HEALTH & DISABILITY COMMISSIONER
TE TOIHAU HAUORA, HAUĀTANGA

Midwifery Care provided by RM B at Health New Zealand | Te Whatu Ora

(Opinion 22HDC02851)

Complaint background

1. On 18 November 2022, a complaint was received from Ms A about the care provided to her by registered midwife (RM) B.

2. Ms A's complaint revolves around two issues:

- Incorrect information provided to Ms A while she was in labour
- Inadequate postnatal visits and no Plunket handover provided

3. In May 2021, Ms A was expecting her second child, and ultrasound scans showed that the baby was presenting in a breech position.

4. Previously Ms A had had a Caesarean section (C-section) and was not a good candidate for a vaginal birth. Therefore, she opted for an elective C-section. Ms A went into labour a week prior to the scheduled C-section date.

5. Ms A's complaint stated that she was provided with incorrect information by RM B during labour.

6. Ms A advised that she called RM B multiple times (three) in a four-hour period to say that her waters had broken, she had increasing pain in five-minute increments, and she had sent photos of her 'bloody show' at 10.43pm.

7. RM B advised Ms A to stay at home and to see her the following morning (11 hours later). The contractions then became so intense that Ms A went to the hospital anyway. Ms A said that there was no time to get a midwife or anyone specialised in breech births, and she was not given any pain relief, and her son's head was trapped for over 10 minutes during the birth. Her son was then born footling breech and diagnosed with hypoxic ischaemic encephalopathy[1] (HIE).

8. Ms A is also concerned about the number of postnatal visits she received. She said that RM B did not schedule the visits but would send a text asking to 'pop round in 10 minutes'. Ms A also said that no Plunket handover occurred.

[1] A brain injury that occurs when a baby's brain does not get enough oxygen or blood flow, either before, during, or after birth. This can lead to various neurological problems and developmental delays.

Scope of investigation

9. The following issue arising from the complaint was investigated:

- *Whether Registered Midwife B provided Ms A with an appropriate standard of care during the labour and birth of her son up until discharge from her midwifery services on 7 June 2021.*

Response to complaint

10. RM B recorded that she received two phone calls from Ms A (at 10.30pm and 11.24pm). RM B acknowledged that she received the photo of Ms A's 'bloody show' but denied that there was any report of ruptured membranes during the phone calls.

11. Regarding postnatal visits, RM B advised: '[L]ooking back at the time stamp on text messages, I accept that regrettably, the notice Ms A was given prior to postnatals was indeed rather short.'

12. RM B advised that she attempted to arrange two visits to conduct a discharge visit but had no confirmation from Ms A until six weeks after the birth, and therefore, it was outside her scope, and as Ms A had already arranged a general practitioner (GP) visit for the six-week immunisations, she was unable to perform her usual discharge.

In-house midwifery advice

13. In-house midwifery advice was received from RM Nicholette Emerson (Appendix 1), who identified the following departures from the accepted standard of care:

- Moderate departure: Failing to consider the known risk factors of the previous Caesarean and current breech presentation when excluding/confirming labour and determining when Ms A should present to the hospital.
- Moderate departure: For not ensuring that a comprehensive discharge took place, particularly given the HIE diagnosis.

Referral to Midwifery Council

14. A referral was made to the Midwifery Council of New Zealand. The Council advised that, through investigation, it identified some opportunities for education to strengthen RM B's competence, specifically around documentation of risk factors and plans of care. Therefore, RM B was required to engage in a competence programme.

ACC claim

15. On 1 November 2022, ACC determined that the HIE was caused by a failure of RM B to treat Ms A in a timely manner on the evening of birth of Baby A.

Decision

16. Having reviewed all the information in this case, I consider that RM B breached Rights 4(1) and 4(2) of the Code of Health and Disability Services Consumers' Rights (the Code). Right 4(1) states that every consumer is entitled to have services provided with reasonable care

and skill, and Right 4(2) states that every consumer has the right to services that comply with legal, professional, ethical, and other relevant standards.

17. In my opinion, the departures from the expected standard of care, although moderate, were significant, and therefore I consider that RM B failed to provide services in line with Right 4(1) and 4(2) of the Code, as per RM Emerson's advice. RM B did not provide Ms A with appropriate support and information when contacted in the early stages of labour, especially given the known risk factors for Ms A's pregnancy. In addition, RM B failed to document the relevant information appropriately, including interactions with Ms A while she was in labour and as part of the aftercare — including the handover to the GP and Well Child provider, particularly given the HIE diagnosis. In line with RM Emerson's advice, I consider these to be moderate departures from practice that had a significant impact on Ms A and her baby. On this basis, I find that RM B failed to provide services in line with Right 4(1) and 4(2) of the Code.

18. To achieve a timely and pragmatic resolution of the complaint, RM B was provided with details of my assessment, a copy of the in-house midwifery advice, and details of the departures from the accepted standard of care (namely Rights 4(1) and 4(2)), together with the reasons why these were considered to be a breach of the Code. RM B accepted the findings.

Response to the provisional decision

19. RM B was provided an opportunity to comment on the provisional opinion; she advised she accepted the decision and the following recommendation.

20. Ms A was provided an opportunity to comment on the provisional opinion. She responded and said she was relieved to see the provisional opinion was supportive of what she has always believed was an error in judgment by RM B.

Changes made since events

21. I am pleased to note that, at the completion of its investigation, the Midwifery Council of New Zealand supported RM B by providing further education and requiring her to undergo a competence programme.

Recommendations

22. In keeping with Ms A's desired outcomes for accountability and improved practice, which have in part been achieved through the Midwifery Council's process, I recommend that RM B:

- Provide a written apology to Ms A and her family with a reflection on the incident, steps taken to improve her practice, including communication and aftercare, and the breach of the Code, which she has accepted. The apology is to be sent to HDC within six weeks of the date of this report, for forwarding to Ms A.

Follow-up actions

23. This report will be provided to RM B, Ms A, and the Midwifery Council of New Zealand.

24. An anonymised version of this report will be provided to Health New Zealand | Te Whatu Ora.

25. An anonymised version of my report will be placed on the Health and Disability Commissioner website www.hdc.org.nz, for educational purposes.

Rose Wall
Deputy Health and Disability Commissioner

Appendix A: In-house midwifery advice

The following advice was obtained from in-house midwifery advisor RM Nicholette Emerson:

'**CONSUMER: Ms A**
PROVIDER: LMC RM B
FILE NUMBER: C22HDC02851
DATE: 17 June 2024

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

2. **I have reviewed the documentation on file: Documents provided.**
   - Complaint from Ms A, including attached documents of ACC review application
   - [Health New Zealand|] Te Whatu Ora clinical records 24 February 2023
     - Response from RM B, including
       - Response to HDC 3 March 2023
       - Response to ACC 9 August 2021
       - Pamphlets including After your Caesarean section, Birth after Caesarean, Delayed cord clamping.
       - Woman/Midwifery registration. Obstetric referral.
       - Clinical records 6 October 2020–21 April 2021.
       - MSS1 result, scans, Laboratory reports. FISH report.
       - Screenshot of text messages 21, 22 April.
       - Screenshot of 'show'.
       - Breech Birth guidelines [Health NZ]. Breech Presentation, previous Caesarean. RANZCOG Management of Breech Presentation.
   - Maternity Services Consumer Council — email from Ms C 3 October 2022

3. **Background:** Ms A was 10 weeks' gestation in her second pregnancy when she booked with RM B for midwifery care. Her medical history included asthma. Surgical history included an emergency caesarean in her previous pregnancy. During the current pregnancy, a high-risk MSS1 (1/10 risk of Down syndrome) was followed up by an amniocentesis, resulting in a normal karyotype. A breech presentation was identified in the third trimester at 36 weeks' gestation. Following an Obstetric consultation, Ms A chose to have an elective caesarean for this

pregnancy. The decision was based on Obstetric advice regarding her previous caesarean and the breech presentation in her current pregnancy. Prior to the date of the booked Caesarean, Ms A commenced spontaneous labour, which progressed rapidly to a footling breech presentation and subsequent head entrapment. Baby A was unresponsive at birth and required resuscitation. He was diagnosed and treated for hypoxic-ischemic encephalopathy (HIE). Ms A's complaint is regarding the advice given by RM B to stay at home when there were several phone calls indicating that Ms A could be commencing labour. Her complaint also questions the degree of postnatal care received from RM B.

4. Advice Request: File review

Rupture of Membranes

There are different accounts of the events regarding whether Ms A's membranes had ruptured (waters had broken) prior to hospital admission. Ms A states that she called RM B several times prior to hospital admission to let her know that her membranes had ruptured.

RM B denies that there was any report of ruptured membranes in the phone calls received. Clinical notes do not record rupture of membranes.

Ms A says that she called RM B three times advising her of ruptured membranes, contractions, and a 'show'. A photo of the 'show' was sent to RM B, and receipt of the photo and two phone calls are acknowledged by RM B.

Phone calls

RM B has recorded two phone calls in her clinical notes and in her complaint response (10.30pm and 11.24pm). She states that she has access to her text messages but no phone logs.

There was an additional text at 10.43pm with a photo of a 'bloody show'. This text is acknowledged and confirmed as a 'show' by both parties.

Ms A states that RM B was called three times in a space of four hours (ACC appeal report page 10/249) .

In her correspondence with ACC, Ms A states (page 4/249):

The night I went into labour my partner and I called our Midwife/LMC multiple times in the 4 hours leading up to his birth to let her know my waters had ruptured, I was having increasing pains at (timed) 5 minute intervals, I had my bloody show, it was at the LMC's direction I stay at home when she should have sent me to hospital for a check up to ascertain if I was indeed in labour and, to implement a birth plan with the hospital where the risks could have been minimised and controlled in a timelier manner. Instead she asked me to see her the following morning, 11 hours after I called her with our concerns at approximately 10pm the night before.

In her complaint response, RM B states:

10.30pm I then questioned Ms A about the consistency, colour and amount of vaginal discharge. Ms A explained she did not feel a "gush" but it did have a mucous consistency and was a light blood colour. I then explained that because the back pain had subsided and did not resemble a pattern, it was most likely Braxton hicks or everyday back pain. I then explained that based on Ms A's description of the vaginal discharge, her waters had not broken and it was most likely a "bloody show". This is because it was thick in consistency; she was not soaking pads and did not feel any "popping of waters". I also asked about baby's movements and Ms A reported that baby had been moving normally.

It is noted that RM B states in her complaint response that she viewed the labour like any other labour cephalic (head presenting) or breech (bottom presenting).

However, it is not expected that the recommendation of when Ms A should attend hospital would differ whether her baby's presentation was breech or cephalic. In either case, it is recommended she attend in early labour for in-person assessment (i.e. contracting once every 5–15 minutes, or if her membranes ruptured (response to ACC 9 August 2021, point 2).

RM B's statement is concerning given that Ms A had made a prior decision to have an elective caesarean founded on the Obstetric recommendation. The recommendation was based on the clinical complexities of the previous caesarean and the breech presentation of Ms A's baby in the current pregnancy. Ms A's decision to have an elective caesarean was made during an obstetric consultation and is documented in midwifery clinical notes, 6 April.

Had Ms A elected the alternative pathway to have a vaginal birth after her previous Caesarean (VBAC), then labour would be allowed to establish with close monitoring. At the antenatal appointment on 6 April, documentation records that an *in-depth discussion took place regarding what to expect from early and established labour, covering coping mechanisms and birth plan.* This entry is incongruent with previous documentation at the same appointment confirming Ms A's decision to have an elective Caesarean.

RM B's antenatal clinical records document:

13 April, as soon as signs of labour ring (RM B) — written by midwife locum.

20 April, explained to Ms A to call urgently if waters break or she thinks she is in labour, especially due to breech presentation.

Consideration has been given to the comment in RM B's complaint response stating:

I consider that this was a precipitous labour (meaning a fast labour).

It would appear that, once the labour established, it was precipitous; however, there was a lead up of time when phone calls and texts were exchanged. There was opportunity for assessment in this period. In particular, there was an opportunity for assessment following the phone call at 10.30 pm. Whilst a precipitous labour cannot usually be predicted, the retrospective observation by RM B that the birth was precipitous supports rather than mitigates the need for an early in-person assessment in the context of a planned caesarean and known breech presentation.

Midwifery Council Competencies

Competency 2

2.5 Attends, supports and regularly assesses the woman/wahine and her baby/tamaiti and makes appropriate, timely midwifery interventions throughout labour and birth:

Code of Ethics

Midwives have a responsibility to ensure that no action or omission on their part places the woman or her baby at risk.

A) If it is accepted that there were two phone calls prior to Ms A attending hospital, then RM B has moderately departed from accepted midwifery practice in not recognising Ms A's plan to have an elective caesarean. RM B has not considered the risk factors of labour establishing and has not made an in-person clinical assessment to confirm or exclude early labour.

B) If it is accepted that there were three phones calls in a four-hour period prior to Ms A attending hospital, then RM B has moderately departed from accepted midwifery practice in not recognising Ms A's plan to have an elective caesarean. RM B has not considered the risk factors of labour establishing and has not made an in-person clinical assessment to confirm or exclude early labour.

The context of a planned caesarean with the known risk factors of the previous Caesarean and the risk factor of the current breech presentation do not appear to have been considered in the decision-making when excluding/confirming labour.

Postnatal visits

Even when we did get home, RM B didn't make appointments to come and do her checks on Baby A, I would just get a SMS message to say something like "Hi, can I pop in for a visit in 10 minutes?" In fact, we never even got a handover to Plunket/final visit from RM B. Even our Plunket nurse commented that this was pretty disappointing. (ACC report page 12/249)

RM B states that she kept in touch via text whilst Baby A was an inpatient (22 April–6 May). RM B visited Whakatane Maternity 7 May; however, Ms A was in a meeting with the paediatrician. She did not interrupt.

According to RM B's complaint response once Ms A and Baby A were home, she visited four times commencing 8 May. RM B does acknowledge and apologises that the notice prior to postnatal visits was short. According to her complaint response, RM B

attempted to visit a further two times (31 May, 2 June). She states there was no response to the further proposed two visits, and she believes that Ms A had temporarily lost her phone in her car.

On June 7, Ms A requested a visit; however, RM B advised that it was post six weeks, therefore she was unable to visit. Ms A had an appointment with the GP the following day for Baby A's vaccinations.

RM B has moderately departed from accepted midwifery practice in not ensuring that a comprehensive discharge has taken place. This is particularly relevant in the context of Baby A's history of HIE. The handover to the GP and a Well Child provider ensures continuity of care and are an expected component of midwifery care.

Midwifery Council Competencies

Competency 2

2.14 performs a comprehensive end-point assessment of the woman/wahine and her baby/tamaiti with the six-week postnatal period, including contraceptive advice and information about and referral into Well Woman and Well Child services, including available breastfeeding support and immunisation advice.

Documentation

There is no submitted documentation for the postnatal period.

Summary

In summary, whether labour had established or not at the time of the phone call at 10.30pm cannot be determined retrospectively. In the context of a planned Caesarean, it was not Ms A's role to determine whether she was in labour but RM B's role to provide safety netting via clinical assessment in the context of the plan and existing risks. In not attending in person, a moderate departure from accepted midwifery practice is identified.

In not completing and handing midwifery care to the GP and Well Child provider, a moderate departure from accepted midwifery care is identified. This is compounded by Baby A's vulnerability as a result of his birth and subsequent HIE.

Finally, I wish Ms A the best in the ongoing care of her precious family.

Nicholette Emerson, BHSc, PG Dip-Midwifery
Midwifery Advisor
Health and Disability Commissioner'