Midwife, Ms B

A Report by the

Health and Disability Commissioner

(Case 13HDC01460)

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

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Executive summary

1. In 2013, Ms A (aged 27 years) was pregnant with her fourth child. Ms A engaged a community-based midwife, Ms C, as her Lead Maternity Carer (LMC). LMC Ms B provided back-up midwifery services for Ms C every alternate weekend.

2. At 26 weeks' gestation, Ms A contacted Ms B at 9.45am advising that she had been experiencing "? labour pains since yesterday". Ms B arranged to meet Ms A at the local Maternity Unit.

3. Ms B met Ms A at the Maternity Unit at 10.10am and carried out an assessment, noting that her observations were normal, the fundal height was 26cm, and good fetal movements could be felt on palpation. Ms B also commenced a CTG, which she noted was normal and did not show any obvious signs of uterine activity. Ms B considered that Ms A had a urinary tract infection (UTI). Ms A did not produce a urine sample at that time, so Ms B asked her to bring back a sample for testing. At that time, Ms B did not perform a speculum examination, or discuss this option with Ms A.

4. Ms A went home and, later that afternoon, her partner, Mr A, took her urine sample to the hospital to be tested.

5. At 6.30pm, Ms A went back to the hospital complaining of lower abdominal pain. At 6.45pm, Ms A was seen by Dr F, who noted Ms A's history, including that she had been seen by her midwife that morning and that the midwife did not consider that Ms A was showing any signs of prelabour. He noted that the urinalysis indicated infection, and wrote a prescription for antibiotics. Ms A left the hospital at 7pm.

6. Just after midnight, Ms A called an ambulance because her pain was getting worse. Ms A was transported to Hospital 1 for assessment. She arrived at 1.40am, and was noted to rate her pain at a score of 12 out of 10. Nursing staff contacted Ms B to come in to assess Ms A.

7. At 1.55am, Ms B arrived and carried out an assessment. Ms B contacted the on-call obstetrician at Hospital 2, and the decision was made to transfer Ms A to Hospital 2. At 2.27am, an ambulance was called but, because of availability, there was a delay of one hour in it arriving. Ms B did not carry out a speculum assessment at that time.

8. At 6.07am, Ms A arrived at Hospital 2. At 6.40am, Baby A was born by vaginal delivery. However, sadly, some time later, Baby A died owing to problems associated with his extreme prematurity.

Decision

9. Ms B failed to perform a speculum examination and take vaginal swabs following her initial assessment of Ms A, and failed to perform a speculum examination prior to Ms A's transfer to Hospital 2.

10. Ms B failed to assess Ms A's symptoms critically, and she gave insufficient consideration to the possibility that Ms A was in labour. Accordingly, it was held that

Ms B did not provide services to Ms A with reasonable care and skill and breached Right 4(1) of the Code of Health and Disability Services Consumer's Rights (the Code).[1]

11. By failing to comply with professional standards with regard to the documentation of her assessments and care of Ms A, Ms B also breached Right 4(2) of the Code.[2]

Complaint and investigation

12. The Commissioner received a complaint from Ms A about the services provided by community-based midwife Ms B. The following issue was identified for investigation:

- *The appropriateness of the care provided to Ms A by Ms B in 2013.*

13. An investigation was commenced on 13 May 2014.

14. The parties directly involved in the investigation were:

Ms A	Consumer/Complainant
Ms B	Provider/Community-based midwife

15. Information was also reviewed from:

Ms C	Midwife
Ambulance service	
Dr D	Obstetric registrar

Also mentioned in this report:

Mr A	Ms A's partner
Ms E	Support worker
Dr F	Rural hospital medicine specialist

16. Independent expert advice was obtained from midwife Ms Bridget Kerkin (**Appendix A**).

[1] Right 4(1) states: "Every consumer has the right to have services provided with reasonable care and skill."
[2] Right 4(2) states: "Every consumer has the right to have services provided that comply with legal, professional, ethical, and other relevant standards."

Information gathered during investigation

Background

17. In 2013, Ms A (aged 27 years) was pregnant with her fourth child.

Midwifery partnership

18. Ms A was under the care of self-employed community-based midwife Ms C. Ms C works in a remote area. At the time of these events, the only other community-based midwife in this area was Ms B.

19. Ms B told HDC that she and Ms C are the only two midwives covering the entire area. Ms B said that there are no alternative midwifery care options available in that area, although women can always access medical care at the local hospital or travel to a hospital in a main centre.

20. Ms B explained that, at the recommendation of the New Zealand College of Midwives, she and Ms C made an arrangement to provide alternate weekend cover for each other's clients, to allow herself and Ms C to have every second weekend off.

21. Ms B told HDC that this arrangement was very unsatisfactory for a number of reasons relating to differences in practice between herself and Ms C, and that on occasion there is only one midwife available for a large area, and there can be communication problems in remote locations. Ms B also raised concerns about there being no "consistent formal handover process" between herself and Ms C, and the problems that arise if either the woman does not wish to have a certain midwife providing her care, or a midwife does not wish to provide care to a certain client.

22. In addition, Ms B said that she and Ms C have a contract with the District Health Board to provide on-call maternity services to women presenting without a lead maternity carer or who are away from their usual place of residence.

Previous relationship between Ms B and Ms A

23. Ms B told HDC that she had been Ms A's lead maternity carer (LMC) during Ms A's previous two pregnancies. However, following the birth of her third child, Ms A had made a complaint about the care provided by Ms B. Ms A did not want Ms B involved in her care during her pregnancy in 2013.

26 weeks' gestation

24. At the time that Ms A was 26 weeks' gestation, Ms B was providing midwifery cover to Ms C's clients.

25. At 9.45am, Ms A contacted Ms B by telephone to advise that she had been experiencing "? labour pains since yesterday". Ms B arranged to meet Ms A at the Maternity Unit for an assessment.

26. Ms A told HDC that from approximately 1pm the previous day she had been experiencing "period like pains" that were coming every 15 to 20 minutes. Ms A said that she thought these were Braxton Hicks contractions,[3] and so ignored them. However, at approximately 4am the next morning, Ms A was woken by very painful contractions. She said that at approximately 9am she went to the toilet and noted that her mucous plug had come away. She then contacted Ms B, and told her that her mucous plug had come away and that she thought she was having contractions and was in labour. Ms A said that she felt that Ms B dismissed her concerns and recalls her saying, "If you were in labour you wouldn't be sitting there having a conversation with me," but arranged to meet Ms A at the Maternity Unit in 20 minutes' time. Ms A said she was very upset when the call ended, and decided to arrange a support person to assist them.

27. At 10.10am, Ms B met Ms A at Maternity Unit. Ms A was accompanied by her partner, Mr A, and her support person, Ms E.

28. Ms A told HDC that Ms E was her family support worker, and that she asked Ms E to support her during this assessment because of her view that Ms B did not like her and because she felt that Ms B did not believe what she was telling her with regard to her being in labour. Ms A told HDC that by the time she arrived at the Maternity Unit she was experiencing painful contractions, and told Ms B that she thought she was in labour.

29. Ms E told HDC that she had agreed to meet Ms A at the Maternity Unit to support her because of Ms A's concerns about her relationship with Ms B. In a documented account of this consultation, Ms E stated that she was asked to accompany Ms A and Mr A to the hospital as Ms A "feels she is in labour". Ms E recalls that just before she arrived at the Maternity Unit she received a telephone call from Ms A, who asked her to wait in the waiting room, as she thought she might need an internal examination and she did not want Ms E in the room while this occurred. Ms E documented: "[Mr A] rang me when I was on my way to the hospital and ask[ed] me to take my time in case [Ms B] was doing an internal on [Ms A]." Ms E recalls that she was waiting in the waiting room when Mr A came out and told her that Ms A was not having an internal examination, so she could come in. Ms E also recalls seeing Ms B before she went into Ms A's room, and telling Ms B that she was there to support Ms A. Ms E said that Ms B was happy with that arrangement.

30. In contrast, Ms B said in response to the provisional opinion that, when she arrived, Ms A, Mr A and Ms E were waiting in the lounge of the Maternity Unit. Ms B stated: "[Ms E] did not inform me she would wait in the waiting room while I did an assessment." Ms B said that she thought it would be counterproductive not to have Ms E present, given Ms A's lack of engagement with her.

31. Ms B recalled that Ms A appeared to be upset and in pain. Ms B noted that Ms A's current pregnancy history included two previous hospital admissions for severe

[3] Uterine contractions experienced during pregnancy.

abdominal pain and bleeding, with the last episode being when she was 18+4 weeks' gestation. Ms B documented that Ms A had experienced no bleeding since then.

32. Ms B carried out an assessment, noting that Ms A's observations were all normal (blood pressure (BP) was 118/74mmHg,[4] pulse 80 beats per minute (bpm),[5] temperature 36.9°C[6]). Ms B palpated the fundal height as 26cm, and noted that good fetal movements were felt on palpation. Ms B commenced a cardiotocograph (CTG).[7]

33. Ms B noted that Ms A reported that she had been "eating minimally" and that she had been given a prescription for iron tablets but had not collected the prescription. Ms B stated that Ms A also reported having experienced "mucousy discharge browny dark discharge" during the night, but that she had not experienced any discharge since. Ms B stated that Ms A did not have a pad on, so Ms B was "unable to ascertain discharge or possible PV [per vagina] loss".

34. In a statement to HDC, Ms B said that Ms A's and Mr A's "mannerism towards [her] was very antagonistic and as a consequence, information was not forthcoming".

35. Ms B documented that Ms A was "showing signs of anxiety". Ms B noted that the CTG was normal (FHR 135bpm, good variability and reactivity) and did not show any obvious signs of uterine activity. She also advised in her response to the complaint that Ms A had not had a show.[8]

36. Ms B assessed Ms A as having a possible UTI, and she did not consider that Ms A was in labour. Ms B requested that Ms A provide a urine sample so that she could test for a UTI, and Ms B said that she explained this to Ms A clearly. Ms B told HDC that Ms A refused to provide a urine sample despite her clearly explaining why one was required, so she gave Ms A the relevant equipment, including a laboratory form, and advised her to collect a mid-stream urine (MSU) sample and take it to the laboratory for testing as soon as possible.

37. The clinical records state: "MSU mane [in the morning]. All equipment given." Ms B then gave Ms A 1g paracetamol.[9] Ms B documented that the plan was to increase Ms A's food and water intake.

38. Ms B said that she did not consider it appropriate to perform a speculum examination[10] at that time, as she did not consider Ms A to be in labour. Ms B further explained her rationale for not performing a speculum examination as follows:

[4] Normal BP is generally considered to be between 90–140/60–90mmHg.
[5] Normal adult pulse is between 60–100bpm.
[6] Normal temperature is around 37°C.
[7] A device that measures the fetal heart rate and frequency and strength of uterine contractions.
[8] A show is when the mucus plug comes away from the cervix.
[9] An over-the-counter pain relief medication.
[10] A speculum is a device used to look inside the vagina, and is used in pregnancy to examine the cervix.

> "[S]he was 26 weeks pregnant, and had a history of bleeding in this current pregnancy, there was no evidence of PV bleeding when I reviewed [Ms A] she was not wearing a PV pad, CTG tracing was within normal limits and did not show any uterine activity suggestive of contractions."

39. Furthermore, Ms B told HDC that Ms A was "non communicative and hostile" towards her and she did not believe that Ms A would consent to such an intimate procedure. In contrast, in communication with the Midwifery Council of New Zealand in relation to this complaint, Ms B said that Ms A declined a speculum examination.

40. Ms A told HDC that she recalls that Ms B attached the CTG to her and told her that she was not in labour, and that she had a UTI. Ms A said that Ms B never discussed doing a vaginal examination but she agreed that she was asked to provide a urine sample. Ms A said that she went to the toilet but was unable to produce a urine sample at that time owing to the pain and pressure in her abdomen, so Ms B gave her the equipment and said that once she had a sample, she was to bring it back to be tested. Ms A said that despite her saying that she thought that she was in labour, Ms B said that she had a UTI and that it was not labour. Ms A said that she was very upset when she left the Maternity Unit, as she still believed she was in labour. She told HDC that she felt that Ms B was very rude to her, and that she clearly did not want to treat her. Ms A denied being hostile or aggressive towards Ms B. Ms A also stated that she responded to all of Ms B's questions and denied being non-communicative.

41. Ms E also told HDC that Ms A was unable to produce a urine sample at the time of the assessment. Ms E recalls Ms B telling Ms A that she had a UTI and was not in labour. Ms E documented that, at the end of the assessment, Ms A was in "[i]mmense pain", and that she was not happy with the outcome. Ms E told HDC that she felt that there was clearly "tension" between Ms A and Ms B, but that Ms B was extremely professional throughout the entire consultation.

Presentation to hospital — 6.30pm

42. Ms A said that, later that afternoon, Mr A took her urine sample back to the hospital to be tested. She told HDC that the urine sample confirmed that she had a UTI, so Mr A was told to bring her back to the hospital so that a doctor could prescribe her antibiotics.

43. At 6.30pm, Ms A arrived at Hospital 1. At 6.40pm, she was seen by a nurse. The nurse documented that Ms A's presenting complaint was "? UTI 26 wks pregnant", and that Ms A "came in c/o [complaining of] Lower abd pain and back pain. Seen by midwife this morning MSU obtained. Taken 1g paracetamol at 1530hrs." The nurse then documented: "[P]t [patient] seen by midwife [that morning], no signs of prelabour, fetal heart good, no other concern from midwife other than ? UTI."

44. At 6.45pm, Ms A was seen by the duty doctor, Dr F.[11] Dr F documented that Ms A had been seen that morning because of lower abdominal pain, had been asked to provide a mid-stream urine sample, and was now presenting with the sample. Dr F

[11] Dr F is a rural hospital medicine specialist who was working as a short-term locum.

noted that Ms A was complaining of a history of lower abdominal pain radiating into her back over the last two days, and that she had dysuria[12] and a decreased oral intake.

45. Dr F noted that, on observation, Ms A was alert and mildly dehydrated. He noted her vital observations (temperature 36.3°C, pulse 108bpm, BP 114/62mmHg, respiratory rate 20 breaths per minute,[13] and oxygen saturations 97%[14]), and noted that Ms A had some lower abdominal tenderness. He then carried out a urinalysis, noting the presence of 2+ white blood cells[15] and 1+ ketone,[16] indicating infection. On the basis of his assessment and the results of the urinalysis, Dr F prescribed Ms A with antibiotics and paracetamol. Dr F advised Ms A to increase her oral fluid intake, and to be followed up by her GP or midwife. Ms A was discharged at 7pm.

46. Ms B advised that at approximately 6.30pm she was contacted by telephone by a nurse at Hospital 1 and advised that Ms A had presented with her MSU sample and reported no change in her abdominal pain since Ms B had seen her that morning. At 6.30pm, Ms B documented in the midwifery notes: "[S]eries of pc [telephone calls] to [A&E] re: abdo pain." The nurse told Ms B that Ms A had been seen by the hospital doctor, who had prescribed antibiotics to treat a UTI, and that Ms A had been given paracetamol for her pain.

47. Ms A told HDC that she told both Ms B when she saw her earlier that day, and Dr F, that she had had urine infections previously, but that this time she did not think she had a urine infection, because it did not burn when she passed urine, and she thought that she was in labour. Ms A said that the hospital staff called Ms B, who told the hospital staff that Ms A was definitely not in labour.

48. Ms A said that after she returned home, her pain became worse. She said that at about 7pm Mr A telephoned the Emergency Department again and told them that her pain was becoming worse, but he was told that there was nothing more they could do. There is no record of this telephone call.

Re-presentation to the Emergency Department

49. Ms A told HDC that around midnight Mr A called an ambulance. At 12.36am, an ambulance was dispatched, arriving at Ms A's house at 1am. The ambulance officer assessed Ms A, noting that she was complaining of abdominal and bladder pain. Ms A's history was noted, including that she "… had sudden onset lower bladder vaginal pain 1/7 [one day ago]. Seen by midwife this am and emergency doctor this pm. Diagnosed with UTI, given 1 antibiotic and [script]."

50. Ms A reported worsening pain and "spot bleeding when wiping after urinating with discharge". Ms A was noted to be lying on a bed, "anxiety +++, moaning & groaning", and complaining of "period pain" that "comes and goes", and that she

[12] Pain on urination.
[13] Normal respiratory rate for an adult is 12–20 breaths per minute.
[14] Normal blood oxygen saturation is between 95–100%.
[15] White cells in urine can indicate the presence of infection.
[16] A ketone is a product of fatty acid metabolism that occurs when the body cannot get enough glucose. High levels of ketones can be caused by diabetes and starvation.

"explained it doesn't feel like UTI". The decision was made to transport Ms A to hospital for further assessment.

51. Ms A told HDC that she kept saying that she thought she was in labour, and felt that no one was listening to her. She said that the ambulance officer saw that she was worked up and panicking, and recommended that she be transported by ambulance to hospital.

Arrival at hospital

52. At 1.40am, Ms A arrived at Hospital 1 by ambulance. It is recorded in the clinical records that Ms A was complaining of pain, which she rated as a score of 12 out of 10, and coming in waves, starting in the lower abdomen and radiating into her back. She was noted to be reporting "brown [and] pussy" discharge, but no pain passing urine and no urinary frequency. The District Health Board (the DHB) stated that shortly after Ms A's arrival, nursing staff felt that Ms A was in labour, and contacted Ms B to attend.

53. Ms B documented that at 1.48am she received a telephone call from Hospital 1 advising her that Ms A had been brought in owing to severe abdominal pain.

54. The DHB advised that Ms B arrived at Hospital 1 at 1.55am. In response to the provisional opinion, Ms B said that Ms A again refused to communicate with her directly and did not engage in discussion. Ms A told HDC that she does not recall Ms B carrying out an assessment on her. However, the clinical records indicate that Ms B did carry out an assessment and noted that, on palpation, the fundus was soft with no tenderness. Tenderness was noted in the suprapubic region, which Ms A reported as radiating into her back. Ms B noted that Ms A reported brown mucousy discharge, and that her pain was "10+++". The FHR was noted to be 135–140bpm via intermittent auscultation. Ms B noted that Ms A had not slept for 48 hours, and had had a decreased food and water intake.

55. Ms B then contacted the on-call obstetrician at Hospital 2 to discuss a "possible management plan". Following her conversation with the on-call obstetric registrar, Dr D, a decision was made to transfer Ms A by ambulance.

56. In a retrospective record written at 6.45am, Dr D documented that Ms B rang her to "inform [her] this patient has been assessed by her and unable to find cause of severe pain. [Dr D] asked for her [Ms A] to be transferred to [Hospital 2]." Dr D told HDC that she is unable to recall any additional details of this conversation, or what advice she may have given.

57. Ms B then contacted a Hospital 2 midwife, and provided her with Ms A's clinical information.

58. Ms B told HDC that Dr D did not instruct her to undertake any further assessment, including a speculum examination, at that time. Ms B said that Dr D was aware that one had not been done, and she took advice from Dr D at that time. Ms B accepts that had she performed a speculum examination she may have been able to identify the presence of any cervical changes. However, she said that, because of Ms A's obstetric

history, administering nifedipine[17] to stop uterine contractions and slow down labour would not have been indicated.

Transfer

59. At 2.27am, Ms B ordered an ambulance for transfer to Hospital 2.

60. The initial call was prioritised as a PTS (patient transport service), which is a non-urgent transfer. However, according to the ambulance service records, at 2.46am, contact was made with Hospital 1 enquiring as to the urgency of the transfer. The ambulance service records state: "Advise [that] the [patient] can not wait. Need to get there sooner rather than later. Advised we would call back with a ETA."

61. At 2.48am, the ambulance service records refer to no one being on roster to make the transfer. At 2.48am, an ambulance was then sent from another town, with the estimated arrival time of one hour. Ms B was informed of the plan.

62. The travel time by ambulance from Hospital 1 to Hospital 2 is approximately one hour. Ms B told HDC that delays owing to staffing and ambulance availability are known issues. Ms B said that whether to use helicopter transfer is the decision of the obstetric staff at Hospital 2, and that even if the decision had been made to transfer Ms A by helicopter, in this case it would not have guaranteed that the transfer would be any more expedient because of availability and weather conditions.

63. Ms B told HDC that she informed Ms A of the delay. Ms B told HDC that in this situation she could not do more than await the arrival of the ambulance.

64. Ms A recalls being told that there would be a delay of two hours before the ambulance was due to arrive. She said that she was in a lot of pain, but was left in a room by herself. She said that she had to beg Ms B to give her some pain relief, and that initially Ms B said that she could not give her anything, but then, approximately one hour later, Ms B gave her some codeine.

65. At 3.30am, the clinical records indicate that Ms B prescribed and administered 30mg codeine. Ms B advised that she prescribed codeine on the instruction of Dr D, although it is not documented in the clinical records that Dr D advised the administration of codeine.

66. The DHB acknowledged that Ms A was requesting pain relief. However, because she had already been given paracetamol, Hospital 1 staff were limited in what they could give Ms A.

67. At 3.59am, the ambulance arrived at Hospital 1. At 4.16am, the ambulance departed Hospital 1. According to the ambulance service records the ambulance travelled under lights to Hospital 2. Ms B accompanied Ms A in the ambulance.

[17] Used to inhibit uterine contractions in preterm labour.

68. Ms A advised that shortly after departure from Hospital 1 she felt that she needed to push, and told Ms B that she thought something was wrong. Ms A said that Ms B "yelled" at her and told her not to push. Ms A said that she also asked if she could have something to drink, but Ms B told her that this was an ambulance, and it did not have drinks.

69. Ms B denies yelling at Ms A. Ms B told HDC that Ms A was very anxious and did not want to go in the ambulance. Ms B said that she spoke to Ms A firmly, explaining to her that she needed to go to Hospital 2, and that it was safe for her to be transferred.

70. Ms A told HDC that throughout the entire trip to Hospital 2 she was telling Ms B that she thought something was wrong, but Ms B did not check her or the baby.

71. Ms B agrees that she did not monitor Ms A during the transfer to Hospital 2. Ms B said that she had heard the FHR prior to leaving, and was more concerned with keeping Ms A calm. Ms B said that listening to the FHR would not have made a difference to the transfer. She also agrees that she did not give Ms A water when she asked for it, as there was none available in the ambulance.

Arrival at Hospital 2

72. At 6.07am, the ambulance arrived at Hospital 2.

73. In her retrospective record, Dr D documented that upon arrival at Hospital 2 she noted a "heavy show" on Ms A's pad, and that Ms A wanted to push. Dr D documented that the FHR was 140bpm, and that Ms B had not carried out a vaginal examination. Dr D then carried out a vaginal examination, noting that the baby was in a cephalic position at station +1cm,[18] and that the cervix was 6cm dilated. Ms A was then transferred to the delivery suite.

74. At 6.30am, Dr D conducted another vaginal examination, noting that the cervix was fully dilated and the baby's head was now at station +3cm. Ms A's membranes were noted to have ruptured spontaneously, and light green liquor was seen.

75. At 6.40am, Baby A was delivered, weighing 930g. He was noted to have cried with good evidence of respiratory effort.[19] The on-call paediatrician was called. Baby A was intubated at 15 minutes and transferred to the Neonatal Intensive Care Unit.

76. Post delivery, Ms A was admitted to the ward, and was noted to be managing well. Ms A was discharged home under the care of her LMC, Ms C.

77. Baby A was stable initially, but then developed clinical problems, including sepsis, bowel obstruction and cardiac problems. He was also diagnosed with bilateral brain haemorrhages. Baby A continued to experience on-going problems related to his prematurity, and sadly, he died.

[18] The baby in a head down position, with the head at 1cm above the ischial spines.
[19] The APGARS were recorded as 8 at one minute, 9 at 5 minutes, and 10 at 10 minutes.

Comment from Ms B

78. Ms B stated:

> "I stand by my midwifery clinical skill and I am under no illusion that the care I provided was well within the expectations of any safe midwifery practitioner. I attended [Ms A] in a timely manner and was professional with her at all times in both instances, where I was contacted."

79. Ms B reiterated her concerns about the environment she was working in, and her lack of support. In particular, in relation to Ms A's case, Ms B reiterated that previously she had had a breakdown in her relationship with Ms A.

80. Ms B accepts that her contemporaneous documentation could have been more detailed in relation to her conversations with Ms A, her impressions, and why certain investigations were not done. Ms B has since attended a New Zealand College of Midwives study day on documentation.

Midwifery Council of New Zealand

81. The Midwifery Council of New Zealand (the Council) told HDC that in 2013 it undertook a review of Ms B's competence, and Ms B was ordered to undertake a programme of education. Following the receipt of Ms A's complaint, the Council amended its order to include the requirement that Ms A practise under supervision.

Responses to provisional opinion

Ms A

82. Ms A made a number of comments in response to the "information gathered" section of the provisional opinion, which have been incorporated into the report where appropriate.

83. In addition to those comments, Ms A reiterated her belief that Ms B would have needed to carry out an internal examination during the initial assessment, and that she clearly recalls her partner, Mr A, calling Ms E and asking her to take her time coming to the hospital for that reason.

84. Ms A also denied ever getting angry and acting in a hostile way towards Ms B.

Ms B

85. In response to the provisional opinion, Ms B made a number of comments, which have been incorporated into the "information gathered" section of the report where appropriate. In addition, Ms B reiterated her view that her relationship with Ms A impacted significantly on the care she provided. In particular, Ms B said that Ms A refused to communicate directly with her during the first assessment, choosing instead to talk only to Ms E.

86. Ms B stated that Ms A's lack of engagement with her meant that, in her view, Ms A would not have consented to any intimate procedures such as a speculum examination. However, Ms B accepted that one was indicated in the circumstances.

Opinion: Ms B

Introduction

87. Ms B had been Ms A's LMC for Ms A's previous two pregnancies. However, following the birth of her third child, Ms A had made a complaint about Ms B. As a consequence, there was a strained relationship between Ms A and Ms B, and Ms A had indicated that she did not want Ms B to provide care to her during her pregnancy in 2013.

88. Nevertheless, at the time of these events, Ms A's LMC, Ms C, was on her scheduled weekend off, and Ms B was providing back-up midwifery services to Ms C's clients. Ms A was aware that Ms B was Ms C's back-up midwife and providing care to Ms C's clients every alternate weekend.

89. Ms A contacted Ms B, concerned that she was in labour. I acknowledge that the history between Ms B and Ms A may have led to some tension in their interactions that day. Furthermore, I note Ms B's submission that these tensions impacted on her being able to carry out all the relevant assessments. However, as noted in the Midwives' Code of Ethics published in the New Zealand College of Midwives *Midwives Handbook for Practice* (2008): "Midwives have a responsibility to uphold their professional standards and avoid compromise just for reasons of personal or institutional expedience." Ms E advised that Ms B acted professionally throughout the consultation she attended.

Standard of care — Breach

First assessment

90. When Ms A contacted Ms B at 9.45am and reported that she was experiencing "? labour pains since yesterday", Ms B appropriately arranged to meet Ms A at the Maternity Unit for an assessment.

91. At 10.10am, Ms B met Ms A at the Maternity Unit and carried out an assessment. Ms A was accompanied by her partner, Mr A. Ms E also supported Ms A during this assessment.

92. I am concerned about the adequacy of Ms B's assessment of Ms A at the Maternity Unit that morning.

93. Ms B documented that Ms A's observations were all normal (BP was 118/74mmHg, pulse 80bpm, temperature 36.9°C). Ms B palpated the fundal height as 26cm, and noted that good fetal movements were felt on palpation. Ms B commenced a CTG.

94. Ms B also noted that Ms A reported that she had been "eating minimally" and was "showing signs of anxiety". Ms B then discontinued the CTG, noting that it was normal (FHR 135bpm, good variability and reactivity) and did not show any obvious signs of uterine activity.

95. Ms B assessed Ms A as having a possible UTI, and did not consider that Ms A was in labour. Ms B gave Ms A 1g paracetamol. She documented that the plan was for Ms A to increase her food and water intake.

96. Ms B asked Ms A to provide a urine sample so that she could test it for a UTI. Ms B told HDC that she clearly explained to Ms A that she needed to produce a urine sample for testing but Ms A refused to provide one at that time. In contrast, Ms A said that she went to the toilet and tried to produce a urine sample but was unable to do so at that time. Similarly, Ms E told HDC that she recalls that Ms A went to the toilet to provide a urine sample. There is no documentation to indicate that Ms A refused to provide a urine sample.

97. Because Ms A did not produce a sample at that time, Ms B gave Ms A the relevant equipment, including a laboratory form, and advised her to collect a mid-stream urine sample and take it to the laboratory for testing as soon as possible. The details of this discussion are not documented. In my view, given that Ms A did not provide a urine sample at that time, Ms B should have clearly documented her discussion with Ms A in relation to this and any advice she provided. In my opinion, this was particularly important given the difficulties in the relationship between Ms A and Ms B.

98. Ms A told Ms B that she did not have the usual symptoms of a UTI, and thought she was in labour. Ms E documented that Ms A felt that she was in labour, and that her pain was "[i]mmense". I accept the advice of my midwifery expert, Bridget Kerkin, that, given the similarities in the symptoms of a UTI and preterm labour, Ms B should have undertaken a thorough assessment of the UTI symptoms. However, there is no recorded assessment or description of Ms A's urinary symptoms, and it is therefore unclear on what basis Ms B concluded that Ms A had a UTI. Unlike Dr F, Ms B's diagnosis was not informed by a urine specimen that tested positive for infection.

99. Ms Kerkin advised that, in the absence of urinary symptoms, "it would have been reasonable to offer a speculum examination of [Ms A's] cervix and take vaginal swabs to check for infection. The lack of these assessments constitutes a moderate departure from expected standards."

100. Ms B told HDC that she did not carry out a speculum examination because she did not believe that Ms A would have consented to such an intimate procedure. In contrast, Ms B told the Midwifery Council of New Zealand that Ms A declined a speculum examination during this consultation. In my opinion, these conflicting accounts from Ms B bring into question her credibility. I note that Ms A had anticipated that an internal examination would be performed, and had specifically asked Ms E to wait in the waiting room until it had been completed. There is no evidence to suggest that Ms B ever offered, or discussed with Ms A, the option of a speculum examination. Based on this evidence, I accept that Ms B did not offer a speculum examination to Ms A.

101. In my view, Ms B failed to assess Ms A's symptoms critically, and she gave insufficient consideration to the possibility that Ms A was in labour. As a result, Ms B failed to provide services with reasonable care and skill by not carrying out a speculum examination of Ms A's cervix and taking vaginal swabs to check for infection.

Second assessment and transfer

102. At 1.40am, Ms A re-presented at Hospital 1 by ambulance. Ms A was complaining of pain, which she rated as being on a scale of 12 out of 10, coming in waves, and starting in her lower abdomen and radiating into her back. She was reporting "brown [and] pussy" discharge. Shortly after Ms A's arrival, nursing staff assessed that Ms A was in labour, and asked Ms B to attend.

103. At 1.55am, Ms B arrived and assessed Ms A, noting that on palpation her fundus was soft with no tenderness. Tenderness was noted in the suprapubic region, which Ms A reported radiated into her back. Ms B noted that Ms A reported brown mucousy discharge, and that her pain was "10+++". The FHR was noted to be 135–140bpm via intermittent auscultation. Ms B documented that Ms A had not slept for 48 hours, and had had a decreased food and water intake.

104. Ms B then contacted the on-call obstetrician, Dr D, at Hospital 2, to discuss a "possible management plan". Following her conversation with Dr D, a decision was made to transfer Ms A to Hospital 2 by ambulance.

105. In a retrospective record at 6.45am, Dr D documented that Ms B rang her to "inform [her] this patient [Ms A] ha[d] been assessed by her and unable to find cause of severe pain. [Dr D] asked for her [Ms A] to be transferred to [Hospital 2]."

106. Ms B told HDC that Dr D did not instruct her to undertake any further assessment, including a speculum examination, at that time. Ms B said that Dr D was aware that one had not been done, and she took advice from Dr D. Dr D does not recall any details of her discussion with Ms B. I am unable to conclude whether or not Ms B discussed the option of a speculum examination with Dr D.

107. Ms B told HDC that she accepts that she may have been able to identify cervical changes had a speculum examination been performed at that time. However, she said that due to Ms A's obstetric history, had any cervical changes been noted, the administration of nifedipine to stop uterine contractions and slow down labour would not have been indicated. Ms B therefore did not consider there to be any value in carrying out a speculum examination.

108. The Midwifery Council of New Zealand Code of Ethics (2008) provides: "Midwives are autonomous practitioners regardless of the setting and are accountable to the woman and the midwifery profession for their midwifery practice …"

109. I note Ms Kerkin's advice that "[i]t was within [Ms B's] scope of practice as a midwife to recommend cervical assessment by speculum in order to help determine the urgency and mode of transfer". Ms Kerkin advised that in light of Ms A's history, a speculum examination was indicated, as it may have alerted Ms B to changes in Ms

A's cervix indicative of labour. This may have had an impact on the urgency of Ms A's transfer to Hospital 2, how closely Ms B monitored the FHR en route, and the pain relief options available to Ms A, such as nitrous oxide. I note Ms Kerkin's advice that "[r]easonable midwifery practice in this circumstance would include discussing with the woman the recommendation to undertake such an assessment".

110. At 2.27am, Ms B ordered an ambulance for transfer to Hospital 2. I note that the ambulance records show that the ambulance was ordered as a "patient transfer service", indicating a low priority. According to the ambulance service records, contact was later made with Hospital 1 enquiring as to the urgency of the transfer. The ambulance service records state: "Advise [that] the [patient] can not wait. Need to get there sooner rather than later. Advised we would call back with a ETA." Having carefully considered all the information collected, I accept that an urgent ambulance was ordered. However, owing to the availability of ambulances, it took over one hour for the ambulance to arrive.

Conclusion

111. Ms B failed to perform a speculum examination and take vaginal swabs following her initial assessment of Ms A, and failed to perform a speculum examination on her second assessment of Ms A and prior to transfer to Hospital 2. Ms B was responsible for Ms A's maternity care and treatment. Ms B failed to assess Ms A's symptoms critically, and gave insufficient consideration to the possibility that Ms A was in labour. In my view, Ms B did not provide services to Ms A with reasonable care and skill and, accordingly, Ms B breached Right 4(1) of the Code.

Documentation — Breach

112. A midwife is required to provide "accurate and timely written progress notes and relevant documented evidence of all decisions made and midwifery care offered and provided".[20]

113. Ms B failed to document her assessment findings or her discussions with Ms A adequately. For example, when Ms B first assessed Ms A at 10.10am that day, she did not document their discussion in relation to obtaining a urine sample in order to confirm her assessment that Ms A had a UTI. There is no documentation of the reasons why Ms B did not consider Ms A to be in labour at that time, her plan for follow-up, or her advice as to when Ms A should contact her again. Ms B noted that Ms A had reported "mucousy discharge browny dark discharge", but there is no documentation of when Ms A experienced the discharge, or in what quantity. In addition, there is no documentation in relation to Ms B's consideration and rationale for not carrying out a speculum examination following her second assessment, nor is there any documentation in relation to what consideration she gave to the mode of transport required in light of the need for an urgent transfer.

[20] Competency 2.16 of the *Midwives Handbook for Practice* (2008), New Zealand College of Midwives. Standard Seven of the Standards of Midwifery Practice (2008) also required the midwife to "clearly [document] her decisions and professional actions".

114. Ms Kerkin advised: "There are deficiencies in [Ms B's] contemporaneous documentation which make it difficult to assess the information provided to [Ms A], [Ms B's] impression of [Ms A's] clinical picture and the reasons for the absence of clinical investigation. This also constitutes a moderate departure from expected practice."

115. I agree. Accordingly, I find that Ms B breached Right 4(2) of the Code for failing to comply with professional standards with regard to documentation of her assessments and care of Ms A.

Recommendations

116. In accordance with the recommendations of my provisional opinion, Ms B has:

a) Provided a written apology to Ms A for her breaches of the Code. This will be forwarded to Ms A.

b) Attended a workshop on documentation.

117. I also recommend that Ms B undertake further training on diagnosis of pre-term labour. Ms B should provide HDC with evidence of her attendance at a relevant course, and the content of the course, within six months of the date of this report.

Follow-up actions

118.
- A copy of this report with details identifying the parties removed, except the expert who advised on this case, will be sent to the Midwifery Council of New Zealand and the District Health Board, and they will be advised of Ms B's name.

- A copy of this report with details identifying the parties removed, except the expert who advised on this case, will be sent to the New Zealand College of Midwives and placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

Appendix A — Independent midwifery advice to the Commissioner

The following expert advice was obtained from midwife Bridget Kerkin:

"My name is Bridget Kerkin and I have been asked by the Health and Disability Commission (HDC) [Complaints Assessor] to provide advice regarding the above complaint. I have read, and agree to follow, the Commissioner's Guidelines for Independent Advisors.

I registered as a midwife in 1998 and have worked primarily as a Lead Maternity Carer since then, with a focus on primary care in the community. I have provided care for women birthing at home and in primary and secondary care facilities. I have worked in rural, remote rural and urban environments. I am currently also employed as a Midwifery Lecturer at Otago Polytechnic. I am an active member of the New Zealand College of Midwives, having represented the Wellington Region as the Midwifery Resolutions Committee Midwife Representative for three years. I have a BSc in psychology, a BHSc in midwifery and have just completed my postgraduate certificate in midwifery. I have reviewed the documents provided to me which include:

a. Complaint dated […];
b. Response from [Hospital 1], dated 8 January 2014;
c. [Ms A's] clinical records;
d. Response from [Ms B] (undated)

Instructions from the Commissioner and advice requested:

1. Was there an adequate assessment at first consultation?

2. Was the care in transit appropriate?

Please feel free to comment on any other aspects of this complaint that you feel may be relevant.

If you consider the care provided was consistent with expected standards, please explain your reasoning. If you consider the care provided by [Ms B] departed from expected standards in any way, please advise whether any departure is mild, moderate, or severe, and explain your reasoning.

I declare that I have no conflict of interest.

Summary of events:

- This was [Ms A's] 4th on-going pregnancy and she had had 3 previous LSCS.
- Although not her LMC, [Ms B] was the midwife on-call when [Ms A] expressed concern about abdominal pain [at 26 weeks gestation].
- [Ms B] assessed [Ms A] and concluded that she might have a urinary tract infection.

- [Ms A] attended Accident and Emergency (A and E) later that afternoon and was treated for a urinary tract infection after being assessed by the medical officer at [Hospital 1].
- She presented to A and E again by ambulance the following morning at 0140hrs with worsening pain, reporting brownish vaginal discharge. [Ms B] attended and consulted with the on-call Obstetric registrar at [Hospital 2] and a plan was made to transfer [Ms A] to [Hospital 2].
- Ambulance transfer was requested at 0226 hours and transfer commenced at 0420hrs.
- [Ms A] arrived at [Hospital 2] at 0630hrs and her baby boy was born at 0640. He was transferred to the neonatal unit.

Commentary

Complicating factors

Having reviewed the materials provided I would like to acknowledge the particular aspects of [Ms A's] circumstances which complicate an assessment of the care provided by [Ms B].

- This first is the previous relationship between [Ms A] and [Ms B]. [Ms B] has explained that she previously provided care for [Ms A] and [Ms A] undertook a complaint process (although what type of complaint is unclear) after discharge from [Ms B's] care.
  - This previous relationship may have made it very difficult for [Ms A] to be reassured by [Ms B's] assessment and may have affected the information shared by [Ms A] and the extent of the assessment undertaken by [Ms B]. [Ms B] has reported, in her response to [Ms A's] complaint, that [Ms A] was largely non-communicative during their initial interaction [that day].
  - [section removed because not relevant to opinion]
  - Significantly, given the rural environment and lack of midwifery care options, [Ms B] reports having felt an obligation to provide care although she felt she and [Ms A] had 'irrevocable differences'.
- Secondly, I would like to acknowledge the rural setting and the impact of the distance from [Hospital 2] in terms of the need to transfer [Ms A] urgently.

Assessment at first consultation

According to [Ms A's] complaint she expressed concern that she might be in labour to [Ms B]. [Ms B] assessed [Ms A] at [Hospital 1] in a timely manner. [Ms A] was seen within 20 minutes of initially making contact with [Ms B].

At her assessment of [Ms A], [Ms B] has documented [Ms A's] concern that she might be in labour and has acknowledged [Ms A's] report of 'mucousy discharge browny dark discharge' but doesn't say when this was passed or in what quantity. At this time [Ms B] has also written '? UTI' but does not explain how she has reached this potential diagnosis. There is no recorded assessment or description of [Ms A's] urinary symptoms. Given the strong association between urinary tract infection (UTI) and preterm labour (Vazquez and Abalos, 2011), thorough assessment of any UTI symptoms is clearly indicated in such clinical circumstances. In the absence of urinary symptoms it would be reasonable to also

consider undertaking a speculum examination of the cervix and vaginal swabs (Thorogood and Donaldson, 2010).

[Ms A's] baseline observations (blood pressure, temperature and pulse) were normal at [Ms B's] assessment. No urinalysis was undertaken during this episode of care. [Ms B] arranged for [Ms A] to have a midstream urine (MSU) test [the following morning]. It is unclear from the contemporaneous record why the MSU was not taken at the time of the original assessment, although [Ms B] has stated, in her response to [Ms A's] complaint, that [Ms A] was unable to provide a urine specimen as requested. This is not recorded in the clinical record. No plan for follow-up or further contact following the assessment was documented by [Ms B]. [Ms A] did not make contact with [Ms B] again but presented to Accident and Emergency when her pain levels increased later that afternoon.

Care in transit

[Ms A] was transferred from [Hospital 1] to [Hospital 2] at 0420hrs the [following morning].

She had been admitted to [Hospital 1] at 0140 and was assessed by [Ms B] at 0155.

- Pain relief: According to [Ms A's] complaint she was very distressed and repeatedly requested pain relief. [Ms B] prescribed and administered oral Codeine (30mg) at 0330. Had [Ms B] undertaken an assessment which indicated that [Ms A] was in labour she may also have considered the provision of further pain relief, such as nitrous oxide.
- Given the rural environment, assessment of [Ms A's] cervix by speculum examination would have informed the urgency of the need to transfer and the likelihood of imminent birth (McNamara, 2003).
- The foetal heart is documented at 0155, but is not recorded again until [Ms A's] arrival in [Hospital 2] at 0630, just prior to the birth of her baby. [Ms B] reports (in her response to [Ms A's] complaint) that she felt monitoring the foetal heart rate would not change the transfer arrangement and that her focus was to keep [Ms A] calm during the transfer. This was not contemporaneously documented in the clìnical record. Again, if [Ms B] had realised [Ms A] was in labour, she may have been inclined to monitor the foetal heart more closely.
- [Ms B] reports having maintained professionalism throughout her interaction with [Ms A]. Once in transit, it would have been difficult for [Ms B] to undertake assessment of [Ms A] or to provide water as [Ms A] requested.

Summary of opinion

1. It is my opinion that [Ms B] should have undertaken urinalysis [when] she first assessed [Ms A], and prescribed antibiotics as appropriate to the result. In the absence of urinary symptoms, it would have been reasonable to offer a speculum examination of [Ms A's] cervix and take vaginal swabs to check for infection. The lack of these assessments constitutes a moderate departure from expected standards.

2. Given [Ms A's] prematurity, cervical assessment by speculum prior to her transfer to [Hospital 2] would have been appropriate, particularly if another transit option were available (i.e. air transfer). At 26 weeks gestation a foetus is considered viable and, in a circumstance of premature labour, the most effective form of transfer to a tertiary unit is indicated. Cervical assessment would have informed the urgency of transfer. Again, the lack of this assessment constitutes a moderate departure from expected standards of care.
3. There are deficiencies in [Ms B's] contemporaneous documentation which make it difficult to assess the information provided to [Ms A], [Ms B's] impression of [Ms A's] clinical picture and the reasons for the absence of clinical investigation. This also constitutes a moderate departure from expected practice.

References:

McNamara, H. (2003). Problems and challenges in the management of preterm labour. British Journal of Obstetrics and Gynaecology 110 (20): 79–80.

Thorogood, C. and Donaldson, C. (2010). Disturbances in the rhythm of labour, in S. Pairman, S. Tracy, C. Thorogood, J. Pincombe. (Eds.) Midwifery: Preparation for Practice. pp 818–862. Sydney: Elsevier.

Vazquez J.C. and Abalos, E. (2011). Treatments for symptomatic urinary tract infections during pregnancy. Cochrane Database of Systematic Reviews Issue 1. Art. No.: CD002256, DOI: 10. 1002/14651858.CD002256 .pub2.

Further advice

The following advice was obtained following the receipt of additional information from Ms B:

"My name is Bridget Kerkin and I have been asked by the Health and Disability Commissioner Principal Advisor … to provide additional advice regarding the above complaint. I have read, and agree to follow, the Commissioner's Guidelines for Independent Advisors.

[Here Ms Kerkin states her background and qualifications. This has been deleted to avoid repetition.]

I have reviewed the additional documents provided to me which include:

1. Letter from [Ms B], dated 9 June 2014.

2. Additional information provided by [Ms B] regarding her competence review and Midwifery Standards Reviews.

3. Statement from [Dr D] dated 19 September 2014.

4. [Ambulance service] records.

Instructions from the Commissioner and advice requested:

1. Please advise whether, having reviewed the new information, you wish to amend your original advice. If so, please re-issue your advice report.

If not already covered please advise on the following:

2. Was it reasonable for [Ms B] to rely on instruction from the on-call obstetrician in relation to:

a. Carrying out a speculum examination prior to transfer.

b. The decision regarding mode and urgency of transfer.

3. Any other comment you wish to make.

I declare that I have no conflict of interest.

Summary of events (from original advice report):

- This was [Ms A's] 4th on-going pregnancy and she had had 3 previous LSCS.
- Although not her LMC, [Ms B] was the midwife on-call when [Ms A] expressed concern about abdominal pain [at 26 weeks gestation].
- [Ms B] assessed [Ms A] and concluded that she might have a urinary tract infection.
- [Ms A] attended Accident and Emergency (A and E) later that afternoon and was treated for a urinary tract infection after being assessed by the medical officer at [Hospital 1].
- She presented to A and E again by ambulance the following morning at 0140hrs with worsening pain, reporting brownish vaginal discharge. [Ms B] attended and consulted with the on-call Obstetric registrar at [Hospital 2] and a plan was made to transfer [Ms A] to [Hospital 2].
- Ambulance transfer was requested at 0226 hours and transfer commenced at 0420hrs.
- [Ms A] arrived at [Hospital 2] at 0630hrs and her baby boy was born at 0640. He was transferred to the neonatal unit.

Summary of additional information provided with this request:

- [Ms B] was the subject of a Midwifery Council of New Zealand competence review in 2013 [section deleted as not relevant to HDC decision].
- In November 2013 the Midwifery Council of New Zealand received a complaint from [Ms A], a copy of which was forwarded to the Health and Disability Commissioner.

[Section deleted as not relevant to HDC decision.]

- [Dr D], the obstetric registrar with whom [Ms B] consulted prior to [Ms A's] transfer to [Hospital 2], has replied to query from the Health and Disability Commissioner's office that she did not document details of the initial conversation with [Ms B].
- The [ambulance service's] record of [Ms A's] transfer shows priority recorded as 'PTS'. I have sought clarification of this and apparently it stands for 'Patient Transfer Service' which is a non-urgent transfer request.

Commentary:

Complicating factors

In my initial advice, I acknowledged the complexity of the circumstances surrounding the care provided by [Ms B] to [Ms A]. The additional material provided to me demonstrates further complexity, detailed below.

Complexities identified in my initial advice:

- The previous relationship between [Ms A] and [Ms B]. [Ms B] has explained that she previously provided care for [Ms A] and [Ms A] undertook a complaint process after discharge from [Ms B's] care. The nature of this complaint is unclear.
    - This previous relationship may have made it difficult for [Ms A] to be reassured by [Ms B's] assessment and may have affected the information shared by [Ms A] and the extent of the assessment undertaken by [Ms B]. [Ms B] has reported, in her response to [Ms A's] complaint, that [Ms A] was largely non-communicative during [their initial interaction].
    - [section removed because not relevant to opinion]
    - Significantly, given the rural environment and lack of midwifery care options, [Ms B] reports having felt an obligation to provide care although she felt she and [Ms A] had 'irrevocable differences'.
- The rural setting and the impact of the distance from [Hospital 2] in terms of the need to transfer [Ms A] urgently.

Complexities identified as a result of the material provided for this additional advice:

- There were significant difficulties in the relationship between [Ms C] and [Ms B].
    - These issues may have impacted on the level of communication and negotiation between the midwives about providing appropriate care arrangements for women like [Ms A], who preferred to avoid contact with one of the midwives.
    - [Ms B] reports that [Ms C], as [Ms A's] LMC, 'was very aware of [Ms A's] discord towards me' (letter to the Health and Disability Commissioner's office dated 9/6/14).

Please note, in my ongoing discussion I have not restated information and opinions already addressed in my preliminary advice dated 6 April 2014, unless I feel further clarification is required, or where revision of information is necessary. As requested, I have commented on all matters I consider to be relevant.

Speculum examination prior to transfer

In my initial advice I stated:

> Given the rural environment, assessment of [Ms A's] cervix by speculum examination would have informed the urgency of the need to transfer and the likelihood of imminent birth (McNamara, 2003).

When clarifying my opinion I concluded:

> Given [Ms A's] prematurity, cervical assessment by speculum prior to her transfer to [Hospital 2] would have been appropriate, particularly if another transit option were available (i.e. air transfer). At 26 weeks gestation a foetus is considered viable and, in a circumstance of premature labour, the most effective form of transfer to a tertiary unit is indicated. Cervical assessment would have informed the urgency of transfer. Again, the lack of this assessment constitutes a moderate departure from expected standards of care.

[Ms B] has responded, in her letter dated 9th June 2014: 'I was provided with a further plan of care by the obstetric registrar. I was not instructed to do a speculum or cervical assessment by the obstetric registrar. The registrar was aware this had not been done.'

Midwives are autonomous practitioners who carry responsibility for their own midwifery assessment and care (New Zealand College of Midwives, 2008). It was within [Ms B's] scope of practice as a midwife to recommend cervical assessment by speculum in order to help determine the urgency and mode of transfer. If, during the consultation process, the obstetric registrar specifically advised against speculum examination, [Ms B] should have questioned the registrar's reasons for doing so and documented the conversation carefully.

[Ms B's] advice to [Ms A] should have included recommendation for a speculum examination to determine cervical change prior to her transfer to [Hospital 2]. This might have helped to diagnose [Ms A's] premature labour.

Decision regarding mode and urgency of transfer

As described above, cervical assessment by speculum may have alerted [Ms B] to changes in [Ms A's] cervix indicative of labour, and may well have increased the urgency of her transfer to [Hospital 2]. [The following day] at 0226 [Ms B] has documented 'Ambulance ordered for transfer to WAU for assessment.' The ambulance service documented the request as 'PTS', standing for Patient Transfer Service. It is likely [Ms B] would have requested a priority transfer if she had the findings of speculum assessment to inform her decision-making.

In her undated response to the complaint, received by the Health and Disability Commissioner's office on 3 Feb 2014, [Ms B] has stated 'Ambulance delay is a very real concern in [the region]. I could do no more than wait for the ambulance to arrive and it delayed our transfer by over an hour.' If a priority transfer request

had been lodged, it may have taken precedence over other transfers and the ambulance may have attended earlier to transport [Ms A].

Summary of opinion:

My general opinion is unchanged from my initial provision of advice although I have clarified some aspects to reflect my discussion above:

1. It is my opinion that [Ms B] should have undertaken urine testing [when] she first assessed [Ms A], and prescribed antibiotics as appropriate to the result. In the absence of urinary symptoms, it would have been reasonable to offer a speculum examination of [Ms A's] cervix and take vaginal swabs to check for infection. The lack of these assessments constitutes a moderate departure from expected standards.

2. Given [Ms A's] prematurity and history, cervical assessment by speculum prior to her transfer to [Hospital 2] would have been appropriate. At 26 weeks gestation a foetus is considered viable and, in a circumstance of premature labour, the most effective form of transfer to a tertiary unit is indicated. Cervical assessment would have informed the urgency of transfer. The transfer process may then have been given an urgent status or another transit option (i.e. air transfer) might have been considered. Reasonable midwifery practice in this circumstance would include discussing with the woman the recommendation to undertake such an assessment. Again, the lack of this discussion and assessment constitutes a moderate departure from expected standards of care.

3. There are deficiencies in [Ms B's] contemporaneous documentation which make it difficult to assess the information provided to [Ms A], [Ms B's] impression of [Ms A's] clinical picture and the reasons for the absence of clinical investigation. This also constitutes a moderate departure from expected practice.

References:

McNamara, H. (2003). Problems and challenges in the management of preterm labour. British Journal of Obstetrics and Gynaecology 110 (20): 79–80.

New Zealand College of Midwives. (2008). Midwives handbook for practice. Christchurch, New Zealand: Author."