Decision 22HDC00154
5 November 2025

HEALTH & DISABILITY COMMISSIONER
TE TOIHAU HAUORA, HAUĀTANGA

Midwife failed to recognise signs of pre-term labour and escalate care

1. On 19 January 2022, the Health and Disability Commissioner (HDC) received a complaint from Mrs A regarding the maternity care provided to her and her son, Baby A, by registered midwife (RM) B. Mrs A's complaint concerns the care she received when she entered early labour at 33 weeks of pregnancy.[1] This investigation is focused on the maternity care Mrs A received from RM B from 3 August 2019 until Baby A was born by emergency caesarean section (CS) on 5 August 2019. I acknowledge the significant impact of these events on Mrs A and her whānau.

Information gathered

2. Mrs A had a complex obstetric history, with two previous pre-term labours (both delivered by CS), antepartum haemorrhage,[2] and CS scar dehiscence.[3] This history made Mrs A's pregnancy higher risk than usual.

3. On the afternoon of 3 August 2019, Mrs A messaged RM B to inform her of irregular cramping and brown discharge, which was described as 'like phlegm'. RM B called to discuss the symptoms and advised Mrs A to contact her if cramping/tightening increased and became regular. This phone call was not documented by RM B. Mrs A messaged RM B again in the evening, when she noted red bloody discharge and decreased cramping. RM B advised Mrs A that she should present to the hospital if cramping/tightening increased.[4]

4. RM B told HDC that she did not recall her contact with Mrs A on 3 August 2019 and that she did not document it. Despite not recalling the communications on 3 August 2019, RM B told HDC that the clinical picture described by Mrs A on this day did not indicate pre-term labour or vaginal bleeding.

5. Mrs A told HDC that she phoned RM B on 4 August 2019, but there is no record of this call or that RM B made any contact with Mrs A that day.

6. On the morning of 5 August 2019, Mrs A experienced more painful and regular contractions. RM B was contacted, and she advised Mrs A to present to the hospital for assessment. Shortly following this contact, Mrs A's waters started breaking. RM B was informed, and she told Mrs A to present to hospital as soon as possible.

[1] 'Early labour' or 'pre-term labour' are terms used to describe the onset of labour before week 37 of the pregnancy. A pregnancy usually lasts around 40 weeks.
[2] Bleeding in the genital tract before birth.
[3] A serious complication in which the scar tissue from a prior CS separates.
[4] Mrs A provided screenshots of the relevant correspondence to support this account of the events.

Names have been removed (except the clinical advisor on this case) to protect privacy. Letters are assigned in alphabetical order and bear no relationship to the person's actual name.

7. RM B informed the hospital staff of Mrs A's pending admission and of her previous pre-term labours and CSs. RM B told HDC that Mrs A discussed further relevant clinical information, including her history of maternity complications, with the obstetric registrar.

8. Mrs A presented to the hospital, where it was determined that she was in established pre-term labour. Subsequently, Baby A was delivered by emergency CS. Baby A was transferred to the neonatal unit because of his premature birth and respiratory issues. He was discharged home after 11 days.

9. In the following months, Mrs A observed that Baby A had developmental delays, and he was diagnosed with cerebral palsy.[5] An MRI[6] showed that Baby A had suffered a brain injury due to lack of oxygen.

Independent advice

10. HDC sought independent clinical advice from RM Valerie Daprini (Appendix A). She identified several aspects of RM B's care that departed from accepted standards of practice.

11. RM Daprini noted that the combination of symptoms described in Mrs A's message on the afternoon of 3 August 2019, in conjunction with her history of two premature births and bleeding, created a concerning clinical picture. RM Daprini is critical that RM B did not instruct Mrs A to present to the hospital following receipt of this information. She considered that this was a severe departure from accepted standards. I accept this opinion.

12. Regarding Mrs A's second message on the evening of 3 August 2019, RM Daprini was again critical of RM B's failure to recognise the concerning symptoms and act accordingly. Mrs A's second message noted the new symptom of red blood. RM Daprini stated that this was clearly a sign of vaginal bleeding, which – in combination with Mrs A's other symptoms – was cause for concern. RM Daprini again considered RM B's failure to recognise the significance of these symptoms as a severe departure from accepted standards, and I accept her advice.

ACC advice

13. HDC received a clinical advice report from RM C, which was prepared in relation to an ACC treatment injury claim by Mrs A. RM C's advice concludes, based on the correspondence between Mrs A and RM B on 3 August 2019, that a referral to the obstetric team was warranted. RM C considered that Mrs A's symptoms, in addition to her complex obstetric history, indicated the potential for the onset of pre-term labour. Accordingly, RM C advised that it would have been appropriate to refer Mrs A for obstetric review at that time.

Responses to provisional opinion

14. Mrs A was given the opportunity to comment on the provisional opinion. Her comments have been addressed in separate correspondence.

[5] A group of conditions caused by abnormal brain development that affect movement and posture.
[6] Magnetic resonance imaging, a technique used to create images of internal structures.

15. RM B was given the opportunity to respond to the provisional opinion. She advised that she accepts my decision and provided a letter of apology for forwarding to Mrs A.

Opinion: RM B — breach

16. Right 4(1) of the Code of Health and Disability Services Consumers' Rights (the Code) states that every consumer has the right to have services provided with reasonable care and skill.

17. Based on the advice provided by RM Daprini and RM C, I am critical of RM B's failure to recognise the significance of Mrs A's symptoms, given her complex obstetric history, and to escalate her care accordingly on 3 August 2019.

18. I am also concerned that RM B failed to adequately document her communications with Mrs A on 3 August 2019.

19. In light of the above, it is evident that RM B did not provide services to Mrs A with reasonable care and skill. I therefore consider that RM B breached Right 4(1) of the Code.

Changes made since events

20. RM B told HDC that, as a result of this complaint, she has reflected on her clinical documentation practices and how records support quality care and communication. RM B advised that she has completed additional training on documentation and has reviewed her documentation using the Midwifery Documentation and Record Keeping Audit Tool.

Recommendations and follow-up actions

21. In my provisional decision, I recommended that RM B provide a formal written apology to Mrs A for the issues identified in this report. In response, RM B provided an apology for forwarding to Mrs A. I therefore consider this recommendation complete.

22. I recommend that RM B provide a written reflection on the criticisms outlined in the advice from RM Daprini and RM C to HDC within three months of the date of this report.

23. I suggest that RM B attend a Carosika Collaborative Preterm Birth Annual Education Day.[7] I trust that this would supplement the above recommendation and assist with RM B's education on this aspect of her care.

24. A copy of this report will be sent to Te Tatau o te Whare Kahu | Midwifery Council, who will determine whether a review of RM B's competency is called for in the circumstances.

25. A copy of this report with details identifying the parties removed will be placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

Rose Wall
Deputy Health and Disability Commissioner

[7] Carosika Collaborative Events.

Appendix A: Independent clinical advice to the Commissioner

The following independent advice was obtained from RM Valerie Daprini:

'Expert advice provided to the Health and Disability Commissioner regarding the care provided by RM [B] to [Mrs A] in August 2019

Reference C22HDC00154

This advice has been provided by Valerie Daprini (15-13676)

Registered Nurse/Registered Midwife/LMC

6.11.2023

I have been asked to review the complaint by [Mrs A] and to address specific questions raised by the HDC. This entailed reviewing over 850 pages of documentation.

The following opinions are based on my considerable experience as a nurse and a midwife of over 30 years, working day-to-day with pregnant, labouring, and post-natal women. As such, I am well positioned to make educated deductions based on the information in this case. I will endeavour to deliver unbiased, logical, and practical opinions based on my midwifery knowledge.

Part A:

I have been asked to comment upon:

The advice provided to [Mrs A] from 2 to 5 August 2019 and the standard of RM [B]'s communication from 2 to 5 August 2019 regarding [Mrs A]'s options.

Analysis of conversations between RM [B] and [Mrs A] - Summary

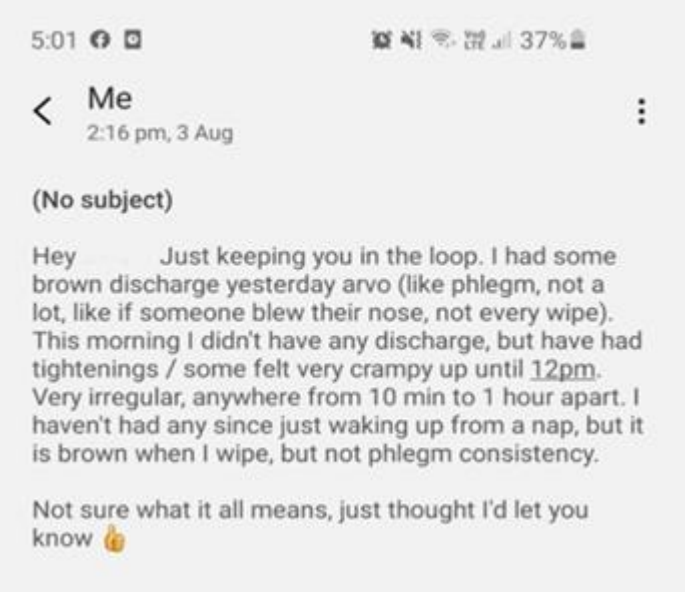
Date	To/From	Time	Summary of subject
3 August	To Midwife	unknown	Point 13 of RM [B]'s response to complaint (18.3.22) "I do not recall or have a record of communications with [Mrs A] on 3 August 2019" However, in point 14 of same complaint: "I attempt to document all phone calls with clients and regrettably

			appear to have overlooked documenting my call to [Mrs A] immediately following her text to me on 3 August at 2.16pm"
3 August	To Midwife	2.16 pm	Brown phlegm-like discharge the day before No discharge in the morning, brown discharge? in the afternoon Irregular tightening
3 August	From Midwife	? mid afternoon	Phone call from Midwife, no documentation as to content
3 August	To Midwife	8.34 pm	Red blood mixed with brown Less tightenings
3 August	From Midwife	8.36 pm	Response to above message; to notify if tightenings increase
4 August	Neither party had communication		
5 August	To Midwife	0830	As per midwife: "Tightening overnight, settled at 0500, woke with further tightening again and PV show/brown dx" As per [Mrs A]: "Regular and painful contractions" Advised to go to [the hospital]
5 August	To Midwife	0915	Call from [Mrs A]'s partner reporting waters breaking in shower and mild tightening continuing Advised to go to [the hospital]

Analysis of conversations between RM [B] and [Mrs A] – Breakdown

This is the first communication between RM [B] and [Mrs A], 3 August 2019, 2.16pm.

Although RM [B] does not have any recollection of this communication, it is clear it occurred.



In my opinion, there are three separate aspects to consider.

The brown phlegm-like discharge

The discharge being described as phlegm-like indicates to me that the mucus plug might be being discharged. (The mucus plug is a protective collection of mucus in the cervical canal. As the cervix begins to open wider in preparation for delivery, the mucus plug is discharged into the vagina. The time between losing the mucus plug and going into labour varies and is not necessarily an indication of impending labour). This information on its own is of limited value.

The tightening/cramps

[Mrs A] was experiencing some tightenings that she described as being quite crampy. These were very irregular, from 10 minutes to one hour apart. Although it is not clear how long these were present, they appear to have been from when [Mrs A] woke until around midday. We can therefore estimate perhaps four to five hours. This information on its own is of limited value as the lack of frequency does not constitute significant uterine activity.

The vaginal discharge changing from no longer being phlegm-like to brown.

Logically, when there is brown blood loss there first must have been fresh/red blood loss. The fact that the blood loss was now brown means that from somewhere bleeding has previously occurred. The questions that I, and I believe my peers, would have been asking ourselves would be: was this from inside the uterus/a placental abruption? Was this from the cervix (it has many blood vessels which can bleed when the cervix is dilating, ergo was [Mrs A] dilating)? Was a uterine scar dehiscence occurring?

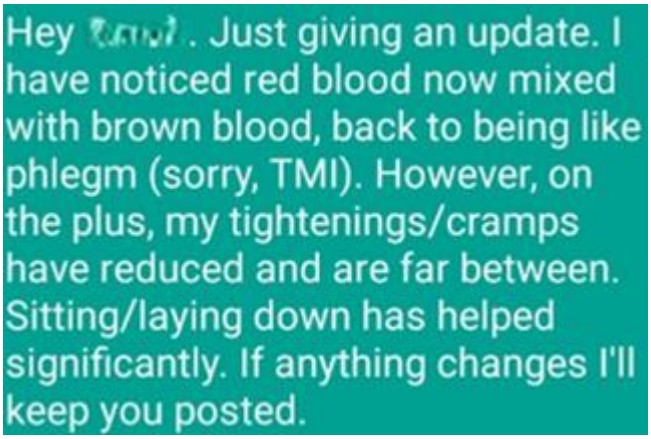
Of concern to me is that when three above aspects contained in the text message are put together – as they should be by an experienced midwife – a clear clinical concern is emerging. Also, RM [B] knew that [Mrs A] had a history of two premature births ending

in caesarean section, a vaginal birth complicated by an APH [antepartum haemorrhage] and a previous uterine scar dehiscence. In simpler terms, in two out of three pregnancies, [Mrs A] had previously had premature births and bleeding.

I believe that upon receipt of this first text, my peers and I would have recommended that [Mrs A] be swiftly reviewed at [the hospital], as she is clearly experiencing deviations from normal in her already high-risk pregnancy. The failure of RM [B] to action this constitutes, in my opinion, a severe deviation from expected practice.

There appears to have been a phone call between RM [B] and [Mrs A] after this first text to discuss what was occurring. [Mrs A]'s recollection is that she was advised about having rest and to contact her midwife if the tightening increased or became regular.

Subsequent text at 3 August 2019, 8.34pm

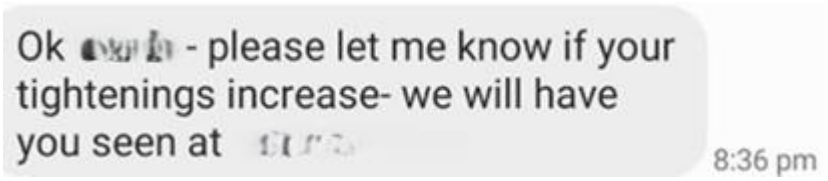


In this text, the alarming addition of now fresh red blood is described by [Mrs A]. This clearly constitutes a fresh antepartum haemorrhage. Again, upon receipt of this text, my peers and I would have recommended that [Mrs A] be swiftly reviewed at [the hospital]. RM [B] failed to make this recommendation. In fact, in RM [B]'s response to this HDC enquiry, she stated: "Again the clinical picture described did not indicate signs of preterm labour or 'PV bleeding'. I considered it appropriate to await any further clinical events and reassess".

This comment illustrates that RM [B] continues to not recognise the importance of what [Mrs A] described in her text, i.e. that there was fresh red blood coming from the vagina. This is undeniably 'PV bleeding.'

I feel that when putting the two texts together, a worrying clinical picture was emerging, to which RM [B] was oblivious. The failure of RM [B] to recognise this constitutes, in my opinion, a severe deviation from expected practice.

Response from RM [B]:



RM [B] appears to have been reassured by [Mrs A] stating that the tightenings "had reduced and were far between." Her focus appears to be on a potential premature labour rather than any other ominous features, such as a haemorrhage. There is no evidence that [Mrs A] was given any information by RM [B] at this point about what to look out for in terms of fetal movements, vaginal bleeding, caesarean scar pain, or abdominal or back pain (different to a tightening pain, which could indicate a placental abruption).

There was no communication from RM [B] to [Mrs A] on the 4th of August. I believe that there should have been a follow-up conversation. Even if RM [B], as is obvious, believed that there was nothing obstetrically concerning, it would have been good midwifery practice to have "touched base" with [Mrs A] and to have received an update.

Final communication

Communications

Telephone call – 05 Aug 19 at 08:30

Contact 1 [RM B] – Lead Maternity Carer

Call Details Phone call from [Mrs A] reporting tightening overnight - settled at approx 0500hrs – has been asleep since. Woke with continued tightening again – and PV show/brown dx

Contact 2 [Mrs A] - Woman

Advice Given Advised to head to [the hospital] for assessment

0915 – further call from (partner reporting? SROM [spontaneous rupture of membranes] in shower – mild tightenings continue 0 advised to head to [the hospital] asap – core staff notified

In RM [B]'s response to this HDC enquiry, it is stated "The LMC midwife documented in her clinical notes that "the tightenings had become regular and painful, which was consistent with contractions. RM [B] therefore advised [Mrs A] to go to [the] hospital for an assessment". In the box above (showing RM [B]'s record of this phone call), this differs from this statement. RM B has not documented that "contractions had become regular and painful". In fact, she has described them (twice) as "tightenings", and not as contractions.

Although at this point RM [B] now decides to have [Mrs A] obstetrically reviewed at [the hospital], her documentation does not make it clear why she did so now and not previously.

Matters that I feel warrant comment

There appears to be some confusion as to whether [Mrs A] was supposed to contact RM [B] or [the hospital] directly with any obstetric concerns. I believe this to be irrelevant. There was a clear duty of care by RM [B] to action the concerning features mentioned in the very first text.

Summary

In summary, I feel that the standard of communication and the lack of advice provided to [Mrs A] by RM [B] from 2 to 5 August 2019 is a severe departure in accepted practice. My expectation, and I believe that of my peers, would be that, upon receiving the first text message, RM [B] should have advised [Mrs A] to be reviewed at a tertiary facility.

Part B

[removed]

Part C

I have been asked to comment on "The standard of post-natal assessments and examinations of [Baby A] (as relevant to midwifery practice)".

In my review of the provided notes, it appears to me that RM [B] had made appropriate and timely visits in the post-natal period. Detailed information such as [Baby A]'s weight, physical checks, etc were well documented, a referral to Plunket was appropriately done by RM [B] and she also provided the GP [general practitioner] with a transfer of care summary.

I therefore surmise that the standard of post-natal assessments and examination of [Baby A] by RM [B] shows no departure in the accepted level of care.

Part D

I have been asked to remark on "any other matters in this case that I consider warrant comment."

I would like to comment that I do not believe there was any evidence of fetal distress prior to [Baby A's] birth. I base this assertion upon:

On admission to the birthing unit, in the clinical notes it states:

> Clinical Note – 05 Aug 19 at 10:15 [RM B] (Specialist Midwife)
>
> Arrival at B&A [Birthing and Assessment]– Not distressed

PV pad in situ

GFMs reported

The fact that GFMs (good fetal movements) were reported indicates to me that at 10:15am there was a low chance of fetal hypoxia. Broadly speaking, if a fetus is being deprived of oxygen its movements will be markedly reduced or absent. To use the analogy of when somebody is not well, they do not go to the gym and do a workout. Similarly, a poorly oxygenated fetus does not move much at all, they conserve every bit of energy and redirect oxygen to vital organs.

RM [B] has not documented what vaginal discharge was present, if any, on the "PV pad in situ." Was there meconium? Was there blood? Also, there is no documentation of whether [Mrs A] was contracting. This lack of clinical information constitutes an important oversight.

Clinical Note – 05 Aug 19 at 10:56 […] (Obstetric Registrar)

Registrar Review

CTG normal

Speculum with consent, blood seen, fresh bleeding

Bugling membranes seen.

VE performed with consent – 6cm

For acute CS

The CTG at this time was determined to be normal by an obstetric registrar. A normal CTG is associated with a low probability of fetal compromise. Accordingly, already being 6cm dilated, having had two previous caesareans, as well as the APH, the sensible decision was made to proceed to caesarean section. I note that this was called an "acute" caesarean section (grade/category 2), not an "emergency" (grade/category 1) caesarean. A grade/category 2 caesarean section is defined as there is no maternal or fetal compromise which is immediately life threatening. The fact that the obstetric registrar did not define this as an "emergency", and that the time was taken to do a spinal, not a general anaesthetic for the caesarean indicates that the fetus was not believed to be in a state of hypoxic compromise at this time.

Intrapartum

Clinical Note – 05 Aug 19 at 11:44 […] (Midwife [hospital] Employed)

1015–1115 CTG in OT - normal trace

Baseline 140 Normal variability

Spinal sited

neonates present

LSCS [lower segment CS] started at 1143

Above it is documented that there was an hour of normal CTG leading up to the arrival in theatre. This indicates no fetal hypoxia.

Clinical Note – 06 Aug 19 at 15:34 […] (Obstetric SHO)

Day 1 post EmLSCS [emergency LSCS] for spontaneous labour post previous LSCS with antepartum haemorrhage

- Rapidly contracting. VE by consultant […] after spinal placed. 7cm -1 station. **CTG showing decelerations without shouldering and reduced variability**

Operation findings:

Attempt by Dr […] at disimpaction of head. very difficult to get below head – strongly contracting uterus. GTN [glyceryl trinitrate] given, reattempted, unable to disimpact. Dr […] took over and Dr […] unscrubbed to be able to push up vaginally. Difficult delivery of head.

The above entry, made the day after [Baby A's] birth, is the only record that states that the CTG (when in the operating theatre) showed concerning abnormalities. *However, this has been documented by a doctor who was not present at the caesarean and is not substantiated by any evidence.*

I have reviewed the CTG segment that was commenced in theatre at 1116. The tracing is of poor quality, being very pale (the ink fades over time). However, my assessment of this CTG is that although it does not meet the definition of a normal CTG, it does *not* show fetal compromise. I base this assertion on the fact that if the fetus were hypoxic, then the baseline would normally rise, there would be a decrease in variability, and fetal heart decelerations would be apparent. Variability is an important feature of a trace in determining fetal wellbeing, as normal variability is indicative of adequate fetal oxygenation. This trace indeed does indicate reduced variability; however, this is also quite common with a premature baby. There are no decelerations on the CTG.

As per [Mrs A]'s complaint

"Although [RM B] states that fetal monitoring was described as normal upon arrival. That does not suggest that it was prior to arrival. In fact, Dr [C] states in the report I

have attached, that by the time I was wheeled into the theatre, CTG monitoring indicated that fetal distress was present".

I have not seen Dr [C]'s report, but documentation by a Senior Medical Officer states that the (one hour of) CTG recording was normal. This refutes that there was any fetal distress, certainly up until potentially close to [Baby A's] birth time of 1151. There was also no meconium liquor present, another indicator that there was not fetal distress.

"I believe that during this prolonged labour of 48 hours up to his birth, that [Baby A] experienced distress and hypoxia. Clinical evidence and handwritten notes support this as:

• *He birthed with an Apgar score of 5*

• *He was pale and floppy at birth*

• *No immediate response to resuscitation*

• *Marked chest recession*

• *Facial and top of head bruising*

• *Abnormal CTG results noted prior to caesarean*

• *Abnormal capillary blood gas results after birth*

I will address each of these statements separately:

• *He birthed with an Apgar score of 5*

The Apgar score information was documented into the computer system presumably by the neonatal nurse specialist present at the birth. This was an Apgar of 7 at 1 minute This contradicts the Apgar of 5 on the handwritten "Immediate postnatal history and examination" sheet. It is therefore unclear which is the correct Apgar score.

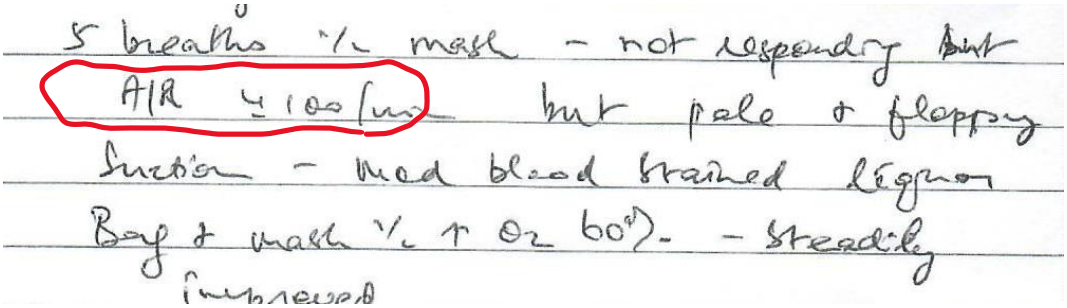
• *He was pale and floppy at birth*

The entry documenting "being floppy at birth" is on the handwritten note (as previously mentioned above). The documentation states at 10 minutes old, "pinking up but still pale". Also stated is "Difficult extraction -> Floppy, responded well to suction and mask CPAP [continuous positive airway pressure]".

"No immediate response to resuscitation"

[Baby A] received five inflation breaths with a mask. On the same handwritten notes (see below), it is stated that he was "not responding but (as circled in red) H/R (heart rate) was *squiggle* 100/min. Unfortunately, this squiggle could be interpreted as the symbol for "above" i.e above 100, or the squiggle could be an equal sign, meaning that the heart rate was equal to 100. Not knowing this fact makes it difficult to reconstruct the events of [Baby A's] resuscitation.

Suction was performed and a moderate amount of blood-stained liquor removed. After the suction, he was given mask ventilation with oxygen increasing to 60% and it is stated that he "steadily improved".



"Marked chest recession"

This is recorded on the same handwritten notes as previously mentioned at 10 minutes of age. Recession is often seen in a premature baby who is "learning" to breathe.

"Facial and top of head bruising"

There is documentation that there was facial (but not head) bruising at 10 minutes old. The disimpaction of [Baby A's] head certainly bruised him, but this extraction appears to have been done appropriately quickly.

As an aside, I cannot logically explain as to how, in a subsequent post-natal clinical note in [Mrs A]'s file (see below) a statement was made that there was no bruising. The presence of bruising is evidenced by the above statement and [Mrs A]'s photos of [Baby A].

> Clinical Note – 05 Aug 19 at 18:15 […] (Obstetric Registrar)
>
> Debrief together with Dr […]
>
> Explained rationale for disimpaction of fetal head from vaginal approach as well as abdominally.
>
> Explained our concern about risk for fetal injury
>
> **Reassured that neonate is doing well with no signs of bruising or skull fracture**.

"Abnormal CTG results noted prior to caesarean".

Previously discussed, and I reaffirm that I do not believe any of the CTG recordings showed a hypoxic fetus.

"Abnormal capillary blood gas results after birth"

I cannot speak to this as it is more appropriate to discuss this with a neonatologist.

[removed]

In general summary

I find fault with RM [B] for her lack of appropriate care from 3 to 5 August. The delay in [Mrs A] being assessed for threatened pre-term labour and APH was, I believe, unacceptable. This delay, no doubt, was a missed opportunity to provide suitable care to both mother and baby.

[removed]

I wish [Mrs A] and her family all the very best. I hope that my responses and opinions, which I believe would be shared by my peers, will give some insight into the concerns that she has raised.'