Health and Disability Commissioner
*Te Toihau Hauora, Hauātanga*

**Antenatal and postnatal care breaches of the Code**
**19HDC00068**

A registered midwife and Bay of Plenty DHB (now Te Whatu Ora Hauora a Toi Bay of Plenty) breached the Code of Health and Disability Services Consumers' Rights (the Code) for the care of a woman during her first pregnancy.

The woman, in her thirties, relocated during her pregnancy to be close to family, transferring her care to a registered midwife in her new area. Sadly, she experienced failures in her antenatal care and in the care she received following the birth of her stillborn son.

Deputy Commissioner Rose Wall found the registered midwife in breach of multiple Rights of the Code, including for failing to provide services with reasonable care and skill and for failing to maintain a professional standard of documentation.

Ms Wall also found the registered midwife failed to adequately inform the woman of her options during her pregnancy when she needed a growth scan. "I am very critical that the registered midwife did not fully inform the woman of her options for obtaining a scan," Ms Wall said. "It is evident that whilst some discussion of options occurred, this was not fulsome."

At 33 weeks, the woman was admitted to Whakatane Hospital with nausea, diarrhoea and vomiting. Test results showed campylobacter.

Ms Wall found Bay of Plenty DHB breached the Code for failing to act appropriately on the Campylobacter result. Bay of Plenty DHB should have notified Manatū Hauora|Ministry of Health about the infection as well as arranging a review by an obstetrician and ensuring the result was communicated to the registered midwife.

"I am [also] concerned that the woman's Lead Maternity Carer (LMC) did not have ready access to Bay of Plenty DHB's clinical health information relevant to a pregnant woman under her care. There were deficiencies with the systems in place for the management and follow-up of test results and discharge summaries," Ms Wall said.

Ms Wall extended her sincere condolences to the woman and her whānau.

Since the event, the Midwifery Council of New Zealand had instructed the registered midwife to complete a competence programme which included a period of supervision and completion of Midwifery Council endorsed courses.

Bay of Plenty DHB has also made changes around, and continues to work on, ensuring equity of access to ultrasounds, as well as changes to how support and follow-up is provided to women in Whakatane following a stillbirth.

In addition to the changes made, Ms Wall recommended the registered midwife provide a letter of apology to the woman, provide an update on her training and undertake an audit of patient records.

Ms Wall also recommended that Bay of Plenty DHB provide a written letter of apology to the woman and review the systems, policies and procedures in place for provision of discharge summaries, communication with and access to clinical records for providers in the community, and the management of test results.

10 July 2023

***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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