Registered Midwife B

Registered Midwife C

A Report by the

Deputy Health and Disability Commissioner

(Case 21HDC00593)

HEALTH & DISABILITY COMMISSIONER
TE TOIHAU HAUORA, HAUĀTANGA

Contents

Complaint and investigation

1. The Health and Disability Commissioner (HDC) received a complaint from Ms A about the services provided by registered midwife (RM) B and RM C. The following issues were identified for investigation:

   - *Whether RM B provided Ms A with an appropriate standard of care in December 2019 and January 2020.*
   - *Whether RM C provided Ms A with an appropriate standard of care in January 2020.*

2. 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.

3. The parties directly involved in the investigation were:

Ms A	Consumer
Mr A	Consumer's partner
Ms E	Consumer's sister
Mr E	Ms E's partner
RM B	Provider/registered midwife
RM C	Provider/registered midwife
RM F	Provider/registered midwife
[…] Ambulance	Provider

4. Further information was received from ACC and Health New Zealand | Te Whatu Ora (Health NZ).

5. Independent advice was obtained from RM Nicolette Emerson (Appendix A).

Information gathered during investigation

6. In 2017 Ms A lost her second baby, Baby D, at 22 weeks' gestation as a consequence of triploidy (a rare genetic condition). In 2019 she became pregnant for the third time. The estimated date of delivery was 16 February 2020.

7. Ms A's lead maternity carer (LMC) was RM B. Ms A is concerned about the antenatal care provided by RM B, including her investigation of vaginal symptoms at 16 weeks' gestation, inadequate response to her raised blood pressure (BP),[1] not weighing her or undertaking urinalysis at any stage, and not providing information about access to, and choice of, obstetric/secondary care.

[1] During pregnancy, normal BP is 120/80mmHg or lower. If BP is 140/90mmHg or higher on two separate occasions after 20 weeks' gestation, it is considered high.

8. […] At 33+4 weeks' gestation, Ms A experienced abdominal and back pain and a hard abdomen. She contacted back-up midwife RM C, but there was a delay in assessing Ms A. When Ms A was assessed at the maternity unit, the cardiotocography (CTG) trace was found to be abnormal and her temperature and BP levels raised. An ambulance transfer to the public hospital was arranged. Sadly, on arrival, no fetal heartbeat could be detected. Ms A had experienced a placental abruption,[2] resulting in the stillbirth of her baby, Baby A.

RM B

Referral information

9. Ms A was diligent about her pregnancy in light of the previous loss of Baby D. She told the Health and Disability Commissioner (HDC) that RM B did not provide her with information about access to, and choices of, obstetric and secondary care. She said that RM B strongly emphasised that Ms A should use only her midwifery services, despite Ms A's request to seek other options — such as obstetrics and secondary care.

10. Ms A said that her first contact with RM B about her latest pregnancy was on 22 July 2019 when she texted RM B that she was pregnant again and asked whether they could catch up to see where they would go from there. RM B had looked after Ms A during her previous two pregnancies. Ms A said that she was not aware of the process for an obstetric referral, which was why she contacted RM B.

11. The first visit was on 1 August 2019. Ms A told HDC that she asked RM B about obstetrics being involved in light of the events with Baby D, and RM B told her, 'You can't be struck by lightning twice' and said that what had happened last time would not happen again. Ms A said that RM B told her that they would 'just have to see how we go' and did not inform Ms A whether she met obstetric care criteria or provide information about the possibility of a self-referral to a private obstetrician.

12. RM B told HDC that she has no recollection of Ms A having requested a consultation with an obstetrician. RM B said that had Ms A done so, she would have submitted a referral based on the referral pathway due to 'maternal request'. RM B stated that there was no indication of a need to refer Ms A to an obstetrician during her pregnancy.

Thrush cream

13. Ms A stated that halfway through her pregnancy, she reported some vaginal symptoms to RM B, who gave her a prescription for thrush cream without establishing by means of a swab or other assessment whether thrush (a yeast infection) was the cause of the symptoms.

14. On 30 August 2019 RM B documented that she had given Ms A a script for thrush cream, more iodine, and paracetamol. There is no documentation of Ms A's symptoms or whether she had had thrush previously. RM B told the HDC that Ms A requested thrush treatment, and she did not order a swab to investigate the symptoms further because it is her practice to provide women with thrush treatment if they are confident about their symptoms.

[2] Separation of the placenta from the inner wall of the uterus.

15. RM B stated that she requests a routine vaginal swab for women who have multiple sexual partners or have risk factors, such as previous sexually transmitted infections, or for young pregnant women. She stated that she also swabs women who describe any unusual vaginal discharge, as that allows her to differentiate micro-organisms that may be causing the change in smell or consistency of their discharge.

16. RM B said that if women are in a monogamous relationship and are familiar with the itchy symptoms of fungal infection, it is not unusual to offer thrush treatment and to investigate further only if the treatment does not clear the symptoms quickly. RM B stated that Ms A made no further mention of vaginal discharge or related concerns, and so it was reasonable to assume that the treatment was effective or not needed/used.

17. Ms A told HDC that the statement from RM B is not correct. Ms A said that she described an itch on the outside of her vagina and said that she was not sure what it was, as she had not experienced it previously. RM B responded that she would write a script for thrush cream. Ms A stated that she mentioned that she was not familiar with thrush, and RM B replied that she had not had it either. Ms A said that she had not had thrush during her previous pregnancies, but RM B did not examine her or ask any further questions about her symptoms, and she proceeded to write a script for thrush treatment.

Blood pressure

18. Ms A said that RM B did not recommend that a consultation and treatment by a specialist was warranted despite her raised BP readings and significantly low ferritin[3] level. The normal range for ferritin is 20–200µg/L. On 2 August Ms A's ferritin was 44µg/L (normal range). On 26 November Ms A's ferritin was 12µg/L (below normal range), and her haemoglobin was 109 (normal range is 100–145). In response to the provisional opinion, Ms A stated that, despite the risks, RM B did not place any urgency on prescribing treatment for the iron deficiency, and there was a nine-day delay in receiving treatment for low iron following the test result.

19. High-dose iron therapy was commenced. It is recorded that iron therapy was discussed further at the next appointment […] at 32+5 weeks' gestation and that Ms A was experiencing gastric disturbance with the iron therapy, so RM B recommended a reduction from two tablets to one tablet. In response to the provisional opinion, Ms A stated that she also experienced irritated skin after taking the iron therapy, and she advised RM B of that additional symptom at her appointment at 32+5 weeks' gestation. Ms A said that she had already reduced the dosage to one tablet after experiencing adverse reactions (skin irritation and loose bowel motions). She said that the dosage on the label stated one tablet, but initially RM B had advised her to take two tablets to avoid constipation. RM B documented that iron therapy was discussed with Ms A and that she advised her to reduce the dose of ferritin tablets from two to one as it was causing loose bowel motions. However, RM B did not document that Ms A was also experiencing skin irritation.

[3] A blood protein that stores iron in the body.

20. Ms A stated that her BP recordings were at the upper end of the normal range on three to five occasions during her antenatal visits.

21. Ms A said that the final BP […] six days before the sudden onset of marked abdominal pain at 33 weeks of pregnancy was at the highest level during her pregnancy. However, her urine levels were never checked for protein or glucose, and no other tests of her wellbeing were carried out. She said that RM B did not inform her that her BP was higher than average and the possible complications of this, such as the possible development of gestational hypertension (high BP in pregnancy) and placental abruption, or what she should watch out for towards her due date, such as sudden abdominal pain indicating abruption.

22. RM B stated that Ms A's BP recordings were as follows:

- 11.6 weeks — 136/72
- 16 weeks — 118/78
- 21.4 weeks — 136/78
- 25.4 weeks — 118/68
- 29.5 weeks — 138/78
- 32.5 weeks — 138/82

23. RM B stated that Ms A's BP readings were not high at any point, and, as Ms A did not have any risk factors for pre-eclamptic toxaemia (PET),[4] RM B treated her as a low-risk woman. RM B said that she had looked after Ms A during her previous two pregnancies, and her BP had remained stable throughout.

24. Ms A disagreed that she was a low-risk woman. She said that she had several risk factors for pre-eclampsia, including weight gain and a rise in BP, particularly between 25 and 32 weeks' gestation. In response to the provisional opinion, Ms A stated that she told RM B that she had swollen feet throughout her pregnancy, and RM B suggested that this was probably due to the summer heat.

25. The booking visit was the only occasion on which RM B recorded Ms A's weight, which at that time was 65kg.

26. Ms A noticed an increase in her size and reported that to RM B. However, RM B did not assess or weigh Ms A. In addition, Ms A's sister, Ms E, had had pre-eclampsia, and RM B was aware of that family history, as she had cared for Ms A's sister during her pregnancy and the birth of her child.

Urinalysis

27. Ms A told HDC that RM B did not undertake urinalysis at any stage throughout the pregnancy, contrary to established accepted standard practice and the NZ College of

[4] Pre-eclampsia is a serious medical condition that can occur around 20 weeks' gestation and can include symptoms of high blood pressure, protein in the urine, headaches, swelling, and blurred vision.

Midwives' 'Midwives Handbook for Practice Guidance', which states that urinalysis is an integral part of each of the first, second, and third decision points in pregnancy.

28. RM B stated that, as she considered that Ms A was at low risk of PET, with her BP within the normal range, she did not deem it necessary to undertake a urinalysis at every visit. However, she did order a laboratory urine test as part of her usual initial screening assessment, which showed negative protein and no bacterial growth.

29. RM B said that she was influenced by studies that questioned the effectiveness and benefit of routine urinalysis, and she was aware that routine urinalysis during pregnancy is a poor predictor of PET. She stated that in her 17 years of experience working as a midwife, she had seen little benefit from urinalysis as a routine test. Therefore, her practice had been to do the more accurate laboratory analysis of urine and blood for women who have any symptoms of PET.

30. RM B told HDC that she regrets that she did not undertake routine dipstick urinalysis during Ms A's pregnancy and, as a result of this case, she has returned to routine urinalysis in her practice.

LMC absent

31. Ms A stated that she was not aware that RM B would be unavailable in January 2020. Other than at in-person visits, she and RM B communicated by way of text messaging, and on two previous occasions RM B had advised Ms A via text message that she was going away. However, Ms A did not receive any communication about RM B's leave in January 2020, so she was not aware of the dates on which she would be away. Ms A stated that RM B had told her that she would be taking some leave over the Christmas period, but Ms A should still contact her if she had any concerns.

32. In contrast, RM B stated that she often uses text messaging with women about scheduling appointments and confirming her arrival time for home visits, but she reminds women not to text her with any important matters and to call her directly on her 0800 number, which ensures that they reach her back-up midwife if a colleague is covering her caseload while she is away or unavailable. RM B stated: 'Miss A had a copy of our […] Midwives Handbook and also knew of my time away over the New Year period.'

Events at 33+4 weeks' gestation

33. At 33+4 weeks' gestation at 3.57pm, Ms A sent the following text message to RM B:

> 'Hey […], Ive been having contractions well I thought it's just Braxton Hicks[5] but it's been an hour and there not going away, I've had a bath to relax but still the same. I'm not leaking fluid or mucus. Should I be worried?'

34. Ms A stated that at that stage, she was not sure whether she needed to be concerned, and her intention was to check in with RM B to assess the urgency of the situation. Ms A said that having not received a response after approximately an hour, she followed the

[5] Tightenings that prepare the uterus for labour

communication process as detailed in the […] Midwives Handbook and contacted the 0800 […] number.

Contact with RM C

35. At 5.15pm Ms A spoke to the midwife on call, RM C. They spoke for eight minutes.[6] Ms A said that she told RM C that she was experiencing severe back pain, her tummy was hard and sore with increased discomfort, and she had had three contractions over four minutes. RM C asked Ms A how far along she was and whether it was her first pregnancy. Ms A said that it was her third pregnancy, and they discussed Baby D's health condition. However, RM C advised that they did not discuss Baby D's health condition during this phone call but during the ambulance ride to the hospital.

36. Ms A said that RM C told her that she was not in labour because 'you are talking to me — normally you wouldn't be able to talk if you were in labour' and told her that it was most likely Braxton Hicks contractions. Ms A told HDC that she told RM C that she did not think they were Braxton Hicks contractions because she had experienced them previously and knew what they felt like.

37. RM C said that Ms A reported that the tightenings were short, lasting 20–30 seconds, and would go away when she changed position, and she did not think they were labour contractions. In contrast, Ms A stated that she expressed clearly that they were painful and different to Braxton Hicks, and they did not discuss whether the contractions would go away when she changed position, as RM C claimed.

38. Ms A said that the symptoms she described in the initial phone call also included generally feeling unwell, feeling the need to pass urine regularly, and having experienced two urgent bowel motions.

39. RM C said that she asked about the baby's movements, and Ms A stated that they had been fine. In contrast, Ms A stated that she told RM C that she could not feel her baby move, as her abdomen was so hard/tight that it was not possible to feel movements. She said that RM C did not offer to 'check in' and did not suggest that Ms A monitor her baby's movements or patterns.

40. RM C said that she made a clear plan that she would check in with Ms A in two hours' time, but if things worsened or she wanted to see her earlier, to call back.

41. RM C made no clinical record of the conversation. She told HDC that her recollection is that Ms A did not say that she was in severe pain or that her stomach was hard. RM C said that her understanding from the call was that Ms A had tightenings that were short and going away and that it was uncomfortable but definitely not severe pain.

42. RM C subsequently recorded on Ms A's […] Hospital Patient Examination and Progress Form: 'Met Ms A at […] the maternity unit as she had called to say that she was having back pain

[6] Ms A provided HDC with her telephone records to verify the times and length of the calls.

and lower abdominal pain with tightenings that she thought could be painful Braxton Hicks but was unsure.'

43. Ms A's partner, Mr A, was present when she spoke to RM C. Mr A told HDC that Ms A's pain was the reason for the initial call. He confirmed that abdominal pain and back pain, as well as contractions that had started out like Braxton Hicks contractions, were definitely mentioned during the call, and he remembered Ms A being concerned that her tummy felt unusually hard.

44. Ms E and her partner, Mr E, were also present during the call between Ms A and RM C. They confirmed that Ms A mentioned the pain she was experiencing in her lower back and abdomen and advised that she could not feel the baby's movements because she had so much pressure in her stomach, and her stomach was too hard to feel any movements. They said that Ms A also made it very clear that what she was experiencing was unlike anything she had experienced in previous pregnancies.

45. Ms A became increasingly concerned, so she did not wait two hours, and at 6.49pm she telephoned the call centre again. The call lasted one minute. Ms A said that she spoke to RM C and insisted that she be seen immediately, and RM C agreed to meet her at the […] maternity unit at 7.30pm.

46. In response to the provisional decision, RM C advised that if Ms A had mentioned severe back pain or a hard abdomen that did not subside, she would have acted immediately to assess her. RM C remains of the opinion that Ms A described only that her stomach would tighten and soften.

47. RM C accepts that she should have documented the initial phone call with Ms A and is regretful that she did not do so at the time. RM C said that since these events, she has ensured that all calls and assessments are documented thoroughly as they occur.

[…] Maternity Unit

48. At 7.35pm RM C recorded that she had met Ms A at the […] maternity unit at 7.30pm as she had called to say that she was having back pain and lower abdominal pain with tightening that she thought could be painful Braxton Hicks contractions. RM C noted that Ms A had reported feeling unwell and shivery and had asked to meet at the maternity unit for an assessment.

49. RM C recorded that, on assessment, Ms A's pulse was 96 beats per minute (bpm) (normal 60–100) and her BP was 132/100mmHg taken with a manual cuff and 140/99mmHg taken on a Dinamap (an automatic electronic BP monitor). Ms A's temperature was 38.8°C (normal 36.5°C). RM C took Ms A's temperature again with a different thermometer and it was 37.9°C.

50. RM C told HDC that on abdominal palpation the baby was longitudinal (spine aligned with mother's spine), cephalic (head down), left occiput anterior (LOA — baby's back on the mother's left side facing toward the mother's back), and Ms A's abdomen was soft and it was easy to palpate the baby's position. RM C said: 'Her abdomen definitely did not feel

board-like at this point. I was aware of the significance of this in relation to an abruption.' RM C did not record this assessment.

51. In contrast, Ms A stated:

> 'I have no recollection of RM C conducting an abdominal examination at […] the maternity unit, and this description does not correlate with my symptoms of having a hard/tight abdomen. Given the state of my abdomen, I would not have thought it was possible for RM C to feel for the baby's position.'

52. In response to the provisional opinion, RM C advised that it is basic midwifery practice to palpate the abdomen prior to applying a CTG as it is not possible to apply a CTG monitor without first palpating the abdomen to locate the baby's position. RM C said that the practitioner needs to know where the baby's back is to know where to place the transducer. RM C advised that she has always conducted this step before attaching the transducer and would never skip this important process, which is standard and invariably routine.

53. Mr A and their daughter were also present. Mr A told HDC that they arrived at the unit both feeling anxious and concerned, because Ms A was in pain and feeling unwell. Mr A said that RM C asked Ms A to provide a sample of urine, but she was unable to do so. RM C then took Ms A's temperature and blood pressure but undertook no physical examination apart from the placing of the CTG. Mr A said that RM C told them multiple times that there was nothing to be concerned about. He said that RM C also mentioned that she could not access Ms A's notes.

54. CTG was commenced at 7.45pm. At 7.55pm RM C asked the core midwife to review the CTG as there was reduced variability, a high baseline, and an irritable uterus. The recommendation was to consult with the […] hospital obstetric team, following which it was decided to transfer Ms A to hospital by ambulance immediately.

[…] Ambulance [provider]

55. The core midwife at […] the maternity unit called 111 and told the call taker that the problem was immediately life threatening. The midwife also completed the Emergency Transfer Checklist. Under the heading 'Priority Given', she wrote 'Urgent. Life threatening — yes.'

56. […] The ambulance told HDC that its Computer Assisted Dispatch (CAD) Report shows that the response priority for the call to […] the maternity unit was allocated as RED. A RED priority response is under lights and sirens. The ambulance was assigned to Ms A at 8.15pm and arrived at the […] maternity unit at 8.26pm. RM C stated that when the ambulance arrived, the paramedics asked Ms A whether she would like a stretcher, but she replied that she was 'fine to walk' to the ambulance.

57. Ms A stated that when the ambulance team enquired about the level of urgency, Ms C advised that lights and sirens were not necessary. In response to the provisional opinion, Ms A noted that the Ambulance Care Summary included 'Status at scene: 3 Unlikely Threat to Life' and she expressed concern that this had been changed from the initial priority.

58. […] The ambulance told HDC that there is no record of whether the ambulance travelled to […] the hospital under lights and sirens. However, the response priority remained at RED in the system until the ambulance arrived at […] the hospital delivery suite at 9.14pm.

59. RM C told HDC that the paramedic asked her whether she wanted to go under lights and sirens, and she replied that they needed to get there quickly. She stated that the paramedic suggested that they travel at road speed but if they encountered any traffic he would put on the lights and sirens. RM C said that she thought that sounded reasonable as it was 8.30pm and she was not expecting a lot of traffic at that time.

60. RM C stated that, while travelling to [the hospital], she called and spoke to the on-call registrar to update her. RM C said that Ms A's observations settled in the ambulance. However, the paramedics recorded at 9pm that Ms A's heart rate was 91bpm, her BP was 129/104mmHg, and her temperature was 38.5°C.

61. RM C said that she chatted to Ms A during the journey, and Ms A did not require any pain relief. In contrast, the […] ambulance records state: 'Paracetamol 1g given by LMC @2035hrs.' RM C made no clinical records during the ambulance transfer.

Assessment at […] Hospital

62. RM C stated that on arrival at the hospital, the paramedic offered to wheel Ms A in on the stretcher, but Ms A said that she was 'fine to walk'. Ms A told HDC that that is misleading. She said that the Ambulance Dock at […] the hospital is located on Level […], and she was transferred to the Delivery Suite on Level […] in a wheelchair. She stated:

> 'I did not feel the need for a stretcher, but I certainly did not walk and would not have been able to walk that far. I walked a few steps to board and disembark the ambulance and on to a wheelchair, then a few steps from the wheelchair to the bed on the delivery suite.'

63. […] The hospital [Registered Midwife] RM F retrospectively recorded that on arrival at the Delivery Suite at […] the hospital at 9.20pm at 33+4 weeks' gestation, Ms A appeared well, not in obvious distress, and walked to the bed unaided. RM F documented that Ms A had felt unwell with chills and noted: '[Ms A] told me that she had been experiencing lower abdominal pain and back pain for several hours.' RM F recorded that she palpated the contractions and that Ms A had periods of tightness over her abdomen, in between which her uterus was soft. RM F noted that she attempted to monitor the fetal heartbeat but could not find it, so she asked RM C to assist.

64. RM C told HDC that at that point she could feel the hard, board-like abdomen that is typical when there is a placental abruption. She was no longer able to feel where the baby was located and was unable to find the heartbeat.

65. RM F recorded that at 9.35pm Ms A's BP was 142/105mmHg and her heart rate was 96bpm, but Ms A did not report other PET symptoms such as visual disturbance, epigastric pain, or headache. Another BP taken five minutes later at approximately 9.40pm was 140/97mmHg and the heart rate was 98bpm. A third BP at 9.45pm was 129/94mmHg and the heart rate

was 100bpm. At 9.45pm the registrar performed a scan, which showed that no fetal heartbeat was present. The registrar noted that Ms A had said that she had last felt the baby move two hours previously. In response to the provisional opinion, Ms A stated that this information is incorrect as what she said was that she had last felt the baby move two hours prior to the phone call she made to RM C at 5.15pm at 33+4 weeks' gestation.

66. Obstetrician and Gynaecologist Dr G recorded that Ms A had been unwell that afternoon and had seen the LMC at […] the maternity unit because of abdominal pain.

ACC advice

67. Dr G advised ACC that Ms A's diagnosis was unclear. When she presented to hospital, her blood pressure was high and proteinuria[7] was identified. Dr G stated that it is difficult to know whether that developed following the abruption. He considered it more likely that the PET was present prior to the abruption, but he noted that there did not appear to be identifiable signs or symptoms of PET.

68. ACC obtained midwifery clinical advice from Dr Lorna Davies. In Dr Davies' opinion, Ms A's BP was on the upper side of normal during pregnancy, but Dr Davies noted that there is a fairly broad spectrum within the normal range, and the accepted range before either gestational hypertension or pre-eclampsia is suspected is a systolic measure of 140mmHg and a diastolic of 90mmHg. Ms A never presented with a BP as high as that during her pregnancy, nor did she present with a rise in a baseline BP of 30mmHg systolic or 15mmHg diastolic, which, although no longer used for diagnostic purposes, could alert the provider to consider additional monitoring.

69. Dr Davies said that Ms A did not have any additional signs of pre-eclampsia during pregnancy, such as headache, epigastric pain, or visual disturbance, which would possibly have alerted the LMC to the need for further screening for pre-eclampsia. Dr Davies stated that the RANZCOG guidelines (2018) advise that routine testing for proteinuria is not helpful in predicting pre-eclampsia and should be confined to women with a BP over 140/90mmHg or with sudden weight gain,[8] and Ms A did not present with either of those criteria.

Responses to provisional opinion

70. Ms A was sent the 'information gathered' section of the provisional opinion. Her responses have been included in the opinion as relevant.

71. RM B advised that she had no further comment to make on the provisional opinion.

72. RM C advised that she fully accepts responsibility for not documenting the initial phone call with Ms A at 33+4 weeks' gestation. However, she respectfully disagrees with some aspects of the report and questions aspects of Ms A's recollection. RM C's responses have been included in the opinion where appropriate.

[7] Protein in the urine.

[8] See above. RM B did not weigh Ms A at any time during her pregnancy.

Opinion: Introduction

73. At the outset, I express my condolences to Ms A and Mr A for the tragic loss of Baby A. I acknowledge that the events at 33+4 weeks' gestation were traumatic and that Ms A has sought answers to her questions about what happened and whether Baby A's death could have been prevented. This investigation has focused on whether RM B and RM C provided Ms A with an appropriate standard of care.

74. The events surrounding Ms A's pregnancy, particularly in the period leading up to the stillbirth of Baby A, have been extremely difficult to investigate, not least on account of the multiple examples recorded throughout the report where both midwives and Ms A have given very different accounts of the events.

75. In considering whether Ms A's maternity care met accepted standards, I have been guided by the advice of my in-house clinical advisor, RM Nicolette Emerson.

Opinion: RM B — breach

Assessments — breach

Thrush cream

76. On 30 August 2019 Ms A told RM B that she had an itch on the outside of her vagina. Ms A said she told RM B that she was not sure what it was and had not experienced that symptom previously. When RM B responded that she would write a script for thrush cream, Ms A told her that she was not familiar with thrush and had not had thrush previously. Ms A said that RM B replied that she had not had thrush either.

77. RM B did not examine Ms A or ask any further questions about her symptoms, and RM B wrote a script for thrush cream. RM B did not document Ms A's symptoms or whether she had had thrush previously, and she did not order a swab to investigate the symptoms further.

78. RM Emerson advised that best practice would include swabbing to exclude bacterial vaginosis, which is associated with pre-term labour. However, if the woman had experienced thrush previously, it would be reasonable to provide her with a prescription.

79. I accept that it is not a departure from accepted midwifery practice to prescribe treatment for vaginal thrush as a first-line treatment for a woman who has experienced vaginal thrush previously, is requesting treatment for thrush, and has no known risk factors for preterm labour. However, that was not the case here.

80. RM B did not record Ms A's symptoms or whether she had had thrush previously. I accept Ms A's account that she had not had thrush previously and did not request treatment for it. I consider that it was inappropriate for RM B to have provided thrush cream without further

investigation in these circumstances. I am also critical that RM B did not follow up with Ms A later to check whether the treatment had resolved the symptoms.

Urinalysis and measurement of weight

81. Ms A is concerned that RM B did not weigh her during her pregnancy beyond recording her booking weight of 65kg, as a sudden weight gain can be a signal of PET. Ms A said that she pointed out her increase in size to RM B, but RM B took no action in response.

82. In addition, Ms A stated that RM B did not perform urinalysis at any time during her pregnancy other than the laboratory urine test undertaken at booking. RM B stated that the reason for not doing so was her view that urine dipstick testing is a poor predictor of pre-eclampsia.

83. RM Emerson acknowledged that there is debate regarding the value of testing urine for protein in the diagnosis of pre-eclampsia. However, she stated that accepted midwifery practice was that dipstick testing was part of routine antenatal care, as is outlined in the NZCOM Standards of Practice decision points. Having considered several sources of information, RM Emerson concluded that failing to test Ms A's urine during her pregnancy was a moderate departure from accepted midwifery practice. I accept that advice.

Conclusion

84. Ms A did not have many of the classic signs of PET prior to 33+4 weeks' gestation, such as a BP at or over 140/90mmHg, headache, epigastric pain, or visual disturbance. However, had RM B conducted urinalysis and monitored Ms A's weight, that may have identified that Ms A was not a low-risk woman, particularly in light of the familial history of PET.

85. In my view, by failing to assess and monitor Ms A's vaginal symptoms, and by failing to monitor Ms A's weight or perform urinalysis, RM B failed to provide services to Ms A with reasonable care and skill and breached Right 4(1)[9] of the Code of Health and Disability Services Consumers' Rights (the Code).

Obstetric referral — breach

86. Ms A became pregnant in 2019, and from the start she was understandably concerned about her pregnancy because of having previously lost Baby D. She stated that she asked RM B about obstetrics being involved, but RM B did not tell her whether she met obstetric care criteria or provide her with information about self-referral to a private obstetrician.

87. RM B does not recall Ms A requesting a consultation with an obstetrician and stated that there was no need to refer Ms A to an obstetrician during her pregnancy. I do not feel that RM B gave due consideration to the background to the request, and in the circumstances Ms A had the right to decide whether she wanted to consult a private obstetrician.

88. I find it more likely than not that Ms A did raise her concerns with RM B, who did not make it clear to Ms A that she could access obstetric care privately at her own cost. RM Emerson

[9] Right 4(1) states: 'Every consumer has the right to have services provided with reasonable care and skill.'

advised that the failure to provide that information was a moderate departure from accepted practice. I accept that advice and find that RM B breached Right 6(1)[10] of the Code.

Other comment

89. Ms A was not aware that RM B would be unavailable in January 2020. Previously RM B had communicated that she was going away by way of text messaging. As Ms A did not receive any communication about RM B's leave in January 2020, she was not aware of the dates on which she would be away. I note that RM B tells clients not to text her with any important matters and to call her directly on her 0800 number. When Ms A was concerned about her symptoms initially, she text messaged RM B for assistance, but when she received no reply, she then used the 0800 number.

90. Given Ms A's concerns about her pregnancy, I find it disappointing that RM B was not more explicit about the dates on which she would be unavailable and assumed that Ms A would be aware of whether her symptoms were sufficiently concerning to need to call the 0800 number initially.

Opinion: RM C — breach

91. At 33+4 weeks' gestation, during their first conversation at 5.15pm, Ms A spoke to RM C for eight minutes. Ms A said she told RM C that she was experiencing severe back pain, her tummy was hard and sore with increased discomfort, and she had had three contractions over four minutes.

92. RM C's recollection is that Ms A did not say that she was in severe pain or that her stomach was hard. RM C said that her understanding from the call was that Ms A had tightenings that were short and going away and that it was uncomfortable but definitely not severe pain.

93. Mr A was present when Ms A spoke to RM C. He confirmed that during the call Ms A mentioned that she had abdominal and back pain as well as contractions that had started out like Braxton Hicks contractions and that Ms A was concerned that her tummy felt unusually hard.

94. Ms E and Mr E were also present during the call between Ms A and RM C. They confirmed that Ms A mentioned the pain she was experiencing in her lower back and abdomen and that she said that she could not feel the baby's movements because she had so much pressure in her stomach, and her stomach was too hard to feel any movements. They said that Ms A also made it very clear that what she was experiencing was unlike anything she had experienced during her previous pregnancies.

[10] Right 6(1) states: 'Every consumer has the right to the information that a reasonable consumer, in that consumer's circumstances, would expect to receive, including …
(b) an explanation of the options available, including an assessment of the expected risks, side effects, benefits, and costs of each option …'

95. RM F recorded that Ms A told her that she had been experiencing lower abdominal pain and back pain for several hours and had felt unwell with chills. Dr G recorded that Ms A had attended the […] the maternity unit because of pain.

96. RM C made no clinical record of the conversation. Taking into account the evidence from Ms A, Mr A, Ms E, and Mr E, and Ms A's contemporaneous comments to staff at […] the hospital, I find it more likely than not that Ms A told RM C that she was in pain and that her stomach was hard.

97. RM C told Ms A to wait because the tightenings would probably go away and said that she would call back in two hours.

98. RM Emerson advised that if it is accepted that Ms A was in severe pain and she reported that her stomach was hard, then it would be a severe departure from accepted practice not to arrange immediate assessment. I agree. RM Emerson also advised that, alternatively, if it is accepted that Ms A was unsure about what she was experiencing and after a process of discussion and reassurance Ms A agreed to observe her discomfort and for RM C to reassess her in two hours' time following the phone call, then there is a mild departure from midwifery accepted practice. However, RM Emerson is critical that the offer of immediate assessment was not made clear to Ms A had she wanted it.

99. As noted above, I find it more likely than not that Ms A told RM C that she was in pain and that her stomach was hard. It is difficult to determine the reasonableness of RM C's actions at this point when the parties concerned hold differing perspectives on what was said in relation to the pain level. However, with reference to the statements from everyone who was there at the time, I am prepared to accept that Ms A described the degree of discomfort she was experiencing. I am therefore critical that RM C did not make it clear to Ms A that she should be assessed straight away.

100. After arrival at […] the maternity unit, RM C took and recorded Ms A's vital signs. RM C told HDC that she also palpated Ms A's abdomen, and it was soft and easy to palpate the baby's position. RM C said that she would have palpated the abdomen to locate the position of the baby before applying the CTG transducer. However, she made no record of an abdominal assessment.

101. In contrast, Ms A stated:

> 'I have no recollection of RM C conducting an abdominal examination at […] the maternity unit, and this description does not correlate with my symptoms of having a hard/tight abdomen. Given the state of my abdomen, I would not have thought it was possible for RM C to feel for the baby's position.'

102. Mr A also told HDC that no abdominal examination took place.

103. I accept that RM C likely palpated Ms A's abdomen for the purpose of placing the CTG transducer correctly. However, given Ms A's recollection that there was no abdominal examination, and because there is no documentation of RM C's findings, this raises concerns

about the thoroughness of the examination and whether RM C noted her findings appropriately (aside from noting where to place the transducer). Notwithstanding this omission, I accept that RM C recognised Ms A's condition as serious and arranged an immediate emergency transfer.

104. Overall, I consider that RM C's care of Ms A was inadequate, particularly because during the initial telephone conversation, RM C did not respond to the symptoms Ms A was describing with sufficient urgency. For this reason, I find that RM C failed to provide services to Ms A with reasonable care and skill and breached Right 4(1) of the Code.

Record-keeping — breach

105. The College of Midwives' Standards of Practice requires that midwives maintain accurate, comprehensive, and accessible records of their care. RM C did not document her telephone conversations with Ms A. RM Emerson advised that failing to do so was a moderate departure from accepted midwifery practice. Furthermore, RM C made no clinical records after leaving the […] maternity unit to travel to […] the hospital.

106. I find that RM C failed to provide services that complied with professional standards and breached Right 4(2)[11] of the Code.

Changes made since events

107. RM B now performs a urine dipstick test at every pregnancy assessment.

108. If RM B is going away, she now sends out a text message to all the women under her care notifying them NOT to text while she is away and including a reminder of the 0800[…] number, as well as the name of the midwife who will be providing cover while she is away.

109. RM B continues to review and discuss her practice with colleagues and mentors (the […] Hospital Delivery Suite charge midwife and lead obstetrician) and ensures that her care is as thorough, risk averse, and as compassionate as possible.

110. Following a competence screening assessment, the Midwifery Council encouraged RM B to review the literature, including the NZ Obstetric Ultrasound Guidelines, the Referral Guidelines, the New Zealand Maternal Fetal Medicine Small for Gestational Age Guideline, and the Perinatal Institute recommendations. The Council also recommended that RM B strengthen her competence in growth assessment by reviewing the Growth Assessment Protocol.

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

111. RM C now documents phone calls as they happen. She has read the document that RM Emerson suggested in her recommendations and has also registered for the NZCOM's course 'Dotting the I's in a Digital Age: Record Keeping for Midwives'.

112. RM C attended a Midwifery Council Competence Review on 20 February 2024. The Council asked RM C to engage in a competence programme within six months.

Recommendations

113. I acknowledge the actions taken by the Midwifery Council and the changes RM B has made to her practice since this event.

114. I recommend that within three weeks of the date of this report, RM B and RM C each separately provide a written apology to Ms A and Mr A for the breaches of the Code identified in this report. The apologies are to be sent to HDC, for forwarding.

115. I recommend that within three months of the date of this report, RM B and RM C each undertake additional education on person-centred care and effective communication with health consumers and complete the HDC online modules for further learning: https://www.hdc.org.nz/education/online-learning/. Evidence of attendance at related training and completion of the online modules is to be provided to the HDC.

116. I recommend that RM B review the Midwifery Council document 'Be Safe Be Sure' and report to the HDC with her learnings regarding documentation and record-keeping, within one month of the date of this report.

117. I recommend that the Midwifery Council consider whether a further review of RM B is called for in the circumstances to ensure that the competency support she received following this event has been effective.

118. In the event that RM C returns to midwifery practice, I recommend that the Midwifery Council consider whether a further review of her competence is required.

Follow-up actions

119. A copy of the sections of this report that relate to RM B will be sent to the Midwifery Council of New Zealand.

120. A copy of the sections of this report that relate to RM C will be sent to the Midwifery Council of New Zealand.

121. A copy of this report with details identifying the parties removed, except the advisor on this case, will be sent to Health New Zealand | Te Whatu Ora […], the New Zealand College of Midwives, the Perinatal and Maternal Mortality Review Committee, and the Midwifery Council of New Zealand, and the anonymised report will be placed on the HDC website (www.hdc.org.nz) for educational purposes.

Rose Wall

Deputy Health and Disability Commissioner

Appendix A: In-house clinical advice to Commissioner

The following in-house advice was obtained from RM Nicolette Emerson:

'**CLINICAL ADVICE — MIDWIFERY**

CONSUMER : [Ms A]

PROVIDER : RM [B], RM [C]

FILE NUMBER : C21HDC00593

DATE : February 8, 2022

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1. Thank you for the request that I provide clinical advice in relation to the complaint from [Ms A] about the care provided by LMC RM [B] and back-up midwife RM [C]. 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:** Letter of complaint dated 11 March 2021, Complaint response from RM [B] dated 7 July 2021, Complaint response from RM [C] 14 July 2021, Clinical records from RM [B] and RM [C] covering the relevant period. Clinical records from […] DHB covering the relevant period. Ambulance care summary from […] Ambulance.

3. **Background:** [Ms A] was in her third pregnancy and receiving care from her LMC RM [B]. [Ms A] raises concerns about the antenatal care provided by RM [B], including her investigation of vaginal symptoms at 16 weeks, not undertaking urinalysis at any stage, and not providing information about access to and choice of obstetric/secondary care.

   [Ms A] is also concerned about a delay in assessment by back-up LMC RM [C] […] at 33 weeks and 4 days' gestation, when she experienced abdominal and back pain. [Ms A] was assessed at […] [the] [m]aternity [u]nit, where the CTG trace was found to be abnormal and [Ms A] had a raised temperature. An ambulance transfer was arranged to […] [h]ospital. Sadly, [Ms A] experienced a placental abruption, resulting in the stillbirth of her precious baby [A].

4. **Advice Request:** I have been asked to review the documentation supplied and advise whether I consider the care provided to [Ms A] by RM [B] and RM [C] was reasonable in the circumstances and why.

In particular, I have been asked:

RM [B]

1. The reasonableness of the care provided with respect to [Ms A's] vaginal symptoms at 18 weeks, including whether further investigations should have been undertaken.
2. The appropriateness of RM [B]'s decision to not undertake urinalysis antenatally.
3. The management of [Ms A's] blood pressure.
4. What information is usually provided to women with respect to access to and choice of obstetric/secondary care, and what recommendations would be made following high blood pressure and low ferritin results?
5. The adequacy of the handover to the back-up midwife.
6. Any other matters that you consider amount to a departure from accepted standards.

RM [C]

1. The appropriateness of the care provided […] when [Ms A] contacted RM [C] reporting abdominal/back pain, including the timeliness of the assessment carried out.
2. The adequacy of her documentation.
3. Any other matters that you consider amount to a departure from accepted standards.

[…] Maternity Unit and […] [Public] Hospital

Any other matters you consider amount to a departure from accepted standards.

RM [B]

1. The reasonableness of the care provided with respect to [Ms A's] vaginal symptoms at 18 weeks, including whether further investigations should have been undertaken.

[Ms A] reported thrush symptoms at her appointment, 30 August. Thrush cream was prescribed by LMC RM [B] who had been [Ms A]'s LMC in the two previous pregnancies. In her complaint response 7 July 2021, RM [B] states that [Ms A] described thrush and had suffered from it previously, requesting treatment at her 16-week appointment. [Ms A]'s complaint states that a swab should have been undertaken to screen for pre-term labour. RM [B] states that the NICE [UK National Institute for Health and Care Excellence] guidelines do not advocate for routine screening for Preterm labour (PTL). In my opinion, best practice may include swabbing for the preclusion of bacterial vaginosis (associated with preterm labour); however, accepted practice would include prescription for and acceptance of, a woman's knowledge of her own body and a condition she has experienced previously. Of note, [Ms A] did not have a history of preterm labour and although [Baby A] was born prematurely in this pregnancy, the

prematurity was the result of an induction of labour following a placental abruption, not spontaneous preterm labour.

In my opinion there is no departure from accepted midwifery practice in prescribing treatment for vaginal thrush as a first line in a woman who has previously experienced vaginal thrush, is requesting treatment for thrush, and has no known risk factors for PTL[.]

2. The appropriateness of RM [B]'s decision to not undertake urinalysis antenatally.

I have considered the Midwifery preparation for practice 4e (2015) chapter 21 Working with women in pregnancy (chapter edited by Aotearoa Midwife Celia Grigg). *Urine screening is offered routinely throughout pregnancy, although there is variation in both methods and markers used and no consensus about what constitutes best practice. The aim of urine screening is the detection of proteinuria (as a marker for pre-eclampsia and urinary tract infection) and glycosuria (as a marker for gestational diabetes). Unfortunately, it has been found to have poor sensitivity and predictive value for all the variables it is used to test.*

In Summary, dipstick screening for proteinuria remains an important first line test. Dipstick screening for gestational diabetes or asymptomatic bacteriuria is less clearly useful. Consider the whole clinical picture and context of the woman.

I have previously discussed an emerging move away from routine dipstick urinalysis with an NZCOM advisor and whilst in my opinion it is not yet accepted practice, I acknowledge there are some NZ midwives electing to delay routine urinalysis based on emerging evidence. In [Ms A]'s pregnancy an initial urine test was undertaken at booking, but no further dipstick urine testing was undertaken throughout [Ms A]'s pregnancy.

The complaint response from RM [B] submits an article link regarding dipstick urine testing being a poor predictor of pre-eclampsia. She further states that her practice had a low threshold for more comprehensive testing for pre-eclampsia if warranted by the clinical picture.

The referral guidelines

1. Ministry of Health. (2012). *Maternity Referral Guidelines* does include: proteinuria > 0.3g / 24 hours; or protein/creatinine ratio ≥.3, or **2+ protein on dipstick testing as diagnostic for pre-eclampsia**
2. The guideline for pre-eclampsia and hypertension in pregnancy *The NZ Ministry of Health document "Diagnosis and Treatment of Hypertension and Preeclampsia in Pregnancy in New Zealand a clinical practice guideline"* states that **Proteinuria is not essential for a pre-eclampsia diagnosis.**

In summary,

- There is debate regarding the value of testing urine for protein in the diagnosis of pre-eclampsia. Accepted midwifery practice currently considers dipstick testing a part of routine antenatal care as outlined in the NZCOM standards of practice, decision points.
- Proteinuria is no longer considered essential in the diagnosis of pre-eclampsia in pregnancy when there are other definitive clinical features. *The NZ Ministry of Health document "Diagnosis and Treatment of Hypertension and Preeclampsia in Pregnancy in New Zealand a clinical practice guideline"*
- The presence of protein in urine may warrant further investigation.

In considering the above, despite debate, current midwifery practice continues to include routine urinalysis during pregnancy. In my opinion, not to have tested at all during [Ms A]'s pregnancy constitutes a moderate departure from accepted Midwifery practice.

In light of this case, RM [B] has stated in her complaint response 14 July 2021 that she regrets that routine dipstick urine analysis was not undertaken in [Ms A]'s pregnancy; however, she was influenced by the research at the time. RM [B] states that, as a result of this case, she has returned to routine urine urinalysis in her practice.

3. **The management of [Ms A's] blood pressure.**

[Ms A]'s booking blood pressure at 11 weeks and 6 days is documented at 136/72. The blood pressure is recorded in RM [B]'s midwifery clinical notes on the booking form and is not duplicated in the body of clinical notes where other blood pressures are recorded. The "AIM report 14 June 2020" states early baseline blood pressure was not established; however, it is not recorded in the body of notes where the other blood pressures are recorded so may not have been seen by "AIM".

The booking blood pressure and subsequent blood pressures in the pregnancy do not independently meet the threshold for referral. RM [B] states in her complaint response that blood pressure was

- 11.6 wks — 136/72
- 16 wks — 118/78
- 21.4 wks — 136/78
- 25.4 wks — 118/68
- 29.5 wks — 138/78
- 32.5 wks — 138/82

RM [B] further states

"The internationally accepted definition of high blood pressure is: Hypertension: Systolic blood pressure (sBP) is greater than or equal to 140 mmHg or diastolic blood pressure

(dBP) is greater than or equal to 90 mmHg, as measured on two or more consecutive occasions at least four hours apart. The NZ Ministry of Health document "Diagnosis and Treatment of Hypertension and Preeclampsia in Pregnancy in New Zealand a clinical practice guideline" adds: It is important to note a rise in baseline blood pressure of 30 mmHg systolic or 15 mmHg diastolic. However, although it may be of clinical importance, it is no longer used to diagnose hypertension."

In my opinion, RM [B]'s statement is in keeping with accepted midwifery practice and the Ministry of Health (2012). Maternity referral guidelines are in agreement: page21, Line 1014 Hypertension >140/90 or on antihypertensive medication.

Consultation

Page 21, Line 1015, >150/100 **Transfer**

The definition of preeclampsia in the referral guidelines is:

> Page 26, line 4022, BP of ≥140/90 and/or relative rise of >30/15 mmHg from booking BP and any of: 1. proteinuria >0.3g/24 hours; or protein/creatinine ratio ≥0.3, or 2+ protein on dipstick testing. 2. Platelets <150 x 10/9/L. 3. Abnormal renal or liver function.

Imminent eclampsia

In consideration of the above, [Ms A]'s blood pressure alone did not meet the threshold for referral. Whether the pre-eclampsia had a sudden onset or whether the presence of proteinuria, symptoms of pre-eclampsia, in combination with the blood pressure may have warranted referral cannot be established retrospectively.

[Baby A] was well grown, there are no documented symptoms of pre-eclampsia, and protein may or may not have been present on urinalysis.

Based on the blood pressure alone, in my opinion there was no departure from accepted midwifery practice in the management of [Ms A]'s blood pressure.

4. What information is usually provided to women with respect to access to and choice of obstetric/secondary care, and what recommendations would be made following high blood pressure and low ferritin results?

A) High blood pressure. Based on the blood pressure recordings alone there was no criteria to refer to secondary services as outlined in question 3 above. A discussion regarding proteinuria has been addressed in question 2.

B) In respect to the ferritin levels, the normal range for ferritin is 20–200ug/L. On 2 August [Ms A]'s ferritin was 44 (normal range).

On 26 November [Ms A]'s ferritin was 12 (below normal range). Her haemoglobin was 109 (100–145 normal range).

The Auckland District Health Board Iron in pregnancy guideline 2015 states that

- Oral iron supplementation is the first-line treatment
- Intravenous iron infusion is indicated in iron deficiency anaemia, which is unresponsive or intolerant to oral iron.
- The pathway (algorithm) for iron supplementation in a pregnant woman ≥-30 weeks' gestation recommends high-dose iron therapy (2 x Ferrotabs or 1 ferrogradumet tablet daily) in women who have a haemoglobin (Hb) <70g/L. Assessment for response is recommended after 3 weeks.

[Ms A]'s ferritin indicated iron supplementation was indicated. Her haemoglobin was above 100, therefore according to the algorithm, oral high-dose iron therapy was appropriate first-line treatment. The high-dose therapy was commenced. RM [B]'s clinical notes record low iron results […] at 29 weeks and 5 days' gestation. Iron therapy is further discussed at the following appointment […] at 32 weeks and 5 days' gestation. At this appointment, iron supplementation is recorded as *"discussed at length"* recording [Ms A] as experiencing gastric disturbance with the iron therapy. A reduction from two tablets to one tablet is suggested. This is the last visit recorded prior to the birth of [Baby A].

In my opinion, RM [B] has not departed from accepted midwifery practice in her treatment of [Ms A]'s iron deficiency.

This was the third pregnancy in which RM [B] was the LMC for [Ms A]. In her complaint, [Ms A] states that she was not provided with access to secondary care despite requesting it. [Ms A]'s care plan submitted by RM [B] contains the following

I follow the referral guidelines and will advise you of any recommended consultations for the health of yourself and baby. Obstetric and paediatric consults are free of charge.

Regarding referral to secondary/obstetric services

A) If it is accepted that [Ms A] was concerned and requested secondary/obstetric services but did not meet the criteria for referral, the option to access Obstetric care privately was available at a cost to [Ms A]. If it is accepted that this was not clarified to [Ms A], then in my opinion this would be a moderate departure from accepted practice.

B) If it is accepted that [Ms A] did not meet the criteria to access secondary/ obstetric services but was aware of the option to access these services privately if she chose to, then in my opinion there was no departure from accepted midwifery practice.

The adequacy of the handover to the back-up midwife.

I have considered the handover documents, and, in my opinion, they do not depart from accepted midwifery practice.

RM [C]

1. **The appropriateness of the care provided on […] when [Ms A] contacted RM [C] reporting abdominal/back pain, including the timeliness of the assessment carried out.**

I have considered RM [C]'s complaint response, RM [B]'s complaint response, and [Ms A]'s complaint.

RM [C] recalls discussing [Ms A]'s concerns regarding pain and states that the conversation included discussion regarding the possible causes. According to RM [C] the discussion eliminated causes such as vaginal loss (amniotic fluid or blood) and possible urinary tract infection. RM [C] states that she concluded that it was possibly ligament pain and [Ms A] was reassured. The conversation concluded with a plan to discuss again in two hours. This conversation was not documented in the clinical notes.

RM [C] states

I am certain that [Ms A] did not at any time report marked abdominal or any back pain. Had she indicated any particular concern about the level of pain or that she could not tolerate it, I would have considered other steps such as an immediate assessment.

I have reflected on this case. In hindsight, I do wish that I had seen [Ms A] after that initial phone call; however, I consider my assessment and advice on the information known to me at the time was reasonable. It is not unusual for me to get many phone calls of a very similar nature that do end up being Braxton Hicks and/or ligament pain. In hindsight I regret I did not make it clear to [Ms A] that I would be happy to assess her straight away if she felt concerned. Had any concerns been expressed, I would have made that offer. I consider I gave [Ms A] safe and appropriate advice around calling me back if she had any further concerns or worries, which she did indeed do an hour and a half later.

[Ms A] states that when she spoke to RM [C], she was experiencing severe pain, her stomach was hard, and she had three contractions over four minutes. She states she was advised to wait for two hours as the pain might go away.

It is agreed that [Ms A] phoned RM [C] at 6.49pm and requested an assessment. RM [C] agreed to meet [Ms A] at […] [the] [m]aternity [u]nit to assess her.

A) If it is accepted that [Ms A] was in severe pain and she reported that her stomach was hard, then in my opinion it would be a severe departure from accepted practice not to arrange immediate assessment.

B) If it is accepted that [Ms A] was unsure what she was experiencing and after a process of discussion and reassurance agreed to observe her discomfort and reassess in two hours following the phone call, then in my opinion there is a mild departure from midwifery accepted practice. I am critical, however, that the offer of immediate assessment was not made clear to [Ms A] had she wanted it.

In [Ms A]'s complaint, the issue of assessment at […] has been raised, stating that initial transfer from home and assessment at […] [the] [h]ospital should have taken place. In my opinion, there was no departure from accepted midwifery practice in assessing [Ms A] at a primary unit where ambulance transfer to […] [the] [h]ospital would be available if required. I have formed my opinion based on the following considerations

- […] [The] [h]ospital was further away and a primary assessment was required prior to transfer. It was not immediately apparent that [Ms A] was experiencing a placental abruption. [Ms A] presented with high blood pressure and a temperature; sepsis and pre-eclampsia were considered as possibilities.
- Assessment and consultation took place and immediate emergency transfer of care was arranged. Ambulance summary reports a stable patient who was able to ambulate to and from the ambulance, declining stretcher.
- It could be argued that transfer to […] [the] [h]ospital without assessment posed a risk to [Ms A] and [Baby A] had [Ms A] been unstable.

The adequacy of RM [C]'s documentation. The phone call between RM [C] and [Ms A] has not been documented, which is a moderate departure from accepted midwifery practice. Clinical documentation from the time of assessment at […] [the] [m]aternity [u]nit is in keeping with accepted midwifery practice with no departures.

2. Recommendations for improvement that may help to prevent a similar occurrence in future.

RM [C] has identified that she regrets not making it clearer that if [Ms A] wanted to be assessed at the first phone call that she was willing to do so. Clarification of this intention in the future may be beneficial. It is impossible to say retrospectively if the outcome would have changed.

Documentation requirements could be addressed by RM [C] by accessing the Midwifery Council website. Under "Be Safe Be Sure" a pdf of documentation and record keeping requirements is available.

Additionally, RM [C] may benefit from attendance at the NZCOM documentation workshop "Dotting I's and Crossing T's".

3. Any other matters that you consider amount to a departure from accepted standards.

No, there are no other departures from accepted midwifery practice identified.

[…] Maternity Unit and […] [Public] Hospital

1. The appropriateness of the midwifery care provided at 33+4 weeks' gestation.

I have read and reviewed the clinical notes from […] [the] [m]aternity [u]nit and […] [the] [h]ospital and in my opinion there are no departures of accepted midwifery practice in the care provided by the midwives at both facilities.

2. Any other matters you consider amount to a departure from accepted standards.

There are no other matters that I consider a departure from accepted midwifery standards.

Clarification

1) [Ms A]'s complaint states that a placental abruption is noted in the post mortem as the cause of [B]aby [A]'s death. Placental abruption has been identified as the cause of death; however, for clarification, this information has not been obtained through a post mortem (post mortem recorded as declined)

   [33+4 weeks' gestation] 01.45 Clinical notes record a definite abruption has occurred.

   09.00 Clinical notes record plan for placental pathology, post mortem declined.

2) Planned clinical debrief with Dr [G] is documented [at 33+4 weeks' gestation] to occur in eight weeks. This is where the issue of aspirin in a subsequent pregnancy would be raised.

Summary

I have carefully considered the notes provided by the HDC and have identified a moderate departure from accepted practice in RM [B] not providing routine urinalysis for [Ms A]. Consideration of documentation requirements and clarity regarding willingness to immediately assess if the woman requests have been identified as recommendations for RM [C].

Retrospectively, I cannot say whether the outcome could have been different; however, I extend my sincere condolences to [Ms A], [Mr A], and their family for the loss of their precious [B]aby [A]. I hope this report helps to clarify some of their unanswered questions.

Nicky Emerson BHSc Midwifery, PG DipHSc
Midwifery Advisor
Health and Disability Commissioner'