baby A. Miss A states that she was not aware that there was a funded option to accompany Baby A's body for the post mortem.

As the decision making and post-mortem or alternative procedures are somewhat time dependant, the information is often relayed at a very vulnerable time. It can be difficult to find a balance between providing the necessary information and applying pressure for a definitive response.

In my opinion, there appears to be several discussions regarding a post mortem or alternatives and no departures from accepted midwifery practice (noting two of these discussions were not midwives). I am not able to comment further regarding making Miss A and family aware of options. I do acknowledge the vulnerability and difficulty absorbing and processing information at this time. I am unable to say whether there was/is a funded option to accompany a loved one out of region for a post mortem. I note that SANDS also visited in this time but cannot comment whether aspects of a post mortem were discussed, but I do note that the Stillbirth and Neonatal Death Checklist and Handover Tool designates this discussion as a doctor and not a midwife responsibility.

7. Concerns regarding inappropriate communication.

I have not identified any instances of inappropriate communication in the clinical notes provided.

8. Any other matters in this case that you consider warrant comment.

Documentation.

Obtaining copies of the ultrasound scans has not been possible prior to writing this report as RM B states that she has left midwifery practice and does not have access to her clinical notes. The circumstances are not clear; however, maternity records must be retained for a minimum of 10 years following the date of the last entry. Legal and professional responsibility requires protection of stored documents and records, including laboratory reports and scans.

Information outlined in the Midwifery Council's paper on Documentation and Record Keeping:
https://www.midwiferycouncil.health.nz/common/Uploaded%20files/Be%20series/Be%20Safe%204%20Documentation%20and%20record%20keeping%20F.pdf

If RM B's records for the last 10 years cannot be accessed, this would be considered a moderate to severe departure from accepted midwifery practice. I note that clinical notes have been provided for this report (with the exception of the scan reports and laboratory reports - only screen shots provided).

Finally, I extend my heartfelt condolences to Miss A and Mr C for the loss of their precious baby. I hope this report addresses some of their unanswered questions.

Nicky Emerson BHSc — Midwifery, PG DipHSc,

Midwifery Advisor
Health and Disability Commissioner