Registered Midwife, RM B

Birthing Unit

A Report by the

Deputy Health and Disability Commissioner

(Case 19HDC00285)

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Executive summary

1. A woman in her twenties had a history of two high-risk pregnancies that had required an emergency Caesarean section, and was pregnant with her third child.

2. The woman saw her lead maternity carer, a registered midwife, for an antenatal appointment, and was suffering from worsening hand and facial oedema, and protein in her urine. The midwife ordered blood tests to rule out the onset of pre-eclampsia.

3. The midwife went on leave the next day, and did not provide a verbal or written handover to her back-up midwife. As a result, both her back-up midwife and her employer were not aware that the woman had undergone a blood test to check for pre-eclampsia, and that the results were pending. Five days later, the midwife's employer came across the blood test results and noted that they were abnormal. The woman was contacted and advised to present to hospital as soon as possible.

4. The woman presented to hospital and, given the impression of possible fulminating HELLP syndrome, the decision was made for her to undergo an emergency Caesarean section. The baby was delivered approximately seven weeks early, and was transferred to a Neonatal Intensive Care Unit (NICU) for further care.

5. This case highlights the importance of good peer support and back-up arrangements, particularly in rural settings where midwifery providers are otherwise working in isolation.

Findings

6. Despite the deteriorating clinical picture and previous medical history, the midwife omitted to follow up (or arrange for another midwife to follow up) the PET blood test results. The Deputy Commissioner found the midwife in breach of Right 4(1) of the Code, and also made adverse comment about her communication.

7. The Deputy Commissioner found the birthing unit in breach of Right 4(1) of the Code for failing to have in place a formal handover procedure to ensure that the blood test results were followed up in a timely manner.

Recommendations

8. The Deputy Commissioner recommended that the midwife provide a written apology. No other recommendations were made regarding the midwife, as she is no longer practising midwifery.

9. The Deputy Commissioner recommended that the birthing unit develop and implement a formal procedure regarding what to do when a midwife goes on leave, including the handover process.

10. The Deputy Commissioner recommended that should the midwife return to practice, the Midwifery Council of New Zealand consider whether a review of her competence is warranted. The Deputy Commissioner also recommended that the Midwifery Council of

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New Zealand consider reminding midwives that when they employ people, they become an employing authority, and may be vicariously liable for the acts or omissions of an individual provider where that individual provider is an employee, agent, or member of that employing authority.

Complaint and investigation

11. The Health and Disability Commissioner (HDC) received a complaint from Ms A about the services provided to her by Registered Midwife (RM) B at a birthing unit. The following issues were identified for investigation:

- *Whether RM B provided Ms A with an appropriate standard of care in 2018.*
- *Whether the birthing unit provided Ms A with an appropriate standard of care in 2018.*

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

13. The parties directly involved in the investigation were:

Ms A	Consumer
RM B	Registered midwife/Lead Maternity Carer/provider
The birthing unit	Midwifery practice/provider

14. Further information was received from:

RM C	Registered midwife
RM D	Registered midwife/Birthing unit owner/manager

15. In-house expert advice was obtained from RM Nicolette Emerson (Appendix A).

Information gathered during investigation

Introduction

16. Ms A (in her twenties at the time of events) became pregnant with her third child. Ms A's first two pregnancies were complicated owing to her high body mass index[1] (over 50[2]), essential hypertension,[3] and the development of severe pre-eclampsia[4] (PE) and

[1] A measure of body fat based on height and weight.
[2] A BMI at or above 40 is classified as class 3 obesity.
[3] High blood pressure.

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fulminating HELLP.[5] As a result, both pregnancies required an emergency Caesarean section at 36 and 35 weeks' gestation.

17. At around 5 weeks' gestation, Ms A engaged RM B to be her Lead Maternity Carer (LMC). Ms A told HDC that she made all of her health and pregnancy issues clear to RM B when she first signed up with her.

18. At the time of these events, RM B was employed by the birthing unit. RM D was the owner, manager, and lead midwife of the birthing unit. RM D advised HDC that at the time of these events she managed a contract with the district health board (DHB) to provide primary maternity services. This involved the running of the birthing unit and the provision of services 24 hours a day, seven days a week, to provide birthing unit back-up to all LMC births in the unit, and to care for all postnatal admissions.

19. RM B, RM D, and a third midwife, RM C (employed by the birthing unit at the time of these events), had their own caseload of clients at the birthing unit, and provided back-up services for one another when they took leave.

20. This report concerns the care provided to Ms A by RM B and the birthing unit in 2018.

Antenatal care

21. Owing to her risk factors, Ms A was referred to the DHB obstetric team, and a plan was documented in which RM B would provide midwifery care until 36 weeks' gestation. At that time, Ms A would be admitted to a main centre hospital (Hospital 2) to be monitored until undergoing an elective Caesarean section at approximately 38 to 39 weeks' gestation.

22. Ms A made regular visits to her general practitioner (GP) throughout the pregnancy to monitor her blood pressure and blood pressure medication. She also had monthly ultrasound scans at Hospital 1 to monitor the baby's growth. The pregnancy was difficult, as Ms A experienced continuous lower abdominal pain and hyperemesis gravidarum,[6] which was managed with antiemetics.[7] RM B carried out routine antenatal assessments, including blood tests for PE when indicated, and liaised with the obstetric team as necessary.

23. At 30 weeks' gestation, Ms A began to experience hand, feet, and facial oedema.[8] At 32 weeks' gestation, she saw RM B for an antenatal appointment. It was noted that her last

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[4] A potentially dangerous pregnancy complication characterised by high blood pressure that can lead to serious, even fatal, complications for both mother and baby. Also referred to as pre-eclampsia toxaemia (PET).

[5] A potentially life-threatening complication of pregnancy that is usually associated with pre-eclampsia. It is characterised by haemolysis (the breakdown of red blood cells), elevated liver enzymes, and a low platelet count.

[6] A pregnancy complication that is characterised by severe nausea, vomiting, weight loss, and possibly dehydration.

[7] Drugs used to alleviate nausea and vomiting.

[8] The abnormal accumulation of fluid in certain tissues within the body.

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ultrasound scan showed that the baby was in the 97th centile for weight, and that the baby was active with a heart rate between 120–140 beats per minute.

24. Ms A told HDC that she knew she was unwell and that she needed to get to Hospital 2, but RM B told her to "go home and rest". Ms A said that at this appointment, she told RM B that she had constant aches and bad migraines, and that she could not keep down food or water. There is no record of this in Ms A's clinical notes, and RM B documented that Ms A was well and cheerful. RM C told HDC that when she contacted Ms A at a later date, Ms A informed her that she had reported a headache to RM B at this appointment. Ms A told HDC that she was not well and cheerful as RM B had documented. Ms A stated that she was very sick and could not even drive herself to the clinic for this appointment.

25. RM B recorded that Ms A's blood pressure was 124/80mmHg but that urinalysis showed "1–2+" of protein in her urine, and she was suffering from worsening hand and facial oedema. RM B organised PET blood tests[9] to rule out the onset of PET. RM B told Ms A that she had planned leave for the following week, and documented: "[Ms A] aware am on leave for [a week]. Contact back-up [midwives] if/when needed — next appointment [in two weeks' time]." Ms A told HDC that she does not recall RM B saying that she was going on leave.

26. RM C was to take over RM B's caseload for her period of leave. RM D told HDC that when a midwife is to take leave from the birthing unit, the midwife is to provide a verbal and written handover to the back-up midwife. The handover is to include any incoming test results, any advice given by the obstetric team, as well as a list of visits to be completed during the period of leave.

27. RM B told HDC that she is unable to recall providing a handover to RM C before going on leave. RM B stated that if no handover occurred, it was because she thought there were no issues with Ms A at the time, and knew that Ms A was also receiving secondary care. Both RM C and RM D told HDC that no written or verbal handover was provided to RM C before RM B went on leave. RM C told HDC:

> "As a second thought, on [RM B's] way out the door, [she] turned around and said something similar to 'you shouldn't have any problems, but as always there is [Ms A] out in the community who is always high risk'. That was the extent of the handover from my recollection."

28. As a result, RM C and RM D were not aware that Ms A had undergone a blood test to check for PET, and that the results were pending.

29. RM B told HDC that the usual procedure is for the midwife who is going on leave to provide a handover, but stated:

> "I always felt very confident that all results of any nature would be followed up by my manager [RM D] as she received copies of my results."

[9] PET blood tests include liver function tests, kidney function tests, and platelet measurements.

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30. RM D told HDC that as the facilitator, she could check test results ordered by other midwives if the results had not been accepted into the system for a while. When a midwife was on leave, RM D would check the system twice a week to double check that all incoming test results had been accepted.

31. The results of Ms A's blood tests were reported at 4.49pm [at 32 weeks' gestation]. They showed very high levels of the liver enzymes alanine aminotransferase[10] (ALT) and aspartate aminotransferase[11] (AST), recorded as 128[12] and 61[13] units per litre respectively. A high level of liver enzymes is one of the symptoms of HELLP syndrome.

32. RM B told HDC that she does not have access to patient results from her personal computer, but that if waiting for results that were deemed urgent, usually she would access them outside of hours by attending the unit to use the unit's computer. However, she said that owing to her personal life out of work hours, this process was not followed in Ms A's case. RM B went on leave the following day.

33. Five days later, RM D was looking at the system to check that all incoming results had been accepted, when she found Ms A's abnormal blood test results. She handed the results to RM C, who called Ms A immediately and asked how she was feeling. Ms A reported having had a headache and abdominal pain since the previous week, which she said she had discussed with RM B at her previous appointment. Ms A was in the city visiting family at this time, so RM C arranged for her to be seen at Hospital 2 as soon as possible.

34. Ms A presented to Hospital 2 and was admitted at 11.49am with a worsening headache, abdominal aches, increasing swelling of the hands and feet, and high blood pressure. Shortly after admission, she developed worsening of symptoms of PET, including an episode of complete loss of vision. Given the impression of possible fulminating HELLP syndrome, the decision was made for Ms A to undergo an emergency Caesarean section. Ms A's baby was delivered at 11.32pm, approximately seven weeks early, and was transferred to the Neonatal Intensive Care Unit (NICU) for further care.

Postnatal care

35. Ms A was kept at Hospital 2 for observation, and was then discharged to accommodation near Hospital 2 while her baby remained in NICU. RM B told HDC that she received no contact from Hospital 2 during this time. Hospital 2 told HDC that a discharge summary was sent to Ms A's GP, but this was not copied in to her LMC, RM B. At the time of discharge, a city midwife was arranged to provide Ms A with postnatal care.

36. A day after discharge, RM B attempted to call Ms A to check how both she and the baby were doing, but received no answer. RM B told HDC that she intended to call Ms A again that day, and apologised for overlooking this. A week later, RM B rang Ms A again, and

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[10] ALT is an enzyme made by cells in the liver; an increased ALT can indicate a damaged or inflamed liver.

[11] AST is an enzyme present in various tissues of the body. AST levels increase when there is damage to the tissues and cells where the enzyme is found. Abnormal levels can be associated with liver injury.

[12] The normal range for ALT levels is 0–30U/L.

[13] The normal range for AST levels is 10–50U/L.

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spoke to her partner. He advised that Ms A and her baby were going to be transferred to Hospital 1 within the next few days. RM B told him that she would see them all then.

37. A few days later, RM B was contacted by a ward nurse at Hospital 1 regarding Ms A's transfer. RM B told HDC that she and the nurse discussed Ms A's on-going hypertension, and that Ms A would require secondary care to monitor her blood pressure more frequently. RM B said that she told the nurse that she would discuss this with her manager. RM B stated:

> "This conversation was misinterpreted due to a language barrier which consequently resulted with [another] midwife taking over [Ms A's] postnatal cares."

38. After receiving notification that a new midwife was taking over Ms A's care, RM B rang Ms A to apologise for the confusion that had occurred around her postnatal care. Ms A stated that during this telephone call, RM B expressed her disappointment that she had chosen to be under the care of a different midwife.

39. RM B did not provide any postnatal care to Ms A.

Further information

RM B

40. RM B told HDC that being the subject of this investigation has made her constructively critique her midwifery practice. She explained that at the time of her leave she was fatigued and was beginning to "burn-out", owing to the irregular manner of her days off. She stated that this was a significant cause of her forgetfulness at the time, but that she acknowledged and accepted her responsibilities a midwife.

41. RM B told HDC: "To ensure I remain alert and vigilant at all times when practising, I will ensure my days off are regular, while also ensuring my work environment remains supportive." She stated that she wished to apologise to Ms A for the failure to check the blood results, and said that she never intended any harm to her or her unborn baby.

The Midwifery Council of New Zealand

42. RM B has not practised midwifery since mid-2018, and was made inactive in 2019. She does not have a current annual practising certificate with the Midwifery Council of New Zealand.

Responses to provisional opinion

43. Ms A was provided with the opportunity to comment on the "information gathered" section of the provisional opinion, and her comments have been incorporated where relevant.

44. RM B was provided with the opportunity to comment on the relevant sections of the provisional opinion and told HDC that she accepts the opinion and recommendations.

45. The birthing unit was provided with the opportunity to comment on the provisional opinion. The birthing unit told HDC:

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"This report has clearly discussed the issue of vicarious liability in the case of employment. We were not aware of this issue at all and it would be beneficial if this issue could be included into the midwifery education within the module of self employed business. This is not only beneficial for employment within the midwifery practice but also will benefit within the employment of locum midwives."

Relevant standards

46. Competency Two of the New Zealand Midwifery Council's "Competencies for Entry to the Register of Midwives" states:

"The midwife applies comprehensive theoretical and scientific knowledge with the affective and technical skills needed to provide effective and safe midwifery care … The midwife:

2.2 confirms pregnancy if necessary, orders and interprets relevant investigations and diagnostic tests, carries out necessary screening procedures, and systematically collects comprehensive information concerning the woman's/wahine health and well-being."

Opinion: RM B

Introduction

47. Ms A was pregnant with her third child, and engaged RM B to be her LMC. Although Ms A received input from her GP and the obstetric team at Hospital 1 during her pregnancy, RM B was her LMC, and was responsible for the care provided to Ms A during this pregnancy.

48. Ms A's third pregnancy was classified as high risk, and required regular monitoring. At 32 weeks' gestation, Ms A became increasingly symptomatic of pre-eclampsia, and RM B ordered PET blood tests. RM B went on planned leave the following day, and the test results were not reviewed for five days. Ms A then required a Caesarean section to deliver her baby urgently.

Antenatal care — breach

49. Ms A's pregnancy up until the appointment at 32 weeks' gestation, while difficult, was largely uneventful. My in-house midwifery advisor, RM Nicolette Emerson, advised that Ms A's pregnancy was well managed by RM B, and was in accordance with accepted standards in the period leading up to 32 weeks' gestation. I accept this advice.

50. Ms A saw RM B for a routine antenatal appointment at 32 weeks' gestation. At this appointment, RM B recorded that Ms A's blood pressure was 124/80mmHg, she had "1–2+" of protein in her urine, and was suffering from worsening hand and facial oedema. Ms A told HDC that at this appointment, she told RM B that she had constant aches and bad

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migraines, and could not keep down food or water. This information is not documented in Ms A's midwifery notes.

51. RM B organised blood tests to rule out the onset of PET, and advised Ms A that she would be on leave from the following day for a week, and that RM D and RM C would be the back-up midwives.

52. The results of Ms A's blood tests were available at 4.49pm the same day, and showed a significantly high level of liver enzymes. RM B had already gone home by this time, and did not follow up on the test results before she went on leave. RM B apologised for this omission, and told HDC that she never intended any harm to Ms A or her unborn baby.

53. The expected process at the birthing unit when a midwife goes on leave is to provide a verbal and written handover to the back-up midwife. The handover is to include any incoming test results, any advice given by the obstetric team, as well as a list of visits to be completed during the period of leave. RM B told HDC that she is unable to recall any handover given to RM C before she went on leave. RM C and RM D told HDC that no handover, verbal or written, was provided to them before RM B went on leave. There is no documentation of any handover. Given this evidence, I consider it more likely than not that no handover was provided to RM C or RM D before RM B went on leave. Consequently, RM C and RM D were not aware of Ms A's pending blood test results.

54. Competency Two of the New Zealand Midwifery Council's "Competencies for Entry to the Register of Midwives" stipulates:

> "The midwife confirms pregnancy if necessary, orders and interprets relevant investigations and diagnostic tests, carries out necessary screening procedures, and systematically collects comprehensive information concerning the woman's/wahine health and well-being."

55. Although RM B appropriately ordered a PET blood test to investigate the cause of Ms A's symptoms, she failed to either follow up on the results once they had been reported, or to arrange for her back-up midwife, RM C, to follow up the results on her behalf. I consider that such an investigation is futile unless the results are followed up.

56. RM B told HDC that she always felt very confident that all results of any nature would be followed up by her manager, RM D. However, Ms A was RM B's client, and thus RM B had full responsibility for Ms A's health and well-being. Given the reasons for the blood tests, which were to exclude or confirm a significant risk to Ms A and her baby, and the fact that RM D was not made aware that any blood test results were pending, I consider RM B's view to be flawed. RM Emerson advised: "In my opinion, it is not acceptable to expect a colleague to view blood results if they have not been made aware of the results pending."

57. I accept this advice. In the context of Ms A's high-risk status, deteriorating clinical picture, and possible symptoms of PET, the results of the blood tests were imperative to either confirm or rule out a serious cause of her symptoms. I consider that the pending blood test was vital information that should have been passed on to the back-up midwife. I am very

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concerned that RM B failed to do this. RM Emerson stated that in her opinion, not to follow up or formally arrange follow-up of the results was a severe departure from accepted midwifery practice, and I agree.

58. The New Zealand College of Midwives requires midwives to adhere to six standards of practice. Standard six stipulates: "Midwifery actions are prioritised and implemented appropriately with no midwifery action or omission placing the woman at risk."

59. RM B's omission placed Ms A and her baby at risk, and was contrary to the above standard. Had she followed up on Ms A's blood test results, or arranged for a back-up midwife to follow up in her absence, the severity of Ms A's condition would have been realised earlier, and earlier intervention could have been sought.

60. By omitting to follow up (or arrange for another midwife to follow up) Ms A's PET blood test results, especially in light of Ms A's deteriorating clinical picture and previous medical history, RM B placed Ms A and her baby at risk and denied Ms A the chance for earlier diagnosis or intervention. Accordingly, RM B did not provide Ms A services with reasonable care and skill, in breach of Right 4(1) of the Code of Health and Disability Services Consumers' Rights (the Code).[14]

Postnatal care — adverse comment

61. Following Ms A's emergency Caesarean section, and her four-night stay at Hospital 2, she remained in the city while her newborn baby spent time at the NICU. RM B returned from her planned leave.

62. RM Emerson advised:

> "On return from holiday, best practice would include a midwife communicating with a woman she had cared for in pregnancy, particularly after an unexpected outcome. In my opinion the contact to offer support and instigate a plan for on going care rests with the midwife."

63. RM B attempted to call Ms A two days after her return from leave, but Ms A did not answer, and RM B did not leave a voice message. RM B told HDC that she intended to call Ms A later that day, and apologised for not doing so. A week later, RM B contacted Ms A and spoke to her partner, who advised that Ms A and her baby were going to be transferred to Hospital 1 in the next few days. RM B told Ms A's partner that she would see the family then. After a misinterpreted conversation regarding blood pressure monitoring with a nurse at Hospital 1, Ms A's postnatal care was taken over by another midwife.

64. Ms A had just experienced an emergency Caesarean, with her baby being born seven weeks early and requiring a lengthy stay in the NICU. I acknowledge that little could be done until Ms A and her baby returned from Hospital 2; however, I consider that RM B's communication with Ms A during this stressful time was lacking. RM B attempted to

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

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contact Ms A only twice during her postnatal period, and never spoke with her directly to provide her with support.

65. RM Emerson considered the postnatal communication offered to Ms A from RM B to be a mild departure from the accepted practice in the circumstances. RM Emerson stated:

> "[T]here appears to be a breakdown in communication regarding on going postnatal care for [Ms A]. In the context of a premature baby who required surgery and a woman who required emergency care this is particularly disappointing."

66. Whilst RM B was not solely responsible for this breakdown in communication, I consider that proactive communication with Ms A was required in order to provide her with postnatal support and to discuss her midwifery care going forward. I remind RM B of the importance of effective communication with both clients and other health professionals.

Opinion: The birthing unit — breach

Introduction

67. At the time of these events, RM B was employed by the birthing unit, a company that was contracted by the DHB to provide primary maternity services in the area. This arrangement allowed RM B, RM D, and RM C each to have their own caseload of clients, while providing back-up services for one another when they took leave.

68. I acknowledge that this arrangement allowed for new midwifery graduates (such as RM C) to be provided with collegial support, and that this is especially important for rural areas to promote a stronger midwifery workforce. I endorse such a model.

Antenatal care

69. RM Emerson advised that the care provided to Ms A prior to 32 weeks' gestation met accepted standards.

70. However, at a routine antenatal appointment at 32 weeks' gestation, RM B ordered PET blood tests for Ms A, and subsequently went on leave without following up on the results or providing a handover to her back-up midwife. The test results were discovered five days later and found to be extremely abnormal. Consequently, Ms A was rushed to Hospital 2 for an emergency Caesarean section.

71. Employing authorities need to be aware that once they engage in an employment relationship, they become liable for the acts and omissions of their employees. Adequate policies and procedures are important to guide employees to avoid adverse outcomes.

72. RM D told HDC that when a midwife takes leave from the birthing unit, a verbal and written handover is to be provided to the back-up midwife. The handover is to include any incoming test results, any advice given by the obstetric team, and a list of visits to be

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completed during the period of leave. However, there was no formal procedure in place for handover at the birthing unit, and the ramifications of this are demonstrated in this case.

73. RM B told HDC that if no handover was provided, it would have been because she had no concerns about Ms A at the time she went on leave. RM B also stated that she felt confident that all results would be followed up by RM D, as she received a copy of all test results. RM D told HDC that she could check the results of tests ordered by other midwives if they had not been accepted into the system for a while, and that she would do this check twice a week when a midwife was on leave. Whilst it is a midwife's responsibility to follow up on any investigations ordered, it is clear that the lack of a formal handover procedure at the birthing unit resulted in different understandings of the process that occurs when a midwife takes leave. This provided RM B with a false sense of security that all results would be followed up in her absence.

74. I consider that a formal handover procedure at the birthing unit would have helped to confirm that RM B knew what was expected of her before she went on leave. The overall responsibility lies with the birthing unit to ensure that employed midwives have this guidance. I find that by failing to have in place a formal handover procedure to ensure that Ms A's blood test results were followed up in a timely matter, the birthing unit did not provide Ms A services with reasonable care and skill, in breach of Right 4(1) of the Code.

75. This case highlights the importance of good peer support and back-up arrangements, particularly in this type of setting where midwifery providers are otherwise working in isolation. This is an opportunity for the birthing unit to review its procedures and oversight of high-risk pregnant woman, to ensure that information and issues of concern are acted upon appropriately.

Recommendations

76. I recommend that RM B provide a written apology to Ms A for the inadequate care identified in this report. The apology is to be sent to HDC within three weeks of the date of this report, for forwarding.

77. I recommend that the birthing unit develop and implement a formal procedure regarding what to do when a midwife goes on leave, including the handover process. Evidence that this has been done is to be sent to HDC within three months of the date of this report.

78. Should RM B return to practice, I recommend that the Midwifery Council of New Zealand consider whether a review of her competence is warranted.

79. I recommend that the Midwifery Council of New Zealand consider reminding midwives that when they employ people, they become an employing authority, and may be

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vicariously liable for the acts or omissions of an individual provider where that individual provider is an employee, agent, or member of that employing authority.

Follow-up actions

80. A copy of this report with details identifying the parties removed, except the expert who advised on this case, will be sent to the Midwifery Council of New Zealand, and it will be advised of RM B's name.

81. A copy of this report with details identifying the parties removed, except the expert who advised on this case, will be sent to the Ministry of Health (in the context of the review of maternity services they are currently undertaking at a national level) and the New Zealand College of Midwives, and placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

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Appendix A: Independent advice to the Commissioner

The following expert advice was obtained from RM Nicky Emerson:

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

2. I have reviewed the documentation on file: [Complaint from Ms A], [Complaint response RM B], clinical notes [to 32 weeks' gestation] including lab results, scans and Obstetric letters. [Hospital 2 notes for Ms A.]

3. **Background**: [Ms A], a young woman [in her twenties] was in her third on going pregnancy. Obstetric history included 1 miscarriage and two on going pregnancies. The previous pregnancies were characterised by hyperemesis, essential hypertension, severe pre eclampsia and fulminating Haemolysis, Elevated Liver Enzymes and Low Platelets (HELLP), which necessitated early delivery of [Ms A's] babies. Medical history, nil of note. BMI was very high, 51.3 at booking. Preeclampsia blood tests were taken by [RM B] [at 32 weeks' gestation] as [Ms A] was unwell. [Five days later] the results were viewed by two other midwives who phoned [Ms A] to request that she present in hospital immediately. [Ms A] was already in [the city] with a relative who was sick. She was admitted to [Hospital 2] and underwent an emergency caesarean the same day for pre eclampsia/HELLP.

4. **Advice Request:** Please advise whether the care provided met the accepted standard of care. Where a departure from the standard of care is identified, please quantify the departure and your rationale for your opinion.

Antenatal Care

According to [RM B's complaint response] antenatal care for [Ms A] commenced with a phone call from the Senior Medical Officer at [Hospital 1]. [Ms A] was 5 weeks pregnant. [Ms A] had been given a prescription for nausea (anti-emetic). Instructions for [Ms A] included the taking of low dose aspirin, folate, iron, B6.

First contact with [Ms A] was via text the following day. Arrangements were made for registration and booking visit following [Ms A's] next scan. Routine booking visit [took place]. [Ms A's] BMI, previous history of severe preeclampsia/HELLP was documented.

Contemporaneous Midwifery notes are comprehensive and record 8 documented antenatal appointments. The notes contain appropriate referral to Obstetric care and a record of on going verbal and written correspondence with the Obstetric and dietician service. Care planning is guided by Obstetricians and includes monthly growth scans, a minimum of fortnightly BP checks (shared with GP). Included in documentation is the plan for [Ms A] to transfer to [Hospital 2] at 36 weeks gestation

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and remain there till delivery, aiming for a caesarean and bilateral salpingectomy (permanent contraception by removing fallopian tubes) at 38–39 weeks gestation.

The additional medications of labetalol, ranitidine and clexane are documented.

In my opinion Midwifery care was appropriate with no departures from accepted Midwifery practice until [32 weeks' gestation].

[32 weeks' gestation]

[RM B] phoned [Ms A] and moved their scheduled appointment [forward a day]. At [this appointment], according to [RM B's] complaint response [Ms A] reported continued aches and pains. BP was recorded as normal at 124/80, 1–2+ of protein was present in dipstick urine. Worsening bilateral hand and facial oedema is documented in Midwifery clinical notes. PET bloods were ordered (Preeclampsia bloods). [RM B's] leave (from the following day) was documented with back up documented.

[Ms A] states in her complaint that when she saw [RM B] [at 32 weeks' gestation] that she knew she was unwell and had started to feel very 'bad'. She states that she knew she needed to get to [Hospital 2] 'before it was too late'. According to the complaint response, [RM B] sent [Ms A] for blood tests. According to [Ms A's] complaint following the blood tests she was sent home to rest.

[Later], [Ms A] accompanied a family member to [Hospital 2] and whilst she was [in the city], the bloods from [32 weeks' gestation] were reviewed by [RM B's] Midwifery colleagues. Contact was made with [Ms A] and her urgent clinical review was arranged at [Hospital 2].

[Ms A] was assessed, admitted, stabilised and underwent a category 2 caesarean section later that day for fulminating preeclampsia/HELLP. She was 33 weeks gestation.

In forming an opinion I have considered the following:

- [Ms A] had a history of severe preeclampsia/HELLP
- In the current pregnancy she had hypertension requiring medication (essential hypertension) which was being monitored by both Midwife and GP
- Both previous pregnancies had necessitated interventions and early delivery due to pre eclampsia/HELLP
- [Ms A's] booking BMI was very raised at 51.3; this compounded her risk factors
- The current pregnancy had been difficult and [Ms A] had been unwell with Hyperemesis throughout
- Care had been appropriately referred by [RM B] for Obstetric Management based on previous history and current BMI

Care until [32 weeks' gestation], in my opinion was in keeping with accepted Midwifery practice with no departures.

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[RM B] explains in [her complaint response] that following her appointment [Ms A] completed the ordered blood tests at [Hospital 1 at 11.50am]. The bloods were received at [Hospital 1] at 2.56pm. The bloods were reported at 4.49pm. The bloods highlighted abnormal liver function results which were considerably outside normal range.

[RM B] reports that there was limited time frame for her to access the blood results as they were reported 4.49pm and she did not access the results after hours [that day]. [RM B] states that all blood results are accessed [online]. Remote Access to results had been previously available from her personal computer however access was now not possible since a system upgrade.

[RM B] states that she was fully aware her manager received results as in the past has informed her of any abnormalities for women in her care. [RM B] was going on leave the following day.

In my opinion accepted Midwifery practice would include follow up of the blood results [that day] and/or arranging a specific Midwifery colleague to follow up results [that day] if [RM B] was unable to follow up.

In the context of [Ms A's] previous history of severe pre eclampsia/HELLP, deterioration in feeling of well being that day, presence of urine protein, documented swelling of hands and face, medicated hypertension, elevated BMI, in my opinion not to follow up or formally arrange follow up of the results on [the same day] is a severe departure from accepted Midwifery practice. In my opinion it is not acceptable to expect a colleague to view blood results if they have not been made aware of the results pending.

Competency Two (NZ Midwifery Council — Competencies for Entry to the Register)

2.2 confirms pregnancy if necessary, orders and interprets relevant investigations and diagnostic tests, carries out necessary screening procedures, and systematically collects comprehensive information concerning the woman's/wahine health and well-being

In my opinion there was a missed opportunity for an earlier intervention when the results were not discovered for 5 days and [Ms A] was severely unwell. Earlier intervention may have limited severity of [Ms A's] symptoms, provided an opportunity to adjust medications (including enoxaparin) and may have provided an opportunity to complete steroids for the maturation of [Ms A's] baby's lungs.

NZCOM Standards of Midwifery Practice: Standard six: Midwifery actions are prioritised and implemented appropriately with no midwifery action or omission placing the woman at risk

In my opinion [Ms A's] risks were known and omitting follow up (or formal arrangement of follow up) placed [Ms A] and her baby at further risk.

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Postnatal Care

Following her caesarean, [Ms A] stayed in [the city] for 3 weeks as her baby had [several operations] and was admitted to the NICU. Following this, [Ms A] was transferred to [Hospital 1]. As no contact had been made by [RM B], [Ms A] elected to receive postnatal care from [another midwife].

In [her complaint] [Ms A] states that [the midwife] sent [RM B] an email to advise that she was taking over postnatal care. It was then, according to [Ms A] that [RM B] made contact and expressed disappointment at not being able to provide postnatal care.

According to the complaint response from [RM B], she was contacted by [Ms A] [two days after her return from leave]. There was no message left and [RM B] did not return the call. She apologises for this.

[A week later] [RM B] contacted [Ms A's] partner and understood that transfer from [Hospital 2] to [Hospital 1] was likely to happen in the next few days.

[Four or five days later] a ward nurse at [Hospital 1] phoned [RM B] advising of [Ms A's] transfer from [Hospital 2] and her on going hypertension. [RM B] states that she indicated that on going monitoring of [Ms A's] hypertension would require secondary care supervision. [RM B] states that the conversation was misinterpreted and consequently postnatal care was taken over by [another] midwife.

In forming an opinion regarding the postnatal care, I have considered the following:

- On return from holiday it would be standard practice to be updated on any developments with your caseload
- [Ms A] was in [the city] and both she and her daughter were receiving care both in [Hospital 1 and Hospital 2]
- There appears to be breakdown in communication regarding on going care

On return from holiday, best practice would include a midwife communicating with a woman she had cared for in pregnancy, particularly after an unexpected outcome. In my opinion the contact to offer support and instigate a plan for on going care rests with the midwife.

My colleagues may view this slightly differently and consider that there was little that could be done until [Ms A] and her baby returned from [the city] and that they would expect to be routinely contacted regarding transfer when appropriate.

I note that [the DHB] states 19 April 2019 that a discharge summary was sent to [the medical centre] and that [Ms A's] LMC ([RM B]) was not copied in. [The DHB] also notes that [Ms A] was admitted to [Hospital 2] under the core Midwife team; LMC details were recorded but did not include contact details. At the time [of discharge] a [city] midwife was organised to continue postnatal care. This is recorded on the discharge.

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In Summary there appears to be a breakdown in communication regarding on going postnatal care for [Ms A]. In the context of a premature baby who required surgery and a woman who required emergency care this is particularly disappointing.

Whilst in my opinion proactive communication with [Ms A] rested with [RM B], I do acknowledge that communication from [the DHB] and [Hospital 1] was not ideal. I recognise that this must have been a particularly stressful time for [Ms A].

In my opinion to not make a proactive approach regarding postnatal care is not best practice; however [Hospital 2] does not appear to have made contact with [RM B] on discharge. I have considered that [RM B] states that she spoke to [Ms A's] partner on 21 January; she felt her instructions to [Hospital 1] were misunderstood.

I cannot be certain to what extent the misunderstanding affected the outcome of postnatal care … and because care was provided throughout, I consider it to be a mild departure from accepted practice for [RM B] to not have proactively offered postnatal support to [Ms A].

Summary

In summary, I have carefully considered the care provided by [RM B] to [Ms A] and consider that the antenatal care until [32 weeks' gestation] is in keeping with accepted Midwifery practice. In my opinion not to have followed up or arranged follow up on blood tests in the context of the history and the deteriorating clinical picture is a severe departure from accepted midwifery practice. In my opinion the postnatal care was affected by poor communication; however I consider that proactive communication from [RM B] was required and in not doing so has mildly departed from accepted practice.

Finally, I acknowledge [Ms A's] complex pregnancy, emergency birth and ongoing stress regarding care for her precious [baby]. I wish [Ms A] and her partner the best in on going care for their precious family. I hope that this report has addressed some of their remaining questions.

Nicky Emerson
BHSc — Midwifery
Midwifery Advisor Health and Disability Commissioner"

The following further advice was received from RM Emerson:

"… I have reviewed and considered my original advice and [RM B's] response to it. Following review and consideration, I have elected not to change my original advice from a severe departure from accepted Midwifery practice in not following up or arranging formal follow up of [Ms A's] blood results [at 32 weeks' gestation]. My reasons are the following:

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- [Ms A] had a history of severe pre eclampsia/HELLP which had necessitated early delivery of her previous babies
- [Ms A] was being treated and monitored for high blood pressure and had additional risk factors including very high BMI
- Pre eclampsia/HELLP can progress rapidly and severe maternal/neonatal morbidity/mortality can result.
- [Ms A] had presented [at 32 weeks' gestation] with documented deteriorating symptoms which resulted in [RM B] ordering bloods
- No formal follow up of the results were arranged prior to [RM B's] leave.

I have considered that the antenatal care to [32 weeks' gestation] had not departed from accepted Midwifery practice and that the postnatal care appeared to be complicated by a series of miscommunications from more than one party. I acknowledge [RM B's] apology to [Ms A] and her reasons for not following up the blood tests; however this put [Ms A] and her baby at risk.

In my opinion, it is a departure from expected Midwifery practice to expect a colleague to follow up on test results when there is no formal hand over making a request for them to do so; particularly on the background of clinical concern/ deterioration.

Please don't hesitate to let me know if you require further clarification.

Regards

Nicky"

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