Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

Midwife breached Code for antenatal care of first-time mother
20HDC00505

The Deputy Health and Disability Commissioner has recommended a midwife undertake further training on the identification and management of antenatal risk factors. She has also asked the midwife to apologise to a first-time mother for breaching her rights to be fully informed and to receive services of an appropriate standard.

Rose Wall found the midwife breached Rights 6 and 4 of the Code. She also made adverse comment against a public hospital (Te Whatu Ora).

The baby was born by emergency Caesarean section due to fetal distress. The infant was born in a poor condition and required resuscitation before transfer to the Special Care Baby Unit for ongoing treatment.

The breaches centred on the midwife's antenatal care of the woman who had complex health needs. The woman had visited the midwife at 11 weeks gestation and the midwife recorded the woman's weight but not her body mass index (BMI), which was found to be 40.7. The midwife also recommended a referral to specialist care because of the woman's high BMI. The woman declined the referral.

A subsequent Midwifery Council competency review of the midwife noted there were several omissions of care which did not reflect safe and effective practice. It stated there was no evidence to reflect conversations were revisited regarding the woman's high BMI, referrals to a specialist were not made, nor were there any conversations about lifestyle changes.

The midwife has acknowledged that, despite her client declining the specialist referral, it was still her duty to consult with another practitioner concerning the woman's position as it could have affected the mother and baby's health.

Rose Wall said, "RM A [midwife] failed to provide Ms B with the information a reasonable consumer in Ms B's circumstances could expect to receive. She also failed to provide services to the woman with reasonable care and skill and breached the Code by failing to assess fetal growth adequately and for not including all relevant information in the secondary care referrals."

Ms Wall was critical of the midwife's fetal growth assessment as a customised growth chart was not used, serial ultrasounds were not arranged, and the fundal height (distance between the top of the uterus and pubic bone) was not recorded correctly.

She also noted that while further specialist referrals regarding gestational diabetes were timely, they lacked relevant specific details such as the woman's BMI, her family history of diabetes and ethnicity.

Ms Wall made adverse comment against Te Whatu Ora for shortcomings in the woman's care saying the system and organisational failures put undue pressure on an on-call consultant.

The Midwifery Council has reported that, since the events, the midwife has made several significant positive improvements to her practice including her documentation of antenatal care. She has also completed several courses to improve her practice.

Te Whatu Ora has also reported significant improvements have been made in communications and processes at the hospital involved. This included having two senior medical officers available to ensure appropriate access to specialist care in times of high acuity or for additional specialist opinion. Other changes include ensuring clinical midwifery managers are rostered on shifts.

Te Whatu Ora has complied with all recommendations in HDC's report.

16 October 2023

Health and disability service users can now access an online animation to help them understand their health and disability service rights under the Code.

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.

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