Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

Two registered midwives and Nelson Marlborough DHB breach Code for failing to provide appropriate maternity services

20HDC00496

Two registered midwives (RMs) and Nelson Marborough District Health Board (DHB) (now Te Whatu Ora Nelson Marlborough) breached the Code of Health & Disability Services Consumers' Rights (the Code) for failing to provide a woman and her baby with services that complied with relevant standards.

The woman, in her late teens at the time of events, had a growth scan at 33 weeks and three days' gestation, which showed that her baby was measuring large for gestational age. An obstetrician recommended that the pregnancy not go beyond 41 weeks. At 40 weeks and 1 day, the woman was admitted to Wairau Hospital and induced that afternoon.

During the labour, a recording of the fetal heart rate showed possible fetal distress. The two midwives caring for the woman did not recognise the signs of fetal distress for an hour and a half. Specialist support was then sought and one of the midwives attempted to deliver the baby, whose shoulders were stuck.

When the obstetrician arrived and took over care, the baby was born in poor condition, requiring resuscitation. The infant was diagnosed with severe HIE (a brain injury caused by insufficient oxygen delivery to the brain that can cause severe complications).

Deputy Commissioner Rose Wall acknowledged the impact of these events for the woman, her daughter and her whānau.

"This was a young woman having her first baby, and she relied on her care team to monitor her baby's wellbeing adequately, to collaborate effectively, and to escalate care promptly when indicated. Unfortunately, this did not occur and, as a result, the baby suffered serious complications, which potentially will have a profound impact on her future wellbeing."

Ms Wall found that the woman's lead maternity carer (LMC) midwife breached Right 4(2) of the Code which states, "Every consumer has the right to have services provided that comply with legal, professional, ethical, and other relevant standards."

The LMC failed to provide the woman with services that complied with professional and other relevant standards, including Nelson Marlborough DHB's internal induction of labour guidelines and fetal monitoring guidelines.

Ms Wall also found the second midwife breached Right 4(2) of the Code for failing to comply with professional and other relevant standards, including advocating for appropriate monitoring of contractions; appropriately responding to the signs of fetal distress; and appropriately using the emergency call system.

Ms Wall was critical of the working environment at Wairau Hospital, which meant staff members felt stressed and unsupported, and, as a result, unable to work together effectively. There were a number of concerning features in the way the woman was cared for by multiple staff at Wairau Hospital.

Ms Wall found Nelson Marlborough DHB in breach of Right 4(2) of the Code for failing to ensure the service provided to the woman was managed in an efficient and effective manner that ensured the provision of timely, appropriate and safe services.

Since the events, the LMC has made changes to her practice, including obtaining support from a midwifery mentor and undergoing a competency review by the New Zealand Midwifery Council.

Nelson Marlborough DHB advised that changes have been made following the events to better support staff and improve staffing levels. The DHB has also updated its fetal monitoring guidelines.

Taking into account the changes made, Ms Wall's recommendations included that both midwives and the DHB each provide a written apology to the woman for the failings identified in the report, and that Nelson Marlborough DHB conduct a review of the effectiveness of the changes made.

7 August 2023

ENDS

Editor's notes

The full report of this case will be available on HDC's website. Names have been removed from the report to protect privacy of the individuals involved in this case.

The Commissioner will usually name providers and public hospitals found in breach of the Code, unless it would not be in the public interest, or would unfairly compromise the privacy interests of an individual provider or a consumer.

More information for the media, including HDC's naming policy and why we don't comment on complaints, can be found on our website here.

HDC promotes and protects the rights of people using health and disability services as set out in the Code of Health and Disability Services Consumers' Rights (the Code).

In 2021/22 HDC made 402 recommendations for quality improvement and providers complied with 98% of those recommendation.

Learn more: Education