Independent Midwife, Mrs B

A Report by the

Health and Disability Commissioner

(Case C09HDC01311)

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

Table of Contents

Executive summary 1
Investigation process 1
Information gathered during investigation 2
Opinion: Breach — Mrs B 11
Recommendations 18
Follow-up actions 18
Appendix A 19
Appendix B 27

Executive summary

1. Mrs A, aged 30, became unwell with vomiting around 37 weeks into her first pregnancy. She made contact with her independent midwife and lead maternity carer, Mrs B, at least twice in two days regarding her symptoms. Mrs B had two other clients in labour during this period. She considered Mrs A had a gastric bug and did not visit her. Mrs B did not routinely perform urinalysis during the pregnancy.

2. Mrs A's symptoms persisted. The following day she visited a GP, who considered she had signs of pre-eclampsia and sent her for urgent blood tests. The abnormal results of the tests indicated that Mrs A was unwell and should be hospitalised that evening. Mrs B was advised of the results, but decided that Mrs A could wait and see her at the hospital the following morning — an appointment that had been previously scheduled.

3. On the following morning, Mrs A had further tests and saw a specialist at the hospital. Her condition had worsened overnight and severe pre-eclampsia was diagnosed. Mrs A's baby had to be quickly delivered, three weeks early, by emergency Caesarean section under a general anaesthetic.

4. Mrs B was the designated LMC and responsible for her client's pregnancy care. She failed to recognise, and react in an appropriate fashion to, Mrs A's ongoing symptoms. The midwifery care provided was substandard, and Mrs B was found in breach of Right 4(1) of the Code of Health and Disability Services Consumers' Rights. She also breached Right 4(2) as her documentation was not of an appropriate standard or completed in accordance with professional midwifery standards.

Investigation process

5. On 5 June 2009 the Commissioner received a complaint from Mrs A about the services provided to her by independent midwife Mrs B. The following issues were identified for investigation:

6. *Whether Mrs B provided Mrs A with midwifery services of an appropriate standard, particularly over a period of six days in 2009.*

7. During the assessment of this complaint, preliminary expert advice was sought. The advice provided did not identify any significant concerns about the services provided by GP Dr C.

8. An investigation into the care provided by midwife Mrs B was commenced on 1 December 2009. Information was obtained from the following parties:

Mrs A	Consumer/Complainant
Mrs B	Midwife, Provider
Mr D	Lawyer

Names have been removed (except the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

Dr C General Practitioner
A Medical Laboratory
The District Health Board

9. Independent expert advice was obtained from midwife Ms Mary Wood (attached as Appendix A). The relevant midwifery standards are attached as Appendix B.

Information gathered during investigation

10. Mrs A appointed Mrs B as her midwife lead maternity carer (LMC) in July 2008, in the first trimester of her first pregnancy. She saw her LMC eight times throughout her pregnancy.

11. Mrs A's pregnancy was uneventful until 37 weeks' gestation. She attended scheduled appointments where Mrs B did not perform routine urine dipstick checks for protein or glucose. At the initial antenatal booking visit (on 1 September 2008 at approximately 10 weeks and 4 days' gestation), Mrs B noted that there was no significant family history. Mrs A's blood pressure was recorded as 130/82 and her weight was 74 kg.

12. Mrs A's first antenatal blood test on 22 July 2008 included a platelet count of 201.[1] By the second antenatal blood test (at 28 weeks) performed on 15 December 2008, the platelet count was 151. The 15 December blood test was negative for gestational diabetes but showed a slightly low serum ferritin result indicating a depletion of iron stores. A mid-stream urine test (MSU) at this time indicated a urinary tract infection. The last face-to-face antenatal visit Mrs A had from Mrs B was on 23 February 2009.

Vomiting symptoms

13. Mrs B's antenatal notes provided to HDC record a phone discussion with Mrs A a few days later. The entry is dated "Saturday" but is slightly unclear as it appears to have been overwritten.[2] It reads:

> "Rang with vomiting PM.
> unable to keep food down.
> Has no diarh [diarrhoea]
> But upset tummy.
> F mvts [fetal movements] good etc no abdominal pain
> Advised to Rest and call Back if any."

14. Mrs A does not recall any discussion that day, but she does remember first starting to feel unwell the previous evening.

[1] Normal platelet count range in pregnancy is 150–450 (or 150,000–450,000 platelets per microlitre of blood).

[2] Mrs B subsequently responded that this entry should have been dated Sunday.

Names have been removed (except the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

15. On Sunday, Mrs A telephoned Mrs B at around 11am to inform her that she had been vomiting for two days. Mrs B instructed her to avoid food and keep up a good fluid intake, suggesting it was a "bug". She warned Mrs A that she would probably develop diarrhoea in the next day or so.

16. Mrs B had a long and busy Monday as she had two clients in labour that day. One client went into labour at approximately 4.30am and delivered normally at 11.09am. Her second client went into labour at approximately 1pm and delivered at 4.22pm (by Caesarean owing to a breech presentation). Mrs B left the hospital that day at approximately 5.30pm.

17. Mrs B sent texts to her antenatal clients who were scheduled to see her that Monday afternoon (including Mrs A) notifying them of rescheduled appointment times. In Mrs A's case the new appointment was for Wednesday. Mrs B received no reply to her text and she assumed all was well. Mrs A has confirmed that she did not reply to Mrs B's text, but instead called her in the evening.

18. Mrs A telephoned Mrs B on Monday evening as her symptoms were persisting. Mrs A's phone records indicate that she called Mrs B at 8.38 and 8.39pm. Mrs A first tried Mrs B's mobile and heard a voicemail message saying that she wasn't available, and giving contact details for another midwife. Mrs A did not record all of the contact number so immediately rang Mrs B's mobile again. This time it was answered by Mrs B, who instructed Mrs A to ring her back on her home line, which Mrs A did, speaking for about three-and-a-half minutes.

19. Mrs A had continued vomiting, had decreased urine output, which was very concentrated, and she could not keep down water. She had not developed diarrhoea. She was given the same advice as previously by Mrs B — that she had a bug, to avoid food, and to keep up fluids — and was told that her urine was dark because she was probably dehydrated. Mrs B did not offer to see Mrs A.

20. A routine full blood count at 36 weeks was not performed. Mrs B had intended giving Mrs A a blood test request form at the cancelled appointment (at 37 weeks), to check her iron levels before the labour. (Mrs A took an over-the-counter pregnancy supplement containing iron prior to her pregnancy and on and off during it. It made her feel "a bit sick" so she didn't take it every day. Mrs A recalls Mrs B telling her to try to keep taking it.)

Visit to GP

21. On Tuesday Mrs A's symptoms were persisting so she decided to see a doctor. She called her GP clinic at 2.38pm and an appointment was made for 4.00pm. She saw Dr C. Her usual GP at the practice she attends was unavailable.

22. Dr C's contemporaneous notes for Tuesday record Mrs A's phone call to the clinic:

> "P/call from pt. Is pregnant and due in 2 and a half week. Has been sick for 4/7. Advised by midwife to stop eating food. Today has a sore stomach, vomited x1

HDC

Names have been removed (except the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

this morning. Nil diarrhoea. Urine very dark. Having difficulty keeping fluids down.

Plan: Pt TCI [to come in] and review with a DR this afternoon. Appointment booked with [another doctor] at 1600."

23. At the 4pm consultation Dr C took a history and examined Mrs A. She found that Mrs A's blood pressure was elevated and that protein was present on a urine dipstick. She made a provisional diagnosis of pre-eclampsia[3] and sent Mrs A for urgent blood tests.

24. During the consultation, and in Mrs A's presence, Dr C called Mrs B's cellphone and apprised her of the situation. Dr C informed Mrs B that Mrs A had been assessed, had suspected pre-eclampsia with high blood pressure and proteinuria, and was being sent for urgent blood tests. Dr C told Mrs B to expect to receive the urgent test results that evening. Dr C's phone records indicate that the call took place at 4.09pm.

25. Dr C asked Mrs B to contact Mrs A once the results were through, and told Mrs A that she (Dr C) would also contact Mrs A if the results were concerning. If the results were normal, Dr C recommended that Mrs A see Mrs B the following morning.

26. Phone records indicate that Mrs B made a call from her cellphone to Mrs A's cellphone at 4.57pm on Tuesday. Neither Mrs A nor Mrs B made any reference to this call in their initial submissions to HDC. Mr and Mrs A have no recollection of this call. After reviewing her phone records, Mrs B responded that the call (of just over six minutes' duration) would likely have been a discussion about tests being ordered, waiting for the results before deciding on the next step, and confirming the appointment for 9.30am the following day.

Midwife's antenatal records

27. Mrs B's midwifery notes for the period Sunday to Tuesday are brief and difficult to follow. There are no entries specifically dated Monday or Tuesday, but there is a reference to "Mon Tues".

28. An entry for Sunday states:

"didn't here [sic] from [Mrs A].
Mon. Tues — not any contact.
Bloods → by GP at 1630.
OK. → lunchtime,
3pm sick again been to GP
Bloods
BP 160/100. No much
Swelling. Δ. PET[4] Starting. Bloods check am"

---

[3] Pre-eclampsia is a serious condition that may develop in late pregnancy. The condition is characterised by a sudden rise in blood pressure, weight gain, generalised oedema, proteinuria, severe headache, and visual disturbances, and may result in eclampsia if untreated.

[4] PET — pre-eclamptic toxaemia.

Names have been removed (except the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

Medical laboratory records

29. The medical laboratory records confirm that Mrs A attended the laboratory at 4.30pm on Tuesday and urgent bloods were taken. Specimens were registered at the laboratory at 5.01pm.

30. On Tuesday Dr C rang the laboratory at 6.15pm,[5] the end of her working day, as she had not yet been faxed all the results she was expecting.[6]

31. The results were given to Dr C over the phone by a scientist, and included a low platelet count (100) and abnormal liver function results. The scientist recorded a comment “spoke to [Dr C] regarding results”. Dr C informed HDC that she requested that the results be urgently faxed to her and Mrs B.

32. The full blood count (including platelet count) had been faxed to Dr C at 5.41pm. Interim urine results had been faxed to Dr C at 6.11pm. All other blood results were faxed to Dr C at 6.29pm.[7] All of these results were sent electronically to Dr C between 5.41pm and 6.45pm on Tuesday.[8] The electronic results sent to Dr C’s inbox by the laboratory on Tuesday state “copy to: [Mrs A], [Dr C]”.

33. Final urine results were faxed to Dr C at 12.08pm on Wednesday. All results were printed and sent to Mrs B by the laboratory; however, these were posted via regular mail on Wednesday and were not faxed to Mrs B.

34. When queried, the laboratory informed HDC that a handwritten note on the laboratory request form read, “Ring [Mrs B] first if abnormal, and if you can’t get hold of her, ring [Dr C]”, and that there was no request for results to be faxed to Mrs B and no fax number on the request form. The laboratory’s computer system has no fax number entry for Mrs B. The laboratory cannot be sure, but they assume that the scientist who spoke to Dr C first tried to ring Mrs B on the business number contained in its system.

Ensuing telephone discussions

35. Upon receiving the Tuesday laboratory test results over the phone, Dr C rang and spoke to Mrs A’s husband, as Mrs A was unwell. This call lasted one minute and 26 seconds and occurred at 6.21pm. Dr C told him that his wife’s blood results were abnormal and that she needed to go to hospital. Dr C instructed him to get his wife’s bag ready, and said that they should hear from Mrs B shortly as Dr C was about to phone her to ensure she had received the results.

---

[5] This call lasted four minutes and three seconds.

[6] The laboratory has a 24-hour urgent result service. Any referrer can phone 24 hours, 7 days a week and speak to a scientist to obtain results.

[7] At this time results requiring faxing were manually faxed by laboratory staff using the Laboratory Information System (LIS) once results became available. (In 2010 an automated faxing system was introduced for results.)

[8] The laboratory confirmed that the liver function, electrolyte and renal function results were electronically entered into the LIS at 6.20pm. These results were available on the instrument and/or interface at least a few minutes before they were electronically sent into the LIS, meaning that the scientist had time to discuss them with Dr C before the results were entered into the LIS.

Names have been removed (except the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person’s actual name.

36. Dr C then rang Mrs B for the second time that day. This call lasted 1 minute 47 seconds and occurred at 6.23pm. Dr C told HDC:

> "I then phoned [Mrs B] at home on her home phone. I discussed the blood tests over the phone as she had not received the fax. I went through all [Mrs A's] abnormal blood tests and told [Mrs B] the levels and normal values of each. This includes [Mrs A's] platelets and liver function tests. We discussed the fact her platelets were 100. [Mrs B] stated to me that although this was low she was happy the patient would be OK overnight and would continue with the planned visit at 9.30 the next morning."

37. Mrs B considers it is "difficult to comprehend" how all the information could have been conveyed in a call of that length.

38. Although not recorded in her entry in the medical records, Dr C's accompanying response to HDC explained that she informed Mrs B that the couple had already been told (by her) that Mrs A would need to go to hospital that night and Mrs B was going to make contact that evening. Dr C stated to HDC that "[Mrs B] said she would 'take it from here'".

39. After the phone call, Dr C documented the blood test results, the conversation, and Mrs B's decision in the clinical notes. Dr C's computerised clinical records show that the entry in the clinical record was last updated at 6.27pm.

40. Dr C recorded:

> "Vomiting since Sat. No diarrhoea Not keeping fluids down Feeling generally unwell. O/E p=80 BP=160/100 abdo 38 weeks preg Head down FMF [Fetal Movements Felt]. No major pitting.
>
> urine=dipstick protein + + + +. for urgent bloods. [Mrs B] contacted and will ring tonight and see tomorrow. PET.
>
> bloods — plts [platelets] 100 alt 177 ast 165 alp 667 alb [albumin] 33 crp 36.7 — phoned and discussed results with [Mrs B] — she will see in [the] hospital tomorrow."

41. When Mrs B did not make contact, Mrs A called Mrs B at home that night. The telephone records indicate that this call occurred at 8.01pm. Mrs A established that Mrs B had spoken with Dr C and received the test results. Mrs A recalls that she told Mrs B during this call that Dr C had recommended she be in hospital. Mrs A recalls Mrs B telling her: there was no need for that; her platelets were down a bit but it was nothing to worry about; and that she would see her the following morning at the hospital at 9.30am as planned.

42. *Hospital admission*
On Wednesday Mrs B assessed Mrs A at the hospital in the morning as planned. Mrs B sought immediate specialist advice on reviewing the full test results from the

Names have been removed (except the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

previous day. Further blood tests were performed. Mrs B recorded in her antenatal notes (written retrospectively after Mrs A was seen at the hospital) that there had been severe deterioration overnight when the previous day's results were compared with those taken at the hospital. Mrs B recorded a footnote: "If GP was concerned about [patient] she was well within her scope of practice to confer with registrar at [the public hospital]."

43. The registrar admission notes for that day record Mrs A's four-day history of vomiting and lethargy and note some right upper quadrant and epigastric pain, a pre-headache feeling and slight oedema. The records show that on Wednesday morning the platelet count had dropped to 69.

44. Mrs B recorded initial entries in the hospital notes on Wednesday at 9.15am, including noting that:

> "[Mrs A] has had well pregnancy
> till [Sunday] when vomiting
> 6x on Sunday and eating minimal
> no [diarrhoea] = felt off monday
> But no contact [with] me. Now 1x daily."

Emergency Caesarean section

45. The specialist saw Mrs A and told her she had HELLP[9] syndrome and needed her baby delivered quickly. Mrs A was admitted to the high dependency unit for a magnesium sulphate infusion and steroid injections. Around noon, about three hours after admission, the baby was delivered — three weeks prematurely by emergency Caesarean section under a general anaesthetic. Mrs A was unhappy that Mrs B remarked to her, in the lead-up, "Isn't that exciting — your baby will be here today." Mrs A was distressed by this comment.

46. Following the surgery, Mrs A spent two nights in acute observation, followed by a ward stay. Mrs B visited Mrs A three times in hospital postnatally.

47. Mrs A was advised by the specialist that her LMC would need to monitor her blood pressure closely postnatally. Mrs A felt no confidence in Mrs B to carry out the monitoring and requested a change in LMC. Mrs A's husband notified Mrs B of their decision to end their relationship with her. Mrs A was discharged home, on blood pressure medication, six days after the birth.

Initial information provided by Mrs B

48. In her initial response to HDC, Mrs B recalled Mrs A phoning her on Sunday complaining of vomiting. She did not recall Mrs A mentioning a time frame of two

---

[9] HELLP syndrome refers to a syndrome, usually of late pregnancy, characterized by Haemolysis, Elevated Liver enzymes, and a Low Platelet count. The syndrome constitutes an obstetric emergency. The most common clinical presentation is abdominal pain and many patients also have nausea, vomiting, and malaise, which may be mistaken for a non-specific viral illness or viral hepatitis. Hypertension and proteinuria are present in approximately 85 percent of cases, but may be absent in women with otherwise severe HELLP syndrome. (From www.uptodate.com accessed 4 August 2009).

Names have been removed (except the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

days, despite the notes she submitted to HDC with her initial response indicating that a discussion took place on Saturday. She considered that had Mrs A indicated such a time frame she would have been concerned. Mrs B assessed Mrs A as having a "tummy upset" and advised her that she might develop diarrhoea, and said to contact her again if she got worse. Mrs B stated that she heard nothing further from Mrs A.

49. Mrs B did not recall Mrs A contacting her on Monday and felt that had she been contacted by Mrs A, she would have asked her to come in for an assessment, as she was at the birthing suite that day.

50. Mrs B considered that the next contact she had regarding Mrs A, following the call on Sunday, was when she received a call from Dr C (which Mrs B thought was at about 4.45pm) on Tuesday informing her that Mrs A's blood pressure was elevated and that she had been sent for urgent blood tests, the results of which would be available that evening. Mrs B's recollection is that "there was no mention of possible pre-eclampsia" and that she received "no further communication from the doctor".

51. Mrs B stated that she received no further blood results from the lab that evening apart from an "electrolite albumin result advising that it was 33, below the normal rate range. On its own that result did not cause any immediate concern".

52. Mrs B did not recall having a conversation with Mrs A on Tuesday and believed that she had discussed with Dr C, in their conversation that day, that she would meet up with Mrs A at the hospital at 9.30am the next day "regardless of what happened" and Mrs A should bring her bag with her "just in case". Mrs B reiterated that she did not have any results other than the albumin, and she "certainly didn't have the platelet results". She stated further that "neither the laboratory or the GP provided me with any further information … that would have caused me to react".

53. Mrs B responded that on Wednesday morning she did not have the opportunity to explain to the couple that she had not been provided with all relevant information the preceding evening and, had she been, she would most certainly have arranged for Mrs A to be admitted the previous evening. She maintained: "I was let down by the GP and/or laboratory who failed to notify the results to me on the Tuesday evening."

Mrs B's response to investigation

54. After Mrs B was notified of HDC's intention to formally investigate Mrs A's complaint — and Mrs B had viewed Mrs A's feedback on her initial response, Dr C's account of events, and information provided by the laboratory — Mrs B responded, via her lawyer, Mr D, that she had carefully checked her notes, her recollection of events, and her initial response to the complaint. She acknowledged that her initial response was honest but "inaccurate in some respects".

55. Mrs B has no recollection or notes relating to Mrs A's calls to her on Monday but accepts that the calls were made. She believes that the time and length of the call that evening at 8.39pm (3 minutes 21 seconds) indicates that she would have enquired as to actual and possible symptoms, but the continued absence of any other symptom

Names have been removed (except the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

other than vomiting did not suggest any urgency or need to react with an out-of-hours attendance.

56. Mrs B maintains that there was no specific mention of pre-eclampsia in Dr C's call to her (which she thought was around 4.45pm but Dr C's phone records show was at 4.09pm) on Tuesday. Mrs B has no recollection of proteinuria being mentioned but stated that it is "quite possible that it may have been".

57. Mrs B maintained that she received only one lab result on Tuesday evening, but that it must have been the Complete Blood Count (CBC) including the platelet result (and not the albumin result on its own as she had previously thought, which she received from the lab by mail the next day). She also responded that it was probably Dr C who phoned her with the CBC result (and not the lab). She has no written record of receiving the result by phone. She has no recollection of being informed of any result other than the platelets, or being told by Dr C that Mrs A had been informed that she needed to go to hospital.

58. Mrs B acknowledged that Mrs A did call her briefly on Tuesday at 8.01pm, and believes that the call was of short duration because she had received only one test result and had already had a lengthy discussion earlier during the 4.57pm call.

59. Mrs B is of the view that as Dr C had seen and assessed Mrs A it was open to Dr C to admit the patient to hospital if she had sufficient concerns, but Dr C did not do so and "allowed [Mrs A] to go home". Mrs B considers it was therefore appropriate for her to wait and see what picture the results indicated and, assuming the patient did not deteriorate, have the results communicated to her before anything further happened.

60. Mrs B stated that she did not check the results with the lab because "the normal procedure is for the practitioner ordering the tests to receive them and take the necessary action on the basis of the results".

Urinalysis

61. In response to Mrs A's concern that urine dipstick test checks were not performed throughout her pregnancy, Mrs B commented that she had previously performed routine dipstick tests for her clients. However, in the course of her practice and on the advice of specialists she worked with (with reference to relevant literature), she adopted the view that the practice of performing a dipstick urine test routinely during pregnancy did not need to occur and she ceased doing so.[10] Laboratory mid-stream urine tests did occur on 15 December 2008 and 12 January 2009.

62. Mrs B therefore considered that as she was aware of up-to-date information relating to the correlation of proteinuria/pre-eclampsia, a GP's urine test showing proteinuria would not, on its own, have been significant to her. She considered that it was more

[10] Mrs B provided a copy of an article entitled "An essential diagnosis" from *Tall Poppies*, Volume 6 Issue 20, dated 1 October 2009. The article summarised a systematic review of test accuracy studies, sourced from *BMC Medicine*, 24 March 2009. The review aimed to determine the accuracy with which the amount of proteinuria predicts maternal and fetal complications in women with pre-eclampsia.

Names have been removed (except the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

crucial that Dr C did not order a urine test for a protein creatinine ratio (PCR)[11] to confirm the provisional diagnosis of pre-eclampsia.

Changes to practice

63. Mrs B indicated that as result of Mrs A's complaint, she has made changes to her practice including: improving communication with GPs; being more particular about record-keeping and making a written record of all calls to/from patients other than routine matters such as changing appointments; insisting that the results of any abnormality in blood/urine tests (whoever orders them) are communicated to her by phone by the lab; following up any instance where an illness extends beyond 24 hours without there appearing to be a resolution; and continuing her on-going education and workshop attendance.

Subsequent response from Mrs B

64. In response to a request from HDC to transcribe a page of the antenatal notes (as some entries were difficult to decipher), Mrs B submitted, after her two previous responses, that where she had dated an entry that appeared to be Saturday (it was somewhat unclear as the date had been overwritten) it was intended to be dated Sunday. She has subsequently altered her notes by crossing out this date. In addition, Mrs B added the date for Tuesday beside one of her entries.

65. Mrs B also advised in her response that all entries in the notes from Saturday onwards were written retrospectively after the birth of Mrs A's baby, and that one of the phone call times was mistakenly recorded as "pm" when it was an "am" call.

Response to provisional opinion

66. Mrs B reiterated in her response to my provisional opinion that her continued recollection is that she had only one blood test communicated to her. She is genuinely at a loss to reconcile that view with the information supplied by Dr C. She is bewildered at apparently being given results she didn't react to.

67. As such, Mrs B made further enquiries of her own to the laboratory regarding its process and submitted responses she obtained to HDC (see page 5). She responded that she was not aware of which laboratory Dr C had sent the results to, nor was she aware of any arrangements to obtain after-hours results, having never previously required that service. She has now ascertained the method by which she can obtain copies of results from a laboratory when necessary.

68. Mrs B unreservedly accepted that her record-keeping was not of an appropriate standard, and tendered an apology because her lack of record-keeping made this investigation more difficult. In relation to urinalysis, in the earlier part of her career she routinely tested urine. She ceased to do so on specialist advice, but now accepts that it is part of standard practice and routinely carries it out.

[11] The ratio of protein to creatinine in the urine, calculated as a measure of proteinuria.

Names have been removed (except the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

Action taken

69. Mrs B informed HDC that the Midwifery Council undertook a review of her competence in December 2009. She accepted its findings and is currently continuing to implement a programme set down for her by the Council. This included her attending the New Zealand College of Midwives' *Dotting the i's, Crossing the t's (midwives and record keeping)* workshop in mid-2010. She was enrolled for an APEC (Action on Pre-eclampsia) study day in November 2010. The balance of the programme's components are being undertaken and she continues to participate in professional re-certification requirements on an ongoing basis.

70. Mrs B supplied HDC with a letter of apology for forwarding to Mr and Mrs A.

Opinion: Breach — Mrs B

Information relied on

71. I have been provided with differing recollections of events throughout this investigation. On the one hand, Dr C and Mrs A have provided information that has been consistent, and compatible with each other's recollections. On the other hand, Mrs B has had difficulty recalling events (hindered no doubt by the standard of her documentation) and, as a consequence, has provided information that is inconsistent and inaccurate.

72. In light of this, I have given more weight to the information provided to me by Dr C and Mrs A. Dr C's account of events is supported by contemporaneous notes, laboratory records, and phone records. Indeed, the phone records of Dr C's back-to-back calls to the laboratory, the couple, and Mrs B at 6.15pm, 6.21pm, and 6.23pm respectively, followed by her updating the clinical records at 6.27pm, reflect the immediacy and diligence of her actions and support the accuracy of her account. Mrs A was also able to support her version of events with phone records, and she remained consistent throughout this process.

73. I am wary of Mrs B's recollection owing to her own admission that the antenatal notes over this crucial time period (from when Mrs A first notified Mrs B that she was vomiting up until the birth) were written retrospectively. These entries were not marked as being made in retrospect, and some were made up to four days later. This important fact was not revealed until Mrs B was asked to transcribe her notes. In addition, Mrs B's initial response to the complaint differed substantially from her later response. I note Mrs B's apology for the factual errors in her earlier response, and her statement that there was no deliberate intention to deceive. However, I remain unconvinced by aspects of her version of events.

Initial management

74. Mrs A recalls first contacting Mrs B on Sunday, while she was 37 weeks pregnant, as she had been unwell and had been vomiting for two days. Mrs B did not ask Mrs A how long she had been ill. If a client does not volunteer information that is needed to

Names have been removed (except the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

help form a diagnosis, such information should be asked for. It is unreasonable, in my view, to account for such information not being known because a patient did not proactively provide it. As my independent expert midwife, Ms Mary Wood, noted:

> "As a practitioner myself, I cannot imagine not asking a woman who has contacted me in this situation, how many times she had been sick and how long she had been sick for, even if the woman didn't offer the information in the first instance."

75. I note that Mrs B made an entry in her records that she did not hear further from Mrs A, and she apparently did not consider calling her client to see how she was.

76. Mrs B accepts that Mrs A telephoned her again the next day (Monday) at 8.39pm. When Mrs A contacted Mrs B with continuing symptoms (and dehydration also seemed apparent), I would have expected Mrs B to have then reviewed Mrs A as soon as possible.

77. My expert, Ms Wood, has advised that an assessment of blood pressure, urine, and blood tests to check for pre-eclampsia was indicated at that time. She acknowledges that "pregnant women do get gastric bugs just like anyone else, but in these situations the symptoms do not normally continue for several days".

78. It is also worthwhile noting Ms Wood's advice, with acknowledged hindsight, that: Mrs A's blood pressure at her first appointment with Mrs B was somewhat high for her age and size; her booking diastolic reading was 82; her blood pressure did not drop during her second trimester; and the hospital medical history recorded hypertension in her father and PET in her mother's pregnancy — all could be considered warning flags for potential blood pressure disorders in pregnancy. Ms Wood also advised that given Mrs A's platelet count at 28 weeks (151) had dropped to the lower limit of normal (150–450), a full blood count at 36 weeks[12] (the week before the events complained of) would have been advisable in the circumstances.

79. Mrs B did not react appropriately to Mrs A's ongoing symptoms of unwellness from Sunday to Tuesday.

Urine testing

80. Ms Wood has advised that routine urinalysis is a normal part of accepted standard maternity care,[13] together with blood pressure recording and fetal growth assessment. Routine urinalysis is primarily performed to test for the presence of protein (as an indicator of pre-eclampsia or possible urinary tract infection) and for the presence of glucose (as an indicator of gestational diabetes).

81. Ms Wood explained that, on its own, the presence of protein in the urine is not necessarily significant, but when considered in the context of other factors (such as blood pressure), it can be very significant. When indicator tests (such as dipstick urine

[12] The NZCOM *Midwives' Handbook for Practice* (2008) (see the fourth decision point in pregnancy, p. 31) recommends a third full blood count be considered at 36 weeks.

[13] Ibid., decision points for midwifery care, pp. 25–42.

Names have been removed (except the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

tests) return results showing the presence of protein or glucose, a midwife or doctor is then able to proceed to more definitive diagnostic testing, such as the protein creatinine ratio (PCR) urine test, which is more important in the diagnosis of pre-eclampsia, and would follow as part of secondary care assessment of a woman.

82. Mrs B adopted the view that the practice of performing a dipstick urine test routinely during pregnancy did not need to occur. Based on Ms Wood's expert advice, Mrs B seemed to have lost sight of the specific purpose of urinalysis in the context of routine antenatal midwifery care and her role as an LMC. Keeping abreast of recent clinical literature is to be encouraged, but Mrs B's rationale for not testing routinely appears somewhat flawed. Ms Wood advised that routine urinalysis is a monitoring tool during the provision of normal antenatal midwifery care in the primary setting. Its omission — a departure from professional midwifery standards — is an action that can potentially and unnecessarily place a woman and her baby's health and well-being at risk. As Ms Wood stated in her advice to me:

> "Disorders of pregnancy such as eclampsia and HELLP syndrome are rare, but potentially fatal for a pregnant woman. These disorders are the reason we monitor blood pressure and urine protein of every woman throughout pregnancy … while the condition could not have been avoided or prevented, earlier intervention may have prevented the seriousness of the situation, and may have allowed time for [Mrs A] to deliver normally and avoid a C-section."

Further management

83. Mrs B was aware that Mrs A continued to be unwell and had been vomiting, based on their phone discussions on Sunday and Monday. Although Mrs A does not recall any discussion on Saturday, and Mrs B submitted very late in this investigation process that her notes were in error, the records she submitted to HDC with her responses suggest that Mrs B was likely to have been aware of symptoms on that day also.

84. Ms Wood is of the view that Mrs A should have been assessed on Monday at the latest. At this stage, the options available to Mrs B included her seeing Mrs A in hospital herself, or, as she was busy with two clients in labour that day, having her back-up midwife assess Mrs A. She could also have advised Mrs A to go to her GP at that time.

85. Mrs B was informed by Dr C on Tuesday afternoon of the elevated blood pressure and proteinuria, that Dr C was concerned about Mrs A developing pre-eclampsia, and that blood tests were being done urgently. Dr C contacted Mrs B again that evening to discuss the blood results, including the low platelet count of 100. Dr C's contemporaneous records and Mrs A's account support this.

86. Mrs B maintains that pre-eclampsia was not mentioned to her, but as my expert stated:

> "There is however notation in the clinical notes of blood pressure of 160/100 on [Tuesday] and [Mrs B] was aware of the platelet result and the history of several days vomiting. Given this, the possibility of pre-eclampsia was clear, even if it wasn't specifically mentioned."

Names have been removed (except the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

87. In relation to Tuesday evening, Ms Wood stated:

> "Platelets of 100, together with significant protein on the urine dipstick (4+ protein), blood pressure of 160/100 and vomiting for several days were an indication for transfer of care to a specialist, or at least, consultation with the specialist obstetric service, prior to knowing what the other liver function test results were."

and

> "Given the seriousness of HELLP Syndrome, it would have been appropriate, when the results of the liver function tests became available on the Tuesday night, for [Mrs A's] care to be formally transferred to secondary maternity services at that time."[14]

88. Mrs B had sufficient clinical information available to her on Tuesday evening to have triggered such a referral. She failed to act on that information.

Test results follow-up

89. Mrs B was initially prompted by both Mrs A's symptoms of ongoing unwellness and vomiting, and then by Dr C's first phone call at 4.09pm to consider a diagnosis of PET and immediate hospital referral.

90. Dr C's contemporaneous record of the second call that evening, at 6.23pm, clearly outlines that she discussed Mrs A's abnormal blood test results over the phone with Mrs B. Dr C's response to HDC explained that she had already told the couple they would need to go to hospital that night. Mrs A reiterated this point during her conversation with Mrs B at 8.01pm. These were further prompts for Mrs B to take action.

91. Dr C's account of the telephone discussion indicates that Mrs B did not consider the hospital referral was warranted that evening, despite the clinical situation outlined to her by Dr C. It is Dr C's recollection that Mrs B said she would "take it from here". This suggests to me that Mrs B, as the lead maternity care provider responsible for pregnancy-related care (including her ability to offer an opinion on pregnancy-specific and antenatal matters), and knowing Mrs A best in this context, communicated that she was taking control of her client's situation and had made a decision to assess Mrs A the next morning. In any event, Mrs B was the designated LMC and, as such, was responsible for the care of Mrs A during her pregnancy, and

[14] I also note that relevant Specialist Referral Guidelines under Code 4022 of *Guidelines for consultation with obstetric and related specialist medical services (referral guidelines)* state that if a diagnosis of pre-eclampsia is suspected (defined as BP > 140/90 (or rise of > 30/15) and any of: proteinuria >0.3g/24 hours; platelets <150 x 10^9/L; abnormal renal or liver function; and imminent eclampsia/eclampsia), the lead maternity carer must recommend to the woman that the responsibility for her care be transferred to a specialist. (These guidelines previously appended to the Section 88 Maternity Services Notice 2002, are to be used in conjunction with the Primary Maternity Services Notice 2007.)

Names have been removed (except the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

for any pregnancy-related issues that occurred. This responsibility had not been formally referred to anyone else.

92. Mrs B maintains that she received only one laboratory result (the CBC including the platelet count) on Tuesday evening. I acknowledge that the laboratory's records show that the lab did not fax the test results to Mrs B that evening. However, Mrs B should have pursued these results had they not been forthcoming in the first instance. Mrs B was not proactive in following up Mrs A's illness or blood results despite being prompted by both Mrs A and Dr C.

93. Mrs B said that she did not follow up the results with the laboratory directly because Dr C had assessed Mrs A and had ordered the tests, and she considered it was therefore appropriate for her to wait and see what picture the results indicated and have the results communicated to her before anything further happened.

94. I agree with Ms Wood's advice that:

> "… it was [Mrs B's] responsibility, as LMC, to check [Mrs A's] blood results on Tuesday evening, given the information she already had about [Mrs A's] situation … [W]hen urgent blood tests are undertaken, it is because there is concern about the well being of the woman or her baby … [I]t was [Mrs B's] responsibility to ensure that [Mrs A] was safe and getting the appropriate care she needed."

95. Ms Wood explained that in the region she works it would be normal for the LMC to follow up in such circumstances as these, where the LMC had been informed that urgent blood tests had been undertaken. After discussing this issue with a midwife colleague in Mrs A's area, Ms Wood advised that it is always the responsibility of the person ordering the tests to follow up the results and ensure admission to hospital if indicated. However, Ms Wood commented that in this situation she would have expected, as would I, a reasonable midwife to have followed up the test results on Tuesday evening, given the information the midwife had about the situation.

96. I acknowledge that Mrs B, once she saw Mrs A on Wednesday morning, then recognised the urgency of the situation and acted appropriately by arranging further blood tests (the results of which included a platelet count of 69) and transfer of care to a specialist.

Documentation

97. The relevant midwifery standards, competencies and responsibilities in relation to documentation are clear (see Appendix B). There is an explicit expectation that documented evidence is kept of all midwifery decisions made.

98. In relation to Mrs B's brief notes in the antenatal clinical notes regarding her telephone contact with Mrs A over the weekend, Ms Wood advised:

> "… I find the notes confusing and difficult to interpret. There is comment that 'B/P 160/100' on [Tuesday], presumably after the phone call from the GP. This is

Names have been removed (except the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

> a significant rise in blood pressure, not 'slightly elevated' as stated in [Mrs B's] letter [of response]…"

99. Ms Wood has also noted deficiencies in Mrs B's antenatal checklist records and booking history. She considers Mrs B's notes to be inadequate and states that the standard of Mrs B's documentation in general is:

> "… below the quality, standard and comprehensiveness expected of a midwife".

100. Ms Wood also advised that:

> "[Mrs B] had two women deliver on [Monday] and as such would have been very busy and possibly not adequately focused on the situation unfolding with [Mrs A]. I would recommend [Mrs B give] consideration to her back-up systems."

101. I acknowledge the often heavy demands placed on health professionals in relation to contemporaneous record-keeping during busy periods, such as those experienced by Mrs B on Monday when she was faced with dealing with two clients in labour, as well as her other usual midwifery caseload. However, as my expert points out:

> "It has been my experience that there are some phone conversations and texts between myself and women that I do not document; those relating to changing appointment times etc. However, any conversation relating to the woman's well being or the baby's well being, are documented in the woman's notes as a matter of professional responsibility. This can be quite difficult at times if you happen to be involved with another woman in labour at the time of the call, but in these situations one would make a note in the clinical notes in retrospect."

102. I see no reason why Mrs B, as LMC, could not make the relevant retrospective entries in her notes, particularly in relation to the discussions she had with Dr C, about an issue as important to Mrs A and her baby as potentially being admitted to hospital.

103. Fuller notes would have documented Mrs B's rationale for actions and decisions she made, as well the nature of discussions with Dr C that were to have a direct bearing on the welfare of Mrs A. Clear records are also important for any health professional subsequently providing care, such as hospital staff at admission. I note that Mrs B took the time, after Mrs A was seen in hospital, to make retrospective entries in her antenatal records in relation to other less client-focused issues (including her commenting on Dr C's care).

104. As emphasised by the previous Commissioner in case 07HDC16053, "all health professionals are required to keep accurate, clear and legible clinical records. They are a record of the care provided to the patient and clinical decisions made, and enable other health professionals to coordinate care".[15]

Other matters

[15] See Opinion 07HDC16053 (10 June 2008), p 11.

HDC

Names have been removed (except the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

105. I am pleased that Mrs B has indicated that she has made changes to her practice as a result of this complaint. In my opinion, Mrs B's shortcomings were, in all likelihood, heavily influenced by placing focus on her two clients in labour. That said, I am concerned at the level of speculation in Mrs B's submissions to me on this matter, as well as attempts to deflect focus away from her LMC responsibilities by apportioning blame on to Dr C, the laboratory, and Mrs A.

106. There are marked deficiencies and omissions in Mrs B's records. Due to the poor quality of her documentation, Mrs B has had to rely almost solely on her recall, which (as evidenced by her second response to HDC acknowledging inaccuracies in her first response) was clearly unreliable. There is little evidence in the written documentation provided by Mrs B to support her account of events, particularly in relation to her discussions with Dr C. Mrs A's account is aligned with Dr C's, and both are supported by additional documentation in the form of contemporaneous and detailed written clinical records, laboratory records, and phone records.

107. The importance of the medical record was highlighted by the former Commissioner when he stated:

> "It is often stated by medical defence lawyers: 'If it isn't documented, it didn't happen.' Baragwanath J made comments to similar effect in his decision in *Patient A v Nelson Marlborough District Health Board*.[16] Justice Baragwanath noted that it is through the medical record that doctors have the power to produce a definitive proof of a particular matter (in that case, that a patient had been specifically informed of a particular risk by a doctor). Doctors whose evidence is based solely on their subsequent recollections (in the absence of written records offering definitive proof) may find such evidence discounted."[17]

108. I consider that this applies to all health professionals' record-keeping. In this regard, I echo a comment of the inaugural Health and Disability Commissioner, Robyn Stent:

> "When I encounter sketchy notes, not only does it become difficult to confirm the facts of a case, but it tends to throw suspicion on any supplemental information provided. In the end, whatever is remembered at a later date, the written record is the most significant witness of your actions. It is important for your sake as well as your patient's, that this is clear and complete".[18]

Conclusion

109. Mrs B failed to recognise, and react in an appropriate fashion to, Mrs A's ongoing symptoms of unwellness and, as a result, I consider that she breached Right 4(1) of the Code of Health and Disability Services Consumers' Rights[19] (the Code). The midwifery care provided and quality of documentation kept was not of an appropriate

---

[16] *Patient A v Nelson-Marlborough District Health Board* (HC BLE CIV-2003-406-14, 15 March 2005).

[17] See Opinion 05HDC07699 (31 August 2006), pp. 29–30.

[18] Stent, R, "For the record". *New Zealand GP*, 12 December 1998.

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

Names have been removed (except the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

standard or in accordance with professional standards. In my opinion, Mrs B breached Right 4(2) of the Code.[20]

Recommendations

110. I recommend that Mrs B:

- continue to review her practice in light of my expert's comments and the competence programme set down by the Midwifery Council, and report back to me her learnings in relation to the APEC (Action on Pre-eclampsia) study day and the New Zealand College of Midwives workshop on documentation by **28 January 2011**; and

- provide me with a progress report, including examples, on all changes made to her practice as outlined in her responses to this complaint, by **28 January 2011**.

Follow-up actions

- A copy of this report will be sent to the Midwifery Council of New Zealand as part of its consideration of Mrs B's ongoing competence programme.

- An anonymised (except for Mrs B's name) copy of this report will be sent to the District Health Board.

- A copy of this report, with details identifying the parties removed, except the name of expert advisors, will be sent to the New Zealand College of Midwives and the Maternity Services Consumer Council, and placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

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

Names have been removed (except the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

Appendix A

Independent advice to Commissioner — midwife

The following expert advice was obtained from midwife Ms Mary Wood:

> "My name is Mary Wood. I have been asked to provide expert midwifery advice to the Health and Disability Commissioner in regard to Case no. 09/01311.
>
> My background is as follows: After completing a Diploma in Comprehensive Nursing at Carrington Polytech (now Unitec) in 1989, I completed a diploma in midwifery at AUT in 1990. I then completed a Bachelor of Health Science Midwifery at AUT in 2001.
>
> I worked as a midwife in the delivery unit of North Shore Hospital, from January 1991 until September 1991. I then began working as an independent midwife on the North Shore in Auckland. I have been working as a full time independent midwife on the North Shore ever since. I work in a practice of (currently) 14 midwives, each of whom carry their own caseloads. I provide midwifery care for women throughout pregnancy, from positive pregnancy test through until six weeks after the birth of the baby, with women birthing either at home, Birthcare Birthing Unit in Parnell, or North Shore Hospital. I provide midwifery care for women in both low risk and moderate risk pregnancies.
>
> I have been involved in the NZCOM at regional and national level and I normally work closely with midwifery students through the course of my practice.
>
> I have read and understood the guidelines for Independent Advisors provided by the HDC and agree to follow these guidelines.
>
> I have reviewed the information provided in the following documentation provided by the HDC:
>
> [Ms Wood noted here the documents she reviewed.]
>
> You have asked me to provide independent expert advice about whether [Mrs B] provided an appropriate standard of midwifery care to [Mrs A], particularly during the last week of her pregnancy in 2009. To this end, you have asked me to comment or provide an opinion in relation to 14 points. I will endeavour to work through each issue in order.
>
> 1. Please comment generally on the standard and appropriateness of midwifery care that midwife [Mrs B] provided to [Mrs A].
>
> [Mrs A] booked with [Mrs B] in the first trimester of her pregnancy. [Mrs B] saw her 8 times throughout her pregnancy, at the normal intervals expected of routine

Names have been removed (except the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

antenatal care. She notes in her initial booking, that [Mrs A] had no family history of note, nor any relevant medical history.

This was [Mrs A's] first pregnancy. Her booking blood pressure was documented to be 130/82. For a woman of her age and size, this is somewhat high, and could be considered a warning flag for possible blood pressure complications in later pregnancy. Somanz (Society of Obstetric Medicine of Australia and New Zealand) identify a booking diastolic recording of 80 or higher as a risk factor for pre eclampsia. (*Somanz Guidelines for the Management of Hypertensive Disorders of Pregnancy 2008*).

Also of note, in the course of a normal pregnancy, blood pressure drops through the second trimester. This has been commented on by Professor Robyn North at the Apec study day 2009, and is also stated in the Somanz Guidelines. "Normal pregnancy is characterized by a fall in blood pressure, detectable in the first trimester and usually reaching a nadir in the second trimester. Blood pressure usually rises toward pre-conceptual levels toward the end of the third trimester". (*Somanz Guidelines for the Management of Hypertensive Disorders of Pregnancy 2008*).

[Mrs B's] clinical records demonstrate that [Mrs A's] blood pressure did not drop through her pregnancy, which with the benefit of hindsight, could also have been considered a warning factor for blood pressure disorders as the pregnancy progressed.

Until [week 37], [Mrs B] provided [Mrs A] with standard midwifery care, other than not routinely checking [Mrs A's] urine for protein or glucose via the use of a urine dipstick. Such urine testing is part of accepted standard maternity care, together with blood pressure recording and fetal growth assessment. I am not aware of any recommendation that advocates departure from this standard. Urine testing such as this is meant to be an indicator test only, not a diagnostic test. A midwife (or doctor) would proceed on with further more diagnostic testing in the situation where the initial indicator tests were positive, such as increasing blood pressure, and/or increasing urine protein on dipstick. It is an assessment that while on its own, is of limited value, when considered in the context of the other factors such as blood pressure, can be significant. Not testing urine as part of normal antenatal midwifery is a departure from normal midwifery care.

2. Please comment on whether [Mrs A's] vomiting and associated signs and symptoms, exhibited initially on [Sunday and Monday], was appropriately assessed, monitored and managed by [Mrs B].

On [Sunday afternoon], when she was 37 weeks pregnant, [Mrs A] contacted [Mrs B] as she was unwell. At that time [Mrs A] had been vomiting for 2 days. While pregnant women do become ill with "tummy bugs" from time to time, sudden onset of vomiting in mid to late pregnancy can also be associated with serious pre-eclampsia, although many women who develop this condition may

Names have been removed (except the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

continue to feel well until the very late stages of the disorder. In the case of gastric upset, I would expect the vomiting to subside within a few hours however, and not continue for 2 or more days.

When [Mrs A] contacted [Mrs B] for the second time the following day ([Monday]), with worsening symptoms ('couldn't keep even water down'), it is my opinion that an assessment of blood pressure, urine and blood tests (specifically liver function tests) to check for pre-eclampsia, was indicated at that time. [Mrs B] states in her letter [of response] that she has no recollection of the time frame (of 2 days vomiting) being mentioned and that she 'would have been concerned if she had known that [Mrs A] had been vomiting for two days'. As a practitioner myself, I cannot imagine not asking a woman who has contacted me in this situation, how many times she been sick and how long she had been sick for, even if the woman didn't offer the information in the first instance.

In my opinion, [Mrs A] was not appropriately assessed, monitored or managed by [Mrs B] during this time.

3. Please provide your opinion on the quality, standard, and comprehensiveness of [Mrs B's] documentation and record-keeping.

Standard four of the NZCOM Standards for midwifery practice states '*the midwife maintains purposeful, on-going, updated records and makes them available to the woman and other relevant persons*'. The criteria under this standard include '*the midwife reviews and updates records at each professional contact with the woman*'.

In general [Mrs B's] notes are inadequate and do not meet the standard expected of a midwife. The antenatal records contain check lists for the first, second and third trimester which apparently indicate that discussion occurred on various issues between herself and [Mrs A], but do not give any information as to what was discussed or decided. Urinalysis is ticked as being done in the check list, but noted as not being done in the antenatal clinical page. [Mrs B's] booking history records no significant family history of note but the hospital medical history records that her father has hypertension, and her mother had PET (Pre-eclamptic Toxaemia) during pregnancy. Both of these factors are significant in that they indicate a potential predisposition for [Mrs A] to develop a hypertension problem during her pregnancy.

However, on occasion it has been my experience that some women are not fully aware of their full family medical history, and can sometimes give different or conflicting answers to the same questions, when giving their medical history at different times.

[Mrs B] had made some brief notes in the antenatal clinical notes regarding her phone contact with [Mrs A] over the weekend. However, I find the notes confusing and difficult to interpret. There is a comment that 'B/P 160/100' on

Names have been removed (except the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

[Tuesday], presumably after the phone call from the GP. This is a significant rise in blood pressure, not 'slightly elevated' as stated in [Mrs B's] [response] letter, especially in light of the other factors that [Mrs B] was aware of.

It has been my experience that there are some phone conversations and texts between myself and women that I do not document, those relating to changing appointment times etc. However, any conversation relating to the woman's well-being or the baby's well-being, are documented in the woman's notes as a matter of professional responsibility. This can be quite difficult at times if you happen to be involved with another woman in labour at the time of the call, but in these situations one would make a note in the clinical notes in retrospect.

It is my opinion that the standard of [Mrs B's] documentation in general, is below the quality, standard and comprehensiveness expected of a midwife. Particularly in relation to the phone conversations between herself and [Mrs A], and herself and [Dr C] in regard to this event, from [Sunday to Tuesday].

4. Please comment on [Mrs B's] stated practice in relation to routine antenatal urine dipstick testing.

Urinalysis is a normal part of the physical assessment of pregnant women at each antenatal visit. (NZCOM Midwives Handbook for Practice — decision points in pregnancy). The test is primarily done both for the presence of protein, as an indicator of pre eclampsia, (or possible urinary tract infection) and for glucose, as an indicator for gestational diabetes. I agree with [Mrs B] in that the presence of protein on the dipstick, *in itself* does not give a good indication for significant proteinuria, just as the presence of glucose does not necessarily indicate gestational diabetes. It is certainly true that the protein creatinine ratio (PCR) urine test is far more important in the diagnosis of pre eclampsia. However, in the provision of normal antenatal maternity care, the urine dipstick is done in conjunction with blood pressure in the primary setting. The PCR test would follow as part of the secondary care assessment of the woman if she demonstrated any signs of pre eclampsia such as increasing blood pressure and protein in her urine. I am unaware of any change to the NZCOM recommendations regarding the use of urinalysis as a part of the normal assessment of a woman's physical well-being during pregnancy.

In [Mrs A's] situation, the presence of significant protein on the urine dipstick, together with her general unwell condition, her increased blood pressure and dropping platelets were together, significant as an indicator that she was developing serious pre eclampsia, and regardless of the outcome of a PCR, had one been done on [Tuesday], her liver function tests had already indicated a serious problem that warranted hospitalisation.

5. Please comment on the appropriateness of [Mrs B's] actions when interacting with the GP in this case, and provide your view whether [Mrs B] fulfilled her professional LMC responsibilities in these circumstances.

Names have been removed (except the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

[Mrs B] was contacted by the GP [Dr C], in the first instance with [Mrs A] present, after the GP had assessed [Mrs A] and was concerned that she was developing pre eclampsia. She contacted [Mrs B] again that evening to discuss the blood results, and informed [Mrs B] of the platelet count of 100. [Mrs B] comments that she was let down by both the GP and the Lab. In her statement via [Mr D], [Mrs B] asserts that there was no specific mention of pre eclampsia. There is however notation in the clinical notes of blood pressure of 160/100 on [Tuesday] and she was aware of the platelet result and the history of several days of vomiting. Given this, the possibility of pre eclampsia was clear, even if it wasn't specifically mentioned.

As [Mrs A's] LMC, I consider that [Mrs B] was responsible for following up the blood test results, especially as she had been informed of [Mrs A's] blood pressure and general illness, and (possibly) proteinurea. In my experience it would be normal practice for a midwife to contact the laboratory directly in a situation such as this, rather than wait for a GP to send through blood results.

6. Do you consider that any part of [Mrs A's] antenatal care should have been formally delegated to another service (prior to [Mrs A's] eventual hospitalisation) and, if so, which type of service provider would have been appropriated to refer to?

It is my opinion that [Mrs A] should have been assessed on the Monday at the latest, when she phoned [Mrs B] for the second time. [Mrs B] had a number of options available to her. She could have seen her in hospital, or as she was busy with a woman in labour, had her back up midwife see her, or she could have advised [Mrs A] to go to her GP at that time. As I stated above, pregnant women do get gastric bugs just like anyone else, but in these situations the symptoms do not normally continue for several days. Given the seriousness of HELLP Syndrome, it would have been appropriate, when the results of the liver function tests became available on the Tuesday night, for [Mrs A's] care to be formally transferred to secondary maternity services at that time.

NZCOM Midwives Handbook for Practice Standard Six: Midiwifery actions are prioritised and implemented appropriately with no midwifery action or omission placing the woman at risk. HELLP Syndrome is a significant risk to the woman and to her child.

7. In your view, at what stage did the clinical picture presented first dictate referral of care or hospitalisation?

An assessment of [Mrs A], in my view, was warranted on the Monday. On the Tuesday evening, the GP's findings upon examination of [Mrs A] would have indicated at least an obstetric assessment in hospital. When her blood results indicated HELLP Syndrome, hospitalisation and transfer of care to tertiary obstetric care was absolutely indicated.

Names have been removed (except the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

8. Would a platelet result of 100 on its own, coupled with [Mrs A's] earlier symptoms that were known to [Mrs B], indicate transfer of care to a specialist?

[Mrs B] was aware of the vomiting from her phone conversations with [Mrs A] on [Sunday and Monday], and had been informed by [Dr C] of the blood pressure and urine results after her examination of [Mrs A] on [Tuesday afternoon], and of the platelet results later that evening. Platelets of 100, together with significant protein on the urine dipstick (4+ protein), blood pressure of 160/100 and vomiting for several days were an indication for transfer of care to a specialist, or at least, consultation with the specialist obstetric service, prior to knowing what the other liver function test results were.

9. Based on her account provided, was it appropriate for [Mrs B] as LMC to decide to wait for the full picture from all the test results and 'not check with the lab because the normal procedure is for the practitioner ordering the tests to receive them and take the necessary action'?

It is my opinion that it was [Mrs B's] responsibility, as LMC, to check [Mrs A's] blood results on Tuesday evening, given the information she already had about [Mrs A's] situation. When women are referred for routine blood testing during pregnancy, it would not be normal practice to phone for the results, but rather to wait until the results were sent out. However, when urgent blood tests are undertaken, it is because there is concern about the well being of the woman or her baby. As such, it would be expected that someone would be responsible for checking the results. As LMC it was [Mrs B's] responsibility to ensure that [Mrs A] was safe and was getting the appropriate care she needed. I am unable to comment on what the normal procedure is for following up urgent blood results in [the area], but in the area I work, it would be normal for the LMC to follow up in such circumstances, where the LMC had been informed that urgent bloods had been done.

The GP, [Dr C], who had actually examined [Mrs A], also had a responsibility to follow up and ensure that she was hospitalised when the results of the abnormal liver function tests became available. In my own experience, I have had a very similar situation occur, with a woman who developed HELLP Syndrome. In my situation, the woman presented to an emergency GP clinic with vomiting at 37 weeks. The GP referred the woman to hospital after she had examined her, then informed me of the situation.

10. Which professional midwifery standards and guidelines are applicable in relation to this complaint?

1. The NZCOM Midwives Handbook For Practice

2. Guidelines for Consultation with Obstetric and Related Specialist Medical Services (Primary Maternity Services Notice 2007 NZ, MOH).

Names have been removed (except the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

11. Please outline any recommendations you may have, to address concerns raised by this complaint?

I would recommend that [Mrs B] consider undertaking the Apec Study day, and the NZCOM study day on documentation. Independent midwifery practice with caseloading involves juggling the demands of women in labour, with phone calls from women for a variety of reasons, antenatal clinics, postnatal home visiting, as well as continuing educational requirements and personal family commitments. [Mrs B] had two women deliver on [Monday] and as such would have been very busy and possibly not adequately focused on the situation unfolding with [Mrs A]. I would recommend [Mrs B] give consideration to her midwifery back-up systems.

It is to her credit that [Mrs B] has undertaken to improve her communication processes with GPs and to improve her record keeping, in particular as regards phone calls from women with clinical issues.

12. If, in answering any of the above questions, you believe that [Mrs B] did not provide an appropriate standard of care, please indicate the severity of her departure from the standard.

Disorders of pregnancy such as eclampsia and HELLP Syndrome are rare, but potentially fatal for a pregnant woman. These disorders are the reason we monitor blood pressure and urine protein of every woman throughout pregnancy. HELLP Syndrome can come on very quickly, and can occur without significant symptoms until it is very advanced and the woman is very ill. In this situation there were symptoms. While the condition could not have been avoided or prevented, earlier intervention may have prevented the seriousness of the situation, and may have allowed time for [Mrs A] to deliver normally and avoid a C Section.

I believe that [Mrs B] did not provide an appropriate standard of care in this instance. Failure to recognise these symptoms and failure to act quickly when the symptoms were reported is a serious departure from the standard of care expected of a midwife.

13. Are there any aspects of the care provided by [Mrs B] that you consider warrant additional comment?

[Mrs A's] booking blood tests indicated platelets at that time to be 201 (22/07/08). The normal range for platelets in pregnancy is 150–450. The second antenatal bloods done on the 15 Dec 2008 indicated platelets of 151. It is normal for a healthy woman's blood to become diluted during the course of pregnancy and as such the platelet count will appear to drop somewhat. The NZCOM Midwives Handbook for Practice recommends a third full blood count be considered at 36 weeks. (*The fourth decision point in pregnancy — 36 weeks: The timing provides an opportunity to evaluate the care so far, reassess the health*

Names have been removed (except the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

and well being of the pregnant woman...). [Mrs B] had not ordered a full blood count at 36 weeks, although she had intended giving [Mrs A] a blood form on [Wednesday], to recheck iron levels. With the benefit of hindsight, given [Mrs A's] platelets had dropped to the lower limit of normal at 28 weeks, a full blood count to note platelets at 36 weeks would have been advisable in my opinion.
[Signed and dated by Ms Wood]

References:

The NZCOM Midwives Handbook for Practice.

Guidelines for Consultation with Obstetric and Related Specialist Medical Services (Primary Maternity Services Notice 2007 NZ MOH).

SOMANZ (Society of Obstetric Medicine of Australia and New Zealand) Guideline for the Management of Hypertensive Disorders of Pregnancy 2008."

On request, Ms Wood provided further advice in relation to the issue of follow-up of urgent blood results in the area.

"I have discussed the issue with [a midwifery colleague] in [the area]. It is always the responsibility of the person ordering the tests, and who has actually examined the woman, to follow up the results and ensure admission to hospital if indicated. In this situation however, I would expect a reasonable midwife to have followed up the test results on [Tuesday evening], given the information the midwife had about the situation. The clinical responsibility of the GP does not negate the professional responsibility of the LMC midwife.

In this situation the midwife's standard of care was below what would be expected of a midwife."

Ms Wood was asked whether she considered the midwifery care departed from expected standards to a mild, moderate or severe degree? She responded:

"In this situation, I would consider the failure to recognise the symptoms, and act quickly when the symptoms were reported as a moderate departure from the standard of care expected of a midwife.

I would consider the midwifery care overall departed from the expected standard of midwifery care to a moderate degree."

Names have been removed (except the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

Appendix B

Relevant professional standards

The relevant standards from the New Zealand College of Midwives (NZCOM) *Midwives' Handbook for Practice* (2008) state:

> "Standard three
>
> The midwife collates and documents comprehensive assessments of the woman and/or baby's heath and well-being.
>
> Standard four
>
> The midwife maintains purposeful, ongoing, updated records and makes them available to the woman and other relevant person.
>
> *Criteria* (under this standard include)
> The midwife:
>
> - Reviews and updates records at each professional contact with the woman.
> - Ensures information is legible, signed and dated at each entry.
>
> Standard six
>
> Midwifery actions are prioritised and implemented appropriately with no midwifery action or omissions placing the woman at risk.
>
> *Criteria* (under this standard include)
> The midwife:
>
> - Ensures assessment is on-going and modifies the midwifery plan accordingly.
> - Ensures potentially life threatening situations take priority.
> - Identifies deviations from the normal, and after discussion with the woman, consults and refers as appropriate.
> - Works collaboratively with other health professionals and community groups as necessary.
>
> Standard seven
>
> The midwife is accountable to the woman, to herself, to the midwifery profession and to the wider community for her practice.
>
> *Criteria* (under this standard include)
> The midwife:
>
> - Recognises that she is an autonomous practitioner, regardless of setting, and is accountable for her practice.
> - Clearly documents her decisions and professional actions."

Names have been removed (except the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

Midwives must maintain their competencies at the level of entry to the Midwifery Register. The relevant competency for entry to the Register of Midwives as outlined by the New Zealand College of Midwives *Midwives' Handbook for Practice* (2008) states:

> "Competency Two
>
> The midwife applies comprehensive theoretical and scientific knowledge with the affective and technical skills needed to provide effective and safe midwifery care.
>
> *Performance criteria* (under this competency include)
> The midwife:
>
> 2.2 confirms pregnancy if necessary, orders and interprets relevant investigative and diagnostic tests, carries out necessary screening procedures, and systematically collects comprehensive information concerning the woman's/wahine's health and well-being;
>
> 2.3 assesses the health and well-being of the woman/wahine and her baby/tamaiti throughout pregnancy, recognising any condition which necessitates consultation with or referral to another midwife, medical practitioner or other health professional;
>
> 2.16 provides accurate and timely written progress notes and relevant documented evidence of all decisions made and midwifery care offered and provided."

In addition, the New Zealand College of Midwives electronic document *Booking Guidelines*[21], in setting out the process and considerations when a midwife LMC "books" a woman for LMC midwifery care, states:

> "2.3 Documentation
>
> … [women held maternity notes] remain with the woman throughout her maternity care episode and contain all of the information (including test results, clinical assessments, information offered, decisions made, and care plan) required to inform the woman's care.
>
> ... Women hold their notes throughout the pregnancy and they are maintained by the midwife to provide a contemporaneous record of the maternity care …"

Section 2.3 also states:

> "Midwifery responsibilities in relation to documentation are governed by:
>
> - NZCOM Code of Ethics, Standards of Practice and Philosophy

[21] Ratified at the New Zealand College of Midwives Annual General Meeting of 11 September 2008. See http://www.midwife.org.nz/index.cfm/3,108,559/nzcom-booking-guidelines-final-sept-08.pdf

Names have been removed (except the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

- Midwifery Council Competencies for Entry to the Register of Midwives
- The requirements of the Code of Health and Disability Services Consumers' Rights
- The requirements of the Privacy Act 1993 and the Health Information Privacy Code 1994
- The requirements of the Health (Retention of Health Information) Regulations 1996
- The requirements of the Section 88 Primary Maternity Services Notice."

Names have been removed (except the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.