HEALTH & DISABILITY COMMISSIONER
TE TOIHAU HAUORA, HAUĀTANGA

A Decision by the Deputy Health and Disability Commissioner

(Case 21HDC00980)

Introduction

1. This report is the opinion of Rose Wall, Deputy Health and Disability Commissioner, and is made in accordance with the power delegated to her by the Commissioner.

2. The report discusses the maternity care provided to Mrs A by Health New Zealand | Te Whatu Ora (Health NZ) Capital, Coast and Hutt Valley. It addresses the circumstances in which vaginal packing was left in situ for six weeks following the assisted birth of Mrs A's daughter and discovered by her GP at the postnatal check. The report also discusses whether the standard of care during Mrs A's post-partum period was appropriate.

3. The following issue was identified for investigation:

- *Whether Health New Zealand | Te Whatu Ora provided Mrs A with an appropriate standard of care in Month1 2021.*

4. The parties directly involved in the investigation were:

Mrs A	Consumer
Health NZ	Provider
RM B	Postnatal care midwife
RM C	Registered midwife

5. Further information was received from the local general practitioner (GP) centre.

6. In-house clinical advice was received from Nicolette Emerson, Midwifery Advisor (Appendix A).

Background

Labour and delivery

7. On Day1 Month1 2021, Mrs A was admitted to the public hospital for the birth of her baby.

8. Mrs A's lead maternity carer for the pregnancy and birth was registered midwife (RM) C, who works as part of a group practice at a local midwifery practice.[1] She was present for Mrs A's labour and delivery, but Mrs A's care was transferred to the hospital Obstetrics team

[1] This local midwifery practice comprises four midwives who share care for the same women.

when it was decided that a ventouse delivery[2] was required given concerns about the fetal heart rate.

9. At 5pm, an episiotomy[3] was carried out by an Obstetrics registrar, Dr D, and this was repaired following the birth. During the repair, the emergency bell was rung, and Dr D had to attend to another patient on the ward. She inserted vaginal packing, namely a swab and tampon, and attended the call. Mrs A's husband, Mr A, recalled: 'At the time of delivery they stuffed lot of pads into my wife's vagina to stop the bleeding from [a] tear [that] happened at the time …'

10. When Dr D returned, she continued to repair the perineum but forgot to remove the packing. Further, at the relevant time, Health NZ did not have a specific count policy regarding management of accountable items for the maternity service.

11. At 7.20pm, Mrs A was given a bed bath by RM C. RM C noted that an in-dwelling urinary catheter (IDC)[4] was in situ, but she advised HDC that she observed no evidence of a tampon string or any swabs protruding from the introitus.[5]

Postnatal care in hospital

12. On Day2 Month1 2021, RM C visited Mrs A on the postnatal ward. Among other things, it was noted that Mrs A's lochia[6] had settled, the IDC had been removed, and no concerns or questions had been expressed regarding the delivery.

13. On Day3 Month1 2021, RM C again visited Mrs A on the postnatal ward. Again, no questions or concerns were expressed, and Mrs A was advised by RM C that she would be seen by RM B, also of the same local midwifery practice, for her next visit.

14. On Day4 Month1 2021, RM B[7] took over responsibility for Mrs A's care from RM C and arranged to make initial contact with her at a home visit scheduled for the following day.

Postnatal care at home

15. On Day5 Month1 2021, RM B undertook her first visit to Mrs A's home, at which Mrs A was complaining of a sore perineum. Clinical notes record that Mrs A was encouraged to fill a script for analgesia and that RM B viewed her perinium. RM B advised HDC that she checked Mrs A's stitches during this visit, noting that she did not see any redness or swelling and that

[2] Assisted delivery using a vacuum device (ventouse) when the second stage of labour has not progressed adequately.
[3] A small incision in the perineum (the area between the genitals and the anus) during childbirth.
[4] A flexible tube inserted into the bladder to remove urine.
[5] The opening that leads to the vaginal canal.
[6] Vaginal discharge that occurs after giving birth. It contains a mix of blood, mucus, and uterine tissue.
[7] At the time of events, RM B had been an employee of the local midwifery practice since September 2020. She was employed for 35 hours per week (Monday to Friday) to provide postnatal care for a caseload of 28 women per month.

the sutures were intact. RM B said that, had she noticed an odour, she would have documented it.

16. On Day6 Month1 2021 (two days after Day5), RM B visited Mrs A at home, and Mrs A's stitches were inspected again. The clinical notes record that Mrs A's perineum was clean and healing. RM B advised HDC that, again, at this point she did not notice any odour, nor was any odour reported by Mrs A.

17. On Day7 Month1 2021 (four days after Day6), RM B undertook a further home visit. Mrs A was reporting some tummy cramps following feeds. As her perineum was still tender, a script for five days of Voltaren[8] and paracetamol was provided.

18. On Day8 Month2 2021 (nine days after Day7), RM B again visited Mrs A at home. Mrs A's perineum appeared to be completely healed. However, Mrs A was reporting tenderness around and behind her clitoris.[9] RM B parted the labia[10] and noted that nothing looked out of the ordinary. She told HDC that she did not notice any odour at this point either.

19. On Day9 Month2 2021 (six days after Day8), a further home visit took place. No further examination of the perineum was undertaken given that it had been noted to have healed. At this point, Mrs A mentioned having brown lochia, which RM B assessed as normal. However, RM B considered that the symptoms of lower abdominal cramp and odour described by Mrs A at this point were consistent with an infection in the uterus. Accordingly, RM B prescribed Mrs A augmentin.[11]

20. On Day10 Month2 2021 (five days after Day9), Mrs A called the local midwifery practice number because she had been experiencing diarrhoea for the past two days. She was advised to increase her fluids and to seek medical advice from her GP or after-hours doctor. Again, no complaints of pain or odour were documented at this time.

21. On Day11 Month2 2021 (two days after Day10), RM B saw Mrs A at home. Clinical notes record that Mrs A was on her last day of antibiotics and that the odour previously mentioned had now gone. RM B advised HDC that Mrs A's lochia had almost stopped, and Mrs A had reported that the diarrhoea was no longer of concern. RM B said that Mrs A was no longer needing to take analgesia and that, had any of her symptoms still been present, Mrs A would have been referred to her GP.

22. On Day12 Month2 2021 (10 days after Day11), RM B undertook her final home visit. Clinical notes record that Mrs A reported that she was still experiencing some light pinkish/brown bleeding and tenderness around and behind her clitoris and was finding sitting uncomfortable. RM B told HDC that she agreed to Mrs A's plan to see her GP about these symptoms when she attended for the baby's six-week check the following week. RM B said

[8] A nonsteroidal anti-inflammatory drug used to treat pain and inflammatory diseases.
[9] The most sensitive part of the vulva.
[10] Folds of skin around the vaginal opening.
[11] An antibiotic.

that she explained to Mrs A that she was unsure what could be causing the clitoral pain and described the process for referral to the outpatient gynaecology clinic should her GP feel this was warranted. RM B advised HDC that, given the absence of odour, excessive bleeding, and fever, she was comfortable with the plan for GP follow-up.

23. On Day13 Month3 2021 (three days after Day12), Mrs A attended the scheduled appointment with her GP. Her GP documented that, on examination, a retained pad was discovered and was removed with forceps. Mrs A's GP also documented the presence of an unpleasant smell and some white discharge and noted that a swab was taken and sent to the laboratory.

24. Mrs A and Mr A advised HDC:

> '[We] discovered a left out pad [the] size of half of an "Arm" inside [Mrs A's] vagina and when [the GP] removed it, the smell was like a dead body coming out of her …
>
> [Mrs A] cried at the time, scared to death that it could lead to some serious illness/ infection or worse death due to this negligence of duty.'

Meeting following discovery of swab

25. On Day14 Month3 2021 (two days after Day13), Dr E (the Clinical Head of the Obstetrics and Gynaecology Department at the public hospital), RM C, and RM B met with Mrs A and her husband. An apology was offered and an assurance provided that strategies were in place to prevent the same type of accident occurring in the future.

26. In addition, Dr D apologised in person and accepted responsibility for forgetting to remove the swab.

27. As well as a physical examination, a scan was requested with a follow-up appointment scheduled for four weeks' time. Mrs A and Mr A were advised that Health NZ would be undertaking a formal internal review into Mrs A's care.

28. On Day15 Month3 2021, a formal apology and letter explaining the incident was sent to Mr A.

Information provided by RM C and RM B

29. As part of the investigation of Mrs A's complaint, HDC provided RM C and RM B with the opportunity to respond to the matters raised.

30. RM B advised that her involvement with a woman commences after she has given birth and that, as she is not involved with women before they give birth, she familiarises herself with their clinical information before and at the first visit. If any particular follow-up is required for the woman or baby, the hospital will call the number for the local midwifery practice and she will receive the information. A verbal handover is provided by the birthing midwife if there has been anything significant arising from the birth.

31. In response to the provisional opinion, RM B's advisor also stated:

> 'RM B advised that until Day9 Month2 2021 Mrs A's recovery appeared to be consistent with a usual postnatal scenario following a difficult birth. She advised that when Mrs A reported odour and lower abdominal pain on Day9 Month2 [2021], she considered Mrs A might have an infection of the uterus which is consistent with the reported symptoms and not uncommon. RM B advised that she had not experienced a foreign body left in situ following delivery, and her immediate thought was the more common presentation consistent with the reported symptoms.'

32. In response to the Serious Adverse Event Review recommendation (paragraph 35) that a speculum[12] examination should be considered, both RM C and RM B explained that they do not carry a speculum or perform speculum examinations at home.

Serious Event Review

33. Health NZ provided HDC with a copy of the serious adverse event report (72-hour form) presented to the Serious Event Review Committee (SERC) mid Month3 2021. SERC undertook a review on Day17 Month4 2021. It confirmed that, following suturing, no swab count occurred, and no plan for removal was documented.

34. Although not a direct cause of the retained swab in this instance, the review noted that midwifery/nursing staffing levels on the maternity ward were short between 3pm and 6pm on Day1 Month1 2021.[13] In addition, a shift note completed at the time documented multiple emergencies during the shift.

35. Regarding the care provided by RM B and RM C, the review made the following findings:

a) A self-administered vaginal swab could have been suggested alongside antibiotic prescription.

b) A speculum examination should be considered (or referral for same) if significant vaginal discharge, pain, or odour is persistent.

36. The review recommended that a swab count is carried out following all perineal repairs and, when appropriate, a plan for removal clearly documented. The review also recommended the implementation of a safety system to prevent discharge in circumstances similar to Mrs A's, including orange hi-vis wrist bands to be put on the person and removed only once the swabs have been removed.

[12] A device used to widen the vaginal walls to enable examination of the vagina and cervix.
[13] Health NZ provided information about utilisation on the PM shift — capacity was at 80.6%, and staff were able to provide 65.9% of the hours of care required on that shift.

Responses to provisional opinion

Mrs A

37. Mrs A was given an opportunity to respond to the relevant sections of the provisional opinion provided and had no comment to make.

Health NZ

38. Health NZ was given an opportunity to respond to the provisional opinion and stated it accepted the finding. Health NZ also stated:

> 'We wish to express our sincere apologies to Mrs A for the care she received while under our services. It was never our intention to cause harm.'

RM B

39. RM B was given an opportunity to respond to the provisional opinion, and she accepted the comments made about the care provided save for some small amendments made to the report to reflect her response to the complaint.

40. In response to a proposed recommendation made in the provisional opinion that RM B reflect on the deficiencies in care identified in this case, particularly around vaginal swabs and speculum examinations, RM B has provided her reflections to HDC.

RM C

41. RM C was given an opportunity to respond to the provisional opinion, and she stated she accepted the provisional decision as it pertained to her.

Opinion: Health NZ — breach

42. I acknowledge that this has been a distressing experience for Mrs A and her family. Following discovery of the swab left in situ, understandably Mrs A was concerned about the possibility of resulting serious illness or infection.

43. As a healthcare provider, Health NZ is responsible for providing services in accordance with the Code of Health and Disability Services Consumers' Rights (the Code), and Mrs A had the right to have services provided to her with reasonable care and skill. Ultimately, Health NZ has an organisational responsibility to provide a reasonable standard of care to its patients. That did not occur in this case, as Health NZ failed to ensure that a vaginal swab was removed following the delivery of Mrs A's baby.

44. In reviewing the circumstances of this incident, I am critical that, at the time, the maternity service did not have a relevant policy in place for ensuring potentially 'retainable' items are accounted for. At a minimum, the policy should have included a robust system for monitoring the number of swabs used during a procedure. Had such a system been in place at the time, likely this would have avoided the issues that arose for Mrs A.

45. As noted above, it was not routine practice at the maternity ward at the public hospital at the time to communicate or document when swabs were inserted into a patient. I am highly critical of this as, in my view, this put patients at risk.

46. As noted above, the SERC review undertaken by Health NZ identified that staffing levels were short at the relevant time. Accordingly, I am concerned that, in addition to the lack of swab counting, systems issues may have contributed to the error, particularly given that a senior medical officer was called away at a critical moment in Mrs A's care.

47. This error is the responsibility of the public hospital's Obstetrics team and of Health NZ, who provided the overall service to Mrs A and ultimately had responsibility for ensuring that policies and procedures were in place to minimise the possibility of retention of a swab. I am highly critical that this error occurred. As a result, Mrs A suffered unnecessary complications and a protracted recovery.

48. Because a swab was retained in Mrs A's vagina in error, I find that Health NZ failed to provide services to Mrs A with reasonable care and skill and therefore breached Right 4(1)[14] of the Code. In addition, given the lack of policies and procedures, which led to Mrs A suffering emotional harm and a protracted recovery process, I consider that Health NZ failed to provide services to Mrs A that minimised potential harm to her, and accordingly I find that Health NZ breached Right 4(4) of the Code.[15]

49. That said, I commend Health NZ's prompt decision to investigate the cause of this incident. Health NZ took responsibility for the errors identified in the SERC review and committed to making changes to policies and processes at Health NZ to prevent a similar incident happening. It is notable that Health NZ's investigation sought a 'full contextual understanding to ascertain learning and improvement points'.

Opinion: RM B — adverse comment

50. To determine whether the care provided by RM B was appropriate, I carefully considered the events in the days after Mrs A gave birth. I also considered the advice of my in-house clinical advisor, RM Emerson.

51. Of relevance is RM B's visit to Mrs A's home four days following the birth. At that point, Mrs A was complaining of a sore perineum. I accept RM B's evidence that no odour was noticed at that time, which may have provided some indication of a retained swab. RM Emerson advised that the actions of RM B in checking Mrs A's sutures and encouraging her to fill her prescription for analgesia were in keeping with accepted midwifery practice. I accept this advice. Similarly, six days following the birth, no odour was noticed or reported. RM Emerson advised that RM B's decision to view Mrs A's perinium at her request, and RM B's

[14] Right 4(1) states: 'every consumer has the right to have services provided with reasonable care and skill.'
[15] Right 4(4) of the Code states: 'every consumer has the right to have services provided in a manner that minimises the potential harm to, and optimises the quality of life of, that consumer.'

documentation that it was clean and healing, was in keeping with accepted midwifery practice. Again, I accept this advice.

52. The first indication of an odour occurred 25 days following the birth. As noted at paragraph 19 above, RM B stated that she did not undertake a further examination at that point because a recent examination had indicated that the perineum had healed. Although Mrs A was reporting other symptoms, including lower abdominal cramping, I accept RM B's evidence that these symptoms were consistent with an infection in the uterus and that Mrs A was advised appropriately on the process for dealing with this. The advice to call the local midwifery practice number if Mrs A was concerned or had no improvement was appropriate in the circumstances. I accept RM Emerson's advice that safety-netting advice was documented in the clinical notes contemporaneously.

53. I note RM B's comment that, although best practice would include a vaginal self-swab on prescribing antibiotics, whilst a swab may have identified an infection, it was unlikely to have identified a retained swab.

54. RM Emerson advised that a set of baseline observations would be expected prior to prescribing antibiotics and that, along with the lack of a vaginal swab, this represented a moderate departure from accepted midwifery practice. I accept this advice.

55. Overall, although RM Emerson identified a moderate departure from accepted midwifery practice, I am cognisant that RM Emerson noted that the contemporaneous documentation and all other aspects of clinical care met accepted midwifery standards. I also acknowledge RM B's comment that, during her 10 years as a midwife, she had never previously encountered a foreign body being left in situ following delivery, and as such would not have anticipated such an outcome. As such, I have made adverse comment regarding the lack of baseline observations and for not taking a vaginal swab. However, I do not consider that RM B breached the Code.

56. RM B told HDC that she is sorry that the circumstances were such that the retained swab could not be identified sooner. She said that she has reflected on this incident extensively and has made changes to her practice as a result.

Opinion: RM C — other comment

57. To determine whether the care provided by RM C to Mrs A in the period immediately following the birth was appropriate, I considered the response received from RM C and the advice of my in-house clinical advisor, RM Emerson.

58. As discussed above, RM C was present for Mrs A's labour and delivery, and RM C visited Mrs A in hospital on the two days following the birth. It is notable that at the first visit on Day2 Month1 2021, no concerns or questions were expressed regarding the delivery.

59. Similarly, at the second visit on Day3 Month1 2021, no concerns or questions were expressed, and Mrs A's lochia remained settled and was noted in her clinical notes as minimal.

60. RM C's next contact with Mrs A was on Day13 Month2 2021, when she was contacted following the discovery of the retained swab by Mrs A's GP. I consider that the actions taken by RM C at that point were appropriate — namely, advising that management would be contacted as soon as possible, and offering an apology for Mrs A's experience.

61. I accept RM Emerson's advice that no departures from care were identified in RM C's midwifery practice and that RM C would not be expected to consider a retained swab when another practitioner had delivered Ms A's baby.

Changes made since events

62. As a result of this incident, Health NZ developed and implemented a Perineal Trauma: Prevention, Assessment and Repair Guideline (MATY063) and a Perineal Injury and Repair Form (MATF135) (the proforma). Health NZ provided HDC with a copy of these documents.

63. Furthermore, Health NZ advised that on 7 March 2023 a first audit looking into the use of the proforma had been completed and that an action plan will be implemented to improve consistency in its use.

64. In addition, as a result of a recent clinical review, orange high-visibility wristbands were introduced to identify any person with swabs/packing in situ.

65. RM B advised HDC that she has made changes to her practice as a result of this incident, particularly regarding the use of swabs when prescribing antibiotics.

Audit

66. Health NZ confirmed that, following the SERC review, a formal process was implemented, and this is used by staff when counting in and out any vaginal packing. In addition, Health NZ provided HDC with a copy of the findings of an audit it completed in March 2023.

67. The audit report set out the following conclusions and recommendations:

> 'Swab counts are routinely documented when cases are done in theatre. For patients who had a tear which was sutured on delivery suite, 62% had a swab count recorded. The perineal assessment was recorded on the new proforma in 63% [of] cases. One pack was used and clearly documented, but the orange band was not used.
>
> Given the high turnover of medical staff and introduction of new midwives to the unit, the use of the proforma was good.
>
> …

Further education needs to be done within the department to highlight the perineal proforma, it should be encouraged that all vaginal births have a perineal assessment and that this is documented on the proforma.'

Recommendations

68. I recommend that Health NZ Capital, Coast and Hutt Valley:

a) Apologise to Mrs A for the breach of the Code identified in this report. The apology is to be sent to HDC within three weeks of the date of this report, for forwarding to Mrs A.

b) Provide HDC with copies of all audits on the use of the 'Perineal Trauma and Repair' proforma and compliance with the process when counting in and out any vaginal packing that has occurred since March 2023. This information is to be provided to HDC within six months of the date of this report.

c) Consider how new staff will be oriented to the 'Perineal Trauma and Repair' proforma, as well as the steps being taken to achieve 100% compliance regarding the use of this following every vaginal birth, and report back to HDC on the outcome of its consideration within three months of the date of this report.

Follow-up actions

69. A copy of this report with details identifying the parties removed, except Health NZ and the clinical advisor on this case, will be sent to Health NZ (national office), Te Tatau o te Whare Kahu | Midwifery Council, and the Health Quality & Safety Commission Te Tāhū Hauora and placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

Appendix A: In-house clinical advice to Commissioner

The following in-house advice was obtained from Nicholette Emerson, Midwifery Advisor:

'1. Thank you for the request that I provide clinical advice in relation to the complaint from Mrs A about the care provided by RN/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:

- Complaint from Mr A on behalf of Mrs A Day13 Month3 2021
- Health NZ Capital, Coast and Hutt Valley response and clinical records Day16 Month4 2021 including response to Mr A, clinical records for Mrs A, surgical count policy 2016, SAC report, details of staff involved.
- Response and clinical records from RM C
- Clinical records from GP
- Complaint response and clinical records from RN/RM B

3. Background: Mrs A was under the care of a local midwifery practice. She laboured spontaneously and birthed her baby with the assistance of a ventouse for fetal distress. The ventouse was performed by Dr D as was an episiotomy and perineal repair. During the course of the postnatal period Mrs A complained of ongoing perineal pain and discomfort. The postnatal midwife RN/RM B has documented assessing the perineum and prescribing antibiotics for uterine symptoms which were temporarily relieved. Following discharge from midwifery care Mrs A continued to have ongoing symptoms. Assessment by the GP resulted in the discovery of a swab/pack retained in the vagina following suturing six weeks previously. The complaint regards the failure to remove the swab/pack following suturing and the failure to identify the retained swab/pack in the postnatal period.

Advice Request: Please could you advise:

- Whether the assessments undertaken by RM B on Day5, Day6, Day7 Month1 and Day8, Day9, Day11 and Day12 Month2 2021 were adequate/appropriate, including whether there was an indication for further investigation or referral at any of those visits.
- Whether the assessments undertaken by RM C while Mrs A was an inpatient were adequate/appropriate.
- Any other matters that you consider warrant comment or amount to a departure from accepted standards.

RM C

RM C works in the local midwifery practice. RM C provided labour care for Mrs A. Labour established and progressed normally. In the second (pushing) stage of labour there was a prolonged deceleration of the fetal heart rate. RM C pushed the emergency button. When support staff arrived the fetal heart rate was fluctuating between 70 and 125bpm with a slow gradual recovery (110–160bpm normal range). A prolonged deceleration of the fetal heart rate followed. Dr D made the decision to perform a ventouse (instrumental delivery) to expedite birth. An episiotomy was cut by Dr D as part of the Ventouse procedure. Dr D delivered the placenta, inspected Mrs A's perineum and commenced a perineal repair. RM C states in her complaint response that

At 1920 hours, I gave Mrs A a bed bath as she did not want to get up to shower. On cleaning, it was noted an In-dwelling Urinary Catheter (IDC) was in situ, however, I observed no evidence of a tampon string or any swabs protruding from the introitus. I was not expecting nor did I understand a swab to still be present internally. I got a wheelchair for her as she did not wish to walk, and we moved down to the postnatal ward.

In the following two days, RM C visited Mrs A in hospital. There was no report of any concerning discomfort. Care was discharged to RN/RM B for postnatal care on Day4 Month1.

RM C was contacted by Mr A on Day13, Month3 explaining the swab/pack removal at the GP that day. RM C was in the delivery unit at the time; however, she did email Mr A and Mrs A that evening apologising for their experience and offered to meet with them whilst she awaited the clinical documentation.

The following day RM C contacted the Hospital Clinical Midwife manager and later spoke to Dr E, Clinical Head of Obstetrics and Gynaecology. A meeting was arranged for Day14 Month3 (discussed below).

There are no identified departures from RM C's midwifery practice identified. It would not be expected to consider a retained vaginal swab/pack or to check for this when another practitioner (Dr D) had delivered Mrs A's baby and had performed the episiotomy and episiotomy repair. By day 2 Mrs A was not reporting any symptoms associated with the retained swab/pack.

Registered Nurse/Midwife (RN/RM B)

RN/RM B reports in her complaint response that she was employed as a postnatal midwife by a local midwifery practice from 2020. Her hours of work were 35 hours per week (Monday to Friday). She carried a caseload of 28 women/birthing persons per month.

When a birth occurred on a weekday, RN/RM B would visit the woman/birthing person in hospital following birth, then at home. RN/RM B states that, as she is not involved in

the birth, she familiarises herself with the clinical notes at the first postnatal visit. She receives handover from the birthing midwife if there is anything significant of note during the birth.

RN/RM B contacted Mrs A via phone on Day4 Month1 following Mrs A's discharge from hospital. A visit was arranged at home the following day. Two postnatal visits had been carried out in the hospital by RM C over the previous weekend, Day2 and Day 3 Month1.

RN/RM B's first postnatal visit took place at Mrs A's home on Day5 Month1. At the visit the birth was discussed. Both the clinical documentation and complaint response report that Mrs A stated that her perineum was sore at this visit. Sutures were checked by RN/RM B at Mrs A's request. No redness or swelling was observed, and the sutures appeared to be intact. Mrs A was encouraged to fill her prescription for analgesia. No odour was noted, and RN/RM B's impression was of a normal healing perineum with pain associated with a healing episiotomy. These actions are in keeping with accepted midwifery practice.

Day6 Month1 Mrs A's perineum was viewed again by RN/RM B at Mrs A's request and was documented as clean and healing. These actions are in keeping with accepted midwifery practice.

Day 10 [post birth]. At a home visit, perineum tenderness was mentioned again so an analgesic script was supplied for 75mg diclofenac twice daily and four hourly Panadol for perineal discomfort and afterpains.

Day 19 [post birth] The perinium was viewed again as Mrs A was still uncomfortable, and it appeared well healed. RN/RM B parted Mrs A's labia to check for internal grazing as the pain described was behind the clitoris. RN/RM B states in her complaint response that she did not note any odour or any clinical signs that healing was not taking place though she does concede that pain behind the clitoris is more unusual. She did not observe a retained swab/pack.

Day 25 [post birth] Mrs A described an odour and lower abdominal cramping. RN/RM B prescribed a 7-day course of a broad-spectrum antibiotic (Augmentin) as she thought that there might have been infection of the uterus present. Mrs A was advised (as contemporaneously documented) to call on the midwifery practice number if she had worsening pain, high temperature, rigors, heavy or clotting bleeding.

At the time of antibiotic prescription, RN/RM B did not undertake a further examination. She did not use a vaginal swab to identify/isolate/culture any possible responsible microbe responsible for Mrs A's symptoms.

A full set of baseline observations were not taken to confirm/exclude Mrs A's degree of infection at the time of prescribing antibiotics. A set of baseline observations would be expected as part of the midwifery critical thinking process and rationale prior to

prescribing antibiotics. Without baseline maternal observations improvement/ deterioration was subjective.

In summary, safety netting advice is contemporaneously documented in the clinical notes Day9 Month2 but baseline observations and vaginal swab were not undertaken. This is not in keeping with accepted midwifery practice and departs moderately.

On Day 32 [post birth] Mrs A was on her last day of antibiotics, the odour had gone and her bleeding had almost stopped. In her complaint response RN/RM B states that, had the symptoms still been present, she would have referred Mrs A to the GP.

On Day 42 [post birth] RN/RM B undertook a discharge visit with Mrs A, and Mr A was home.

They told me that they had been to the doctor that morning for a postnatal check as Mrs A still had some light pinkish/brown bleeding, and tenderness around and behind her clitoris, and was finding sitting uncomfortable. I understood that she had described her symptoms to the GP and asked to be assessed while she was there for the baby's check. The GP had given Mrs A an appointment to come back next week. I agreed with this plan and encouraged them to see the GP. I explained I was unsure of what could be causing the clitoral pain and talked about the process of referral to the outpatient gynaecology clinic if the GP felt this was needed. I enquired about the previous symptoms of odour which she denied. I asked about her lochia, and she said it was pink/ brown but not stopped which is not unusual at this time. She denied excessive bleeding or feeling unwell today. Given the absence of odour, excessive bleeding, and fever I was comfortable with the plan for GP follow up the following week.

Midwifery contemporaneous clinical documentation is in keeping with the above comment.

The GP clinical documentation submitted does not record a visit on Day 42 post birth; however, this could be because the visit on this day was for Mrs A's baby and would not be recorded against Mrs A's clinical notes.

On Day14 Month3 RN/RM B met with Mrs A, Mr A, RM C and Dr E (Clinical Head of Obstetrics and Gynaecology) following the GP discovery of the retained swab/pack.

RN/RM B states that Mrs A's complaint has had a significant impact on her and her practice. She states in her complaint response that she has discussed the care provided with colleagues, attended a [Health NZ] review and reflected considerably on events. She has also attended an informal review with the hospital educator. RN/RM B notes

Following review of the matter, it has been noted that best practice would include a vaginal self-swab on prescribing antibiotics. I agree with this recommendation and now ensure this is always undertaken when antibiotics are prescribed. A swab may have identified an infection but was unlikely to identify a retained swab.

On consideration of these comments, accepted practice would also include recording maternal baseline observations when prescribing antibiotics.

RN/RM B reflects that the GP used a speculum to identify the retained swab but notes that

The use of a speculum in the early postnatal period following an episiotomy and suturing would also need to be undertaken cautiously. By the time Mrs A saw her GP she was six weeks post-delivery and her perineum had healed.

A recommendation was made following review to consider use of a speculum investigation if pain, odour or significant vaginal discharge is persistent. In Mrs A's case the reported symptoms of odour and pain had resolved by Day11 Month2. They were not reported again until Day12 Month2 when the couple had already reported the symptoms to the GP and had planned a visit.

On review, RN/RM B does make valid considerations; however, whether or not the retained swab/pack had been identified sooner with a vaginal swab cannot be determined retrospectively.

RN/RM B has documented ongoing review of Mrs A's perineum and offers a reasonable argument for not identifying the retained swab/pack. She has considered and incorporated recommendations for a vaginal swab in similar circumstances in the future and accepted that a speculum examination would be appropriate in similar circumstances.

A moderate departure from accepted Midwifery practice has been identified in not undertaking a vaginal swab and baseline maternal observations prior to prescribing antibiotics.

It is noted that the contemporaneous documentation and all other aspects of clinical care meet accepted midwifery standards. RN/RM B's visits continued for the full six weeks postpartum as Plunket were unable to visit until mid Month2.

Events following the discovery of the retained swab.

Day14, Month3: A meeting between Mr A, Mrs A, RN/RM B, RM C, and Dr E took place. Dr E is reported to have been extremely apologetic and accepted a mistake had occurred. Strategies were in place to prevent this recurring. A physical examination of Mrs A took place noting the healed episiotomy. The clitoris was observed to be a little pink, so oestrogen cream was prescribed. A scan and counselling was offered. Dr D came and apologised and accepted responsibility. Plans for a full incident review were discussed with assurance that the review outcome would be provided to Mr A and Mrs A. A further apology was made for systems not being in place to prevent the occurrence of this incident.

Health NZ Capital, Coast and Hutt Valley have developed a perineal Trauma and Repair form as a result of this incident and placed it in all clinical areas in Maternity from mid Month3 2021 (Health NZ Capital, Coast and Hutt Valley Response 2021).

Summary

In consideration of the midwifery care provided to Mrs A, no departures from accepted midwifery care are identified in the care provided by RM C. There is a moderate departure in accepted midwifery care identified in the care provided by RN/RM B in not undertaking a vaginal swab and not undertaking baseline maternal observations prior to the prescription of antibiotics.

It is noted, however, that safety netting advice was provided to Mrs A regarding signs of clinical deterioration. I hope this report addresses some of Mr A and Mrs A's ongoing questions. I wish them the best in the ongoing care of their precious family.'