Registered Midwife B
Registered Midwife C

A Report by the
Deputy Health and Disability Commissioner

(Case 21HDC00115)

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 2020 and 2021.*
- *Whether RM C provided Ms A with an appropriate standard of care in 2020 and 2021.*
- *Whether RM B provided Baby A with an appropriate standard of care in 2021.*
- *Whether RM C provided Baby A with an appropriate standard of care in 2021.*

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
Ms B	Provider/registered midwife
Ms C	Provider/registered midwife

4. Further information was received from Health New Zealand|Te Whatu Ora (Health NZ) and the Midwifery Council of New Zealand.

5. Inhouse clinical advice was obtained from RM Isabelle Eadie (Appendix A).

Information gathered during investigation

Introduction

6. In 2020 Ms A (then aged 28 years) became pregnant. This report relates to the antenatal and postnatal care Ms A received from RM C and RM B and the care provided to Baby A after his birth.

7. On 7 Month1[1] Ms A registered at a maternity service with RM C as her lead maternity carer (LMC). However, the maternity service operated as a midwifery team and Ms A's antenatal care was provided by RM C, RM B, and locum midwives.

8. RM C and RM B[2] stated that Ms A knew how the maternity service operated from the time of her first telephone call to them, as they always explained to women before the initial

[1] Dates have been removed to protect privacy.
[2] RM C and RM B wrote a joint response to Ms A's complaint, which they sent to the Midwifery Council of New Zealand and HDC.

booking visit how they worked, in order to give the women time to consider whether shared care was the right choice for them.

9. RM C and RM B said that they worked a one-week on-call and one-week off-call roster. They stated that they also had scheduled time off throughout the year, during which a locum midwife covered the clinics for the person who was on leave. They noted that they worked across the midwifery scope of practice, completing antenatal, labour and birth, and postnatal modules with the women registered. They said that they worked in collaboration with a public hospital and had a good working relationship with all services in the community.

Booking visit

10. On 7 Month1 Ms A telephoned RM C, who made a booking appointment for 14 Month1. Ms A did not attend the appointment, so she was contacted to re-book her appointment for 21 Month1. RM C stated that at that date Ms A was at 8+3 weeks' gestation.

11. RM C recorded that previously Ms A had had miscarriages (at 12 weeks' gestation and at five weeks' gestation) and her estimated date of delivery (EDD) was 20 Month8. RM C stated that Ms A also disclosed that she suffers from depression and anxiety and was not medicated, but she had been seeing a counsellor. However, the sections in the antenatal records referring to maternal depression are not completed.

12. In her complaint, Ms A stated that at her first appointment she informed RM C that she had had 'colposcopy surgery[3]' when she was 23 years old, which meant she has a shortened cervix,[4] and she also told RM C that she had had a miscarriage at 12 weeks' gestation 10 years previously. Ms A said that these events were not documented and, as a result, she was viewed as being at low risk during her pregnancy. Ms A said that she expressed concern about her pregnancy in light of the miscarriages and the shortened cervix. However, RM C did not complete the gynaecological history section of the 'Medical and Obstetric History' in the antenatal records.

13. The cause of Ms A's shortened cervix is unclear. RM C and RM B appear to believe that she had undergone a loop electrical excision (LETTZ) procedure (a procedure that uses a thin wire loop with an electrical current to remove the areas of the cervix with cell changes). Ms A did not tell HDC that previously she had had a LETTZ procedure, and RM C and RM B said that they were unable to confirm whether Ms A disclosed this information to RM C. They said that if it had been disclosed, they would have recommended that Ms A have a 16-week cervical length scan and, if the scan results had been abnormal, they would have made a referral to the obstetric team at the public hospital for an obstetric consultation.

14. RM C and RM B noted in their response that there is no documentation in Ms A's records regarding the LETTZ procedure she had undergone. They stated: 'We do reflect that this bit

[3] The cervix is viewed with a low-powered microscope, and pieces of tissue may be removed and sent to a laboratory for testing.
[4] A short cervix is one that is less than 25mm at around 20 weeks' gestation. A short cervix increases the chance of a preterm birth.

of information had been missed, and [Ms A] was not given the opportunity to discuss the risk of her LETTZ with a specialist.'

15. The first record of Ms A having a shortened cervix is at her appointment on 13 Month7 at 33 weeks' gestation. At that appointment, Ms A's shortened cervix and family history of preterm labour were discussed with a locum midwife, who gave Ms A advice about the signs of preterm labour.

Antenatal appointments

16. Ms A told HDC that each appointment with the midwives lasted less than 10 minutes. She said that they would do a urine test, check the baby's heartbeat, and she would be booked for her next appointment. She stated that there was no small talk, or chance to bond with the midwives. She said that she saw locum midwives three times, which was more than she saw her actual midwives, whom she saw a total of only two times each.

17. RM C and RM B said that they scheduled antenatal appointments monthly from booking until 28 weeks' gestation, in the third trimester they scheduled appointments every 2–3 weeks, then they scheduled weekly appointments from 36–37 weeks' gestation. However, during Ms A's first trimester and part of her second trimester, they were having to schedule as per COVID-19 Level 3 and Level 2 guidelines.[5]

18. RM C and RM B stated that Ms A had 12 appointments booked and did not attend three. They said that in total she had nine face-to-face appointments with midwives — Ms A was seen twice by the locum midwife while one of them was on holiday, and she had five appointments with RM C and two with RM B. RM C and RM B stated that the maternity system they used did not have a separate login for locums, so the locum needed to sign in under one of their logins, then add extra initials at the end of the entry. On that basis, the records indicate that Ms A saw RM C six times, RM B twice, and a locum once. However, this appears to be incorrect, as the appointment on 17 Month8 (discussed below) appears to have been with a locum despite no further initials having been appended.

19. RM C and RM B stated that generally their appointments lasted 20–30 minutes, depending on the woman's needs. They said that if Ms A felt that her appointments were short, she could have mentioned that to them at the time.

Antenatal growth chart

20. Ms A's records contain an antenatal growth chart, but it was completed only at 33 weeks' and 38 weeks' gestation. RM C and RM B agreed that they failed to assess the fetal growth in the third trimester, and did not plot the fundal height measurements on the customised growth chart. RM B said that it was her normal practice to plot the fundal height, and 'this was a huge error in the care provided'.

[5] The New Zealand College of Midwives 'COVID-19 Alert Level 3 or 4 Information for Midwives' included that in-person visits for well women who did not meet high index of suspicion (HIS) criteria should be conducted partially by phone or video, and in-person contact limited to 15 minutes or less where possible, for the physical assessment. It includes a recommended schedule of visits for antenatal care.

Dilated renal pelvis

21. At Ms A's anatomy ultrasound scan[6] on 13 Month4, her cervical length was checked and reported to be 36mm (normal). The baby's anatomy survey showed a mildly dilated renal pelvis (the area of the kidney that collects the urine before it drains out of the kidneys) of the right kidney of 4.3mm, which was classified as a Low Grade A-1, and it was recommended that Ms A have a follow-up ultrasound scan at 32 weeks' gestation.

22. At 32 weeks' gestation Ms A had a follow-up scan as recommended, which also included a growth ultrasound. The renal pelvis was still low-grade A1, and the national protocol in such a case is to refer the baby to a paediatrician postnatally, and for the baby to have an ultrasound scan at one to three months of age. The scan showed that the baby's growth was normal and the presentation was cephalic (head down).

Confidentiality concern

23. Ms A told HDC that RM C brought up a 'personal matter' during an appointment, which Ms A thought was unprofessional. Ms A provided no details about the nature of the personal matter. She said that she was around 35 weeks pregnant at that time (the last recorded appointment with RM C was on 22 Month6 when Ms A was 30+1 weeks' gestation). Ms A said:

> 'I was immediately uncomfortable as that meant that my midwife had breached my confidentiality and had spoken about me outside of a business context with others. I started to feel as if I was not being provided the proper care because of this. This caused my stress levels to spike.'

24. Ms A stated that she discussed with RM C that she did not feel she was receiving adequate care because of this concern and wanted to know whether she should find a new midwife in the short amount of time she had left, to ensure her baby was being cared for properly, and whether the personal matter was going to pose a risk during the birth. She said that RM C told her, 'I shouldn't say this but I personally don't like either of them,' when referring to a midwife who worked for the public hospital maternity unit.

25. RM C agreed that there was discussion about a personal matter during an antenatal visit. She told HDC that it was a conversation regarding Ms A's previous partner, who had been 'seeing' RM C's friend/colleague. RM C said that Ms A's confidentiality was not breached, and none of her information was ever shared with colleagues outside of the maternity service.

26. RM C stated:

> 'I only mentioned it because I wanted her to be aware that my colleague was my friend and I wanted to give her the opportunity to bring up any concerns she may have felt to be uncomfortable.'

[6] A prenatal ultrasound performed between 18 and 22 weeks of pregnancy. It checks the development of fetal organs and body parts and can detect certain congenital defects.

27. RM C made no record of this discussion. Her entry for 22 Month6 states that Ms A had 'nil further questions or concerns'.

Appointment 13 Month7

28. At her appointment on 13 Month7 at 33 weeks' gestation, Ms A discussed with the locum midwife her shortened cervix and family history of preterm labour. The locum recorded that she gave advice about the signs of preterm labour and also discussed the results of the anatomy scan and the follow-up that the baby would need after birth.[7]

Appointment 26 Month7

29. RM B said that at the 35-week appointment on 26 Month7 she was concerned about the baby's growth, so she ordered a growth ultrasound scan. However, there is no mention in the antenatal record of that concern. RM B said she did not measure Ms A's fundal height at that appointment.

30. A growth ultrasound scan conducted on 3 Month8 showed that the fetal size was within normal limits, but the baby was in a footling breech position (feet down).

31. The scan report states that Ms A had a cervical length of 14mm and notes: 'Specialist review recommended.' RM C and RM B stated that because Ms A was over 28 weeks' gestation, the cervical length information was irrelevant, as a shortened cervix is common in women who are near to full term, when the cervix is preparing for labour.

External cephalic version

32. On 8 Month8 at 37+1 weeks' gestation, Ms A attended an appointment at the public hospital maternity unit to have an external cephalic version (ECV) to turn the baby to a head-down position. This was successful and the baby was turned from the breech position to the cephalic position.

33. Ms A stated that she had no follow-up from her midwives immediately after the ECV. RM C and RM B said that this was because the maternity unit had arranged for Ms A to go back on 9 Month8 to check that the presentation was still cephalic. On that day, Ms A had another scan, which showed that the baby remained cephalic, and CTG monitoring was normal.

Hospitalisations

34. Ms A was hospitalised three times during her pregnancy. On 24 Month6 she had a fall up some stairs, on 24 Month7 she had decreased fetal movements and a possible urinary tract infection (UTI), and on 17 Month8 a locum midwife sent Ms A to the maternity unit for intravenous (IV) fluids because she was not feeling well and could not keep food down.

[7] The notes state: '[Ms A] is well and she reports lots of Braxton Hicks contractions since her last visit especially at night. She reports having a shortened [cervix] and a family history of pre-term birth. We have discussed the difference between Braxton Hicks and labour and not to ignore the signs of labour. Baby will need to be born in the hospital and will most likely need to go to the NNU if born early. Discussed results of anatomy scan and paed[iatric] referral and follow up will be needed after birth.'

35. Ms A told HDC that the midwives never followed up with her following the hospital admissions. RM C and RM B said that the public hospital did not send them discharge summaries, and Ms A did not inform them of the admissions. The hospital records do not include discharge summaries for Ms A's admissions.

Maternal weight gain

36. Ms A told HDC that she gained only 4.9kg during the pregnancy, and she expressed concern to the midwives about her low weight gain. She said she had to ask to be weighed.

37. The records state that at booking, Ms A's weight was 69.9kg. At 14.1 weeks' gestation RM C recorded that they had talked about weight gain in pregnancy and the weight they 'recommend[ed] that [Ms A] gain' (the recommended figure is not recorded). At 21+6 weeks' gestation Ms A's weight is recorded as 75kg, and at 30+1 weeks' gestation it is recorded as 74.9kg. The record for that visit states that RM C discussed Ms A's weight gain with her and that so far she had gained 5kg, which was 'tracking on normal'. At the final visit on 17 Month8 at 38+1 weeks' gestation, the recorded weight is 74.7kg.

38. RM C and RM B told HDC that Ms A's weight was monitored and she did put on weight, although she gained only 5kg in total. They stated that during her pregnancy she did not disclose that she had severe hyperemesis (severe nausea and vomiting during pregnancy) and often would say that she was eating healthily and keeping well hydrated.

39. However, there is evidence in the records that vomiting had been a problem throughout the pregnancy. The record for 17 Month8 when Ms A was at 38+1 weeks' gestation states that she had been struggling to eat and drink and had been vomiting. The record states: '[T]his has been a problem all pregnancy and is really bad at the moment with [Ms A] only able to tolerate very small amounts of food and fluids.' Ms A told HDC that this visit was with a locum midwife, but, as stated above, no extra initials were noted at the end of the record. The midwife sent Ms A to the public hospital's maternity unit for IV fluids.

40. That day, Ms A presented at the public hospital and was reviewed by an obstetrician & gynaecologist. The hospital record states that Ms A had been having difficulty holding down food and fluids and that she had 'had vomiting throughout the pregnancy and only gained 5kg in weight'. Ms A had an ultrasound scan and CTG, which were normal. The obstetrician & gynaecologist advised that if she continued to vomit, she should have an induction of labour on 27 or 28 Month8.

Birth

41. On 20 Month8 Ms A's membranes ruptured and she went to the public hospital maternity unit at 10pm. RM C and RM B stated that usually they would attend to assess the woman, but as Ms A had not contacted them, she arrived unannounced.

42. The core midwife telephoned RM B to tell her that Ms A had arrived. The core midwife said that she had checked Ms A to make sure she was in labour. Ms A was 4cm dilated and the core midwife gave her the option of staying in the maternity unit or going home. Ms A decided to go home until she was in stronger labour.

43. Ms A said that when she was at home, she began to push, and an ambulance was called. She was transferred back to the maternity unit. Ms A called RM B before she left home, and RM B met her at the maternity unit. Ms A was in strong labour and giving involuntary pushes, and at 1.25am when RM B checked her cervix with consent, she was fully dilated. Baby A was born in a good condition at 1.46am weighing 2,865gm.

Post-birth

44. RM B recorded that at 2am on 21 Month8 she examined Ms A's perineum and the placenta. RM B noted that Ms A was very tense and would allow only a brief check, which prevented a proper examination. RM B noted: 'I could only see labial grazes, no perineal tears[8] seen. [Ms A] told me to stop checking and that she felt fine! Offered to use entonox[9] but she declined.' RM B recorded that she told Ms A that the grazes were superficial and did not need sutures, and there was no bleeding.

45. RM B told HDC:

> 'In hindsight offering for having her legs to be up in stirrups would have helped to check her perineum adequately, she may have been more relaxed. She was offered gas and analgesia but declined, she wanted me to stop checking and stated she felt fine. I did identify a 1st degree labial laceration. This was not bleeding and I did not feel that this needed suturing.'

46. Ms A stated that RM B told her that she did not have a tear, and she was not checked again.

47. RM B said that she saw Ms A on day 0, day 1 and day 2 of her baby being born, and at each point of contact Ms A did not disclose that her nipples were uncomfortable or that she had trauma to her nipples.

48. Ms A was discharged from hospital on 22 Month8. On that day, RM B visited her home, and found that Baby A looked well, and he was breastfeeding on demand. RM B noted that Baby A had a tongue tie (a band of tissue connecting the underside of the tongue to the floor of the mouth, which can impede breastfeeding). RM B said that she told Ms A that because the tongue tie was not causing any issues at that point, she would wait to refer Ms A to the lactation consultant, as the service was closing for the public holidays.

49. RM B and RM C told HDC that in the area, a frenotomy[10] is not done immediately after birth in the hospital. There needs to be a review by a lactation consultant, who then refers the baby to a midwife trained to do frenotomy, or to an ear, nose and throat (ENT) doctor. They said that at the time, there was only one community lactation consultant working in the area, who was unlikely to be available during the holiday period.

[8] A laceration of the skin between the vagina and the anus.
[9] Inhaled nitrous oxide gas used as pain medication.
[10] A procedure to cut or modify the binding tissue in the mouth.

50. Ms A stated that on 24 Month8 she was in immense pain and could not urinate. At 10pm she phoned RM B and told her that she had been unable to pass urine all day and had a lump on her labia. RM B advised her to go to the public hospital's Emergency Department (ED).

51. Ms A told HDC that she was examined by the ED doctor, who informed her that she had a major tear from her urethra to her perineum that had become infected. She said that she also had a haematoma on her lower labia that had to be drained of approximately 4ml of blood, and a catheter was inserted to remove 1.3 litres of urine that had accumulated, as her urethra was blocked.

52. The public hospital records state that Ms A presented with urinary retention and pain and was found to have an infected vaginal tear and a haematoma that was drained by a general surgeon. She was prescribed Augmentin (an antibiotic).

53. RM B told HDC:

> 'I do really apologise that this was missed and feel that if I had known that extent of the laceration there is no way I would have left it. The hematoma that was identified on day 4 was unfortunate, but again out of my control. Women can have a hematoma even if she had a repair.'

54. RM B did not follow up with Ms A on 25 Month8. Ms A stated that RM B texted her on 26 Month8 to ask how she was, and after Ms A told her what had happened, RM B's text reply was 'oh wow, hope you're feeling better now', and RM B did not contact her further.

55. RM B told HDC that her reply to Ms A's text message was a genuine response. She said: 'I am sorry that [Ms A] took it the wrong way, and I should have phoned her instead of texting her.'

56. On 28 Month8 Ms A returned to the hospital for a review of the infected wound. The records state that she was still in discomfort when sitting and having difficulty passing urine because of the pain.

Visit 28 Month8

57. On 28 Month8 RM C reviewed Ms A and Baby A. Baby A weighed 2,570g and had lost 295g since his birth. RM C recorded that Baby A was alert, no jaundice was present, and he had good output and good wet nappies. Ms A was breastfeeding and topping up Baby A with formula by bottle. RM C recorded that the reason for doing so was that Baby A had lost 10% of his birth weight. However, RM C told HDC that Ms A told her that she had sore nipples, which was the reason she was supplementing the baby with formula.

58. RM C told HDC that she accepts that she should have reweighed the baby a few days after the visit on 28 Month8. She said that usually she would reweigh a baby in 2–3 days' time if the baby had lost weight in the first week. She noted that the guidelines state that a referral to a paediatrician is recommended if a baby is not at its birthweight by two weeks of age. She said that a referral to the community lactation service would have been appropriate, but because of the time of year, the service was closing. RM C said: 'We cannot say that [Ms

A] and baby would have been seen by the lactation consultant, but the referral could have been made.'

59. Ms A stated that her aunt, who is a midwife (in a different city), came to visit when her son was two weeks old, and she cut his tongue tie (a frenotomy). Ms A stated that the midwives did not make a referral to a lactation consultant until after her aunt had expressed her concerns to them.

60. RM C said that they tried to explain the process to Ms A, but Ms A may not have understood the barriers to the lactation service in the area, especially during the holiday period when the lactation service takes time off. RM C said that a referral to the community lactation consultant was completed, and Ms A was booked in when the consultant returned from leave on 15 Month9.

61. RM C stated that when she visited Ms A, she did not disclose any pain from the graze/ laceration of her perineum and was mobile. RM C said that she did not offer to inspect Ms A's perineum because Ms A said that her per vaginal (PV) loss had settled, and she had no concerns. However, RM C also said that on reflection, she considers that she should have offered to inspect Ms A's perineum, but at the time she felt that she did not need to investigate further.

Termination of services

62. On 5 Month9 RM B visited Ms A for her routine postnatal check. At that visit, Baby A's weight was 2,779g (ie, he had not regained his birth weight).

63. RM B stated that as she was weighing the baby, Ms A started to raise concerns, mentioning that she was not happy with her care and that the midwives had been negligent. RM B stated: '[Ms A] was very aggressive and would not let [me] explain.'

64. Ms A told HDC that she remained calm and attempted to raise her concerns about her aftercare and her son's care. She said that RM B was immediately defensive and began to run her down and said that everything was her own fault. Ms A said that RM B stated: 'I don't have to put up with this shit, find yourself a new midwife.' Ms A said she told RM B that she would be making a complaint of negligence, and RM B scoffed, then left.

65. RM B said that she felt threatened by Ms A and unsafe, so she had to leave the house. She admitted to having said, 'I do not need to put up with this shit,' but stated that she was shocked by the aggression.

66. RM B informed Ms A that she would need to find another midwife to care for her from that point, and RM B phoned the manager at the public hospital's maternity unit to make her aware that Ms A and her baby had been discharged early from their care and explained the

reason why. RM B also sent a discharge letter to the Well Child Tamariki Ora[11] team and Ms A's GP.

67. The manager advised RM B to contact Well Child Tamariki Ora to arrange for Ms A's care to be taken over, and in the meantime the public hospital maternity unit provided care, including weighing the baby.

68. RM B said that she failed to refer Baby A to the paediatrician when he was not at his birthweight at 14 days old. She said that this was missed because Ms A and Baby A were discharged early from LMC care. However, she did organise for Ms A to have care provided to her by the hospital midwives and gave a thorough handover of events.

69. The hospital notes record that RM B had a telephone conversation with the manager on 6 Month9. RM B asked whether the baby could be seen and reweighed in the maternity unit the following day. The notes state that RM B said that the baby was two weeks and two days old and, when seen by RM C the previous week, the baby had not regained his birth weight but he had since regained 200g.

Confidentiality

70. Ms A is concerned that after the relationship had been terminated, RM B and RM C told people that she had fired them, which was not the case as they ended the relationship. Ms A also stated that after RM B and RM C learned about her complaint, they told midwives in the area a story about her and spoke about her in a professional forum in a degrading and insulting manner, referring to her character and parenting skills.

Further information

71. RM B told HDC that she agrees that there was a major breakdown in the partnership of care between Ms A and her midwives. RM B said that the issues include the failure to assess fetal growth in the third trimester, not plotting fundal height measurements on the customised growth chart, the failure to obtain and document important information about Ms A's gynaecological history, and the failure to document the perineal assessment after birth appropriately.

72. RM B agreed that she responded to Ms A in an unprofessional manner on the visit of 15 Month9. RM B said that she had not expected the 'hostile and aggressive behaviour' from Ms A.

73. RM B stated that there were multiple inadequacies in their documentation. She noted that there is no documentation of Ms A's gynaecological history, the discussions about the shortened cervix, the reasons for ordering scans, the fundal heights, or the GROW chart.

[11] The Well Child Tamariki Ora programme is a series of free health checks and follow-up support for tamariki from six weeks old.

Responses to provisional opinion

74. Ms A was provided with the 'information gathered' section of the provisional opinion. She did not provide any comments.

75. RM C and RM B were provided with copies of relevant sections of the provisional opinion and both said that they had no further comments.

Opinion: Introduction

76. RM C and RM B operated the maternity service on a shared-care model. Despite this, I consider that each midwife is individually responsible for the services she provided to Ms A and Baby A.

77. Ms A indicated that she was seen by locum midwives more frequently than by RM B or RM C. From the antenatal clinical notes, it appears that every visit was with the midwives, since they are the named practitioners.

78. RM B and RM C explained that the computer system does not allow for the locum midwives' names to display because they do not have a login for the system, but Ms A was seen five times by RM C and twice by RM B, and twice by the locum midwife, who wrote her initials at the end of the clinical notes. However, there is only one entry with the locum's initials at the end of the notes. Given the conflicting evidence from Ms A and RM C and RM B, together with the records, which do not altogether support their accounts, I am unable to determine who saw Ms A on some occasions.

79. In considering the care provided to Ms A, I obtained in-house clinical advice from RM Isabelle Eadie. RM Eadie identified several mild to moderate departures from accepted standards of care on the part of both RM C and RM B. In my view, cumulatively these indicate an inadequate standard of midwifery care on the part of both midwives.

Opinion: RM C

Care of Ms A — breach

Booking visit

80. Ms A had her booking visit on 21 Month1 when she was at 8+3 weeks' gestation. RM Eadie advised that during the booking visit it is normal to enquire about the woman's previous medical, surgical, and obstetric history.

81. RM C stated that Ms A disclosed that she suffered from depression and anxiety, and that she was not medicated but had been seeing a counsellor. However, the sections in the antenatal records referring to maternal depression were not completed.

82. Similarly, the gynaecological history section of the 'Medical and Obstetric History' in the records is also blank. Ms A stated that she informed RM C that she had had colposcopy surgery when she was 23 years old and had a shortened cervix. She said that she expressed her concern about her pregnancy in light of her previous miscarriages and the shortened cervix.

83. Possible causes of a shortened cervix include having had a procedure in which part of the cervix is removed, or having had a previous preterm birth. A colposcopy would not normally involve removal of part of the cervix apart from that needed for a biopsy. However, some women are born with a shortened cervix.

84. Ms A did not say that she had undergone a LETTZ procedure. However, RM C and RM B appear to believe that Ms A did have a LETTZ procedure and noted that there is no documentation in Ms A's records regarding the LETTZ procedure. They said that they were unable to confirm whether Ms A disclosed this information to RM C, but they said that if it had been, they would have recommended a 16-week cervical length scan and, if the scan results had been abnormal, a referral for consultation to the obstetric team at the public hospital would have been made.

85. RM C and RM B stated that information about the LETTZ was missed, and, as a result, Ms A was not given the opportunity to discuss the risk of her LETTZ with a specialist. However, there is no evidence that Ms A actually had a LETTZ procedure, and she herself referred to having had colposcopy surgery.

86. It is clear that the shortened cervix was of concern to Ms A and she was aware of it being linked to preterm birth. Whether or not the shortened cervix was caused by the colposcopy, it was RM C's responsibility to obtain Ms A's gynaecological history and document it. In my view, given Ms A's previous miscarriages and her concerns about the pregnancy, it is more likely than not that she did mention the shortened cervix.

87. There is no information about Ms A's cervix in the records made at the booking visit. RM Eadie advised that if the information was discussed and RM C failed to document it and offer appropriate management and referral, this would reflect a mild to moderate departure from expected practice. I agree.

88. Ms A's cervical length was measured during the anatomy ultrasound scan on 13 Month4 and was 36mm, which is normal. At her appointment at 33 weeks' gestation, Ms A's shortened cervix was discussed with the locum midwife and safety-netting advice was given about signs of preterm labour. At her 36 weeks' gestation growth scan, the cervical length was measured at Ms A's request, and it showed that her cervical length was 14mm. The scan report recommended obstetric referral, but RM C and RM B said that the cervical length was irrelevant, as Ms A was over 28 weeks' gestation. RM Eadie advised that the risk associated with a shortened cervix is preterm birth, but at that stage it was no longer a concern. I accept that advice. However, although Ms A was seen by a locum midwife, RM C had access to the records, so this was a missed opportunity for her to alleviate Ms A's ongoing concerns about the shortened cervix by having a thorough conversation with her.

Assessment of fetal growth

89. There was no assessment of the fetal growth prior to 32 weeks' gestation. RM Eadie stated that the recommendations are to assess growth from 26–28 weeks. The aim is that from 26–28 weeks' gestation the symphysis fundal height (SFH)[12] is measured every 2–3 weeks and plotted on the GROW chart, and if the SFH plots below the 10th centile, initial management is to refer the woman for a growth scan and plot the estimated fetal weight on the GROW chart.

90. Ms A's GROW chart shows only two SFH measurements, which were plotted at 33 weeks' gestation and 38 weeks' gestation. RM Eadie advised that there is an expectation that midwives use the GROW chart as a tool to detect small for gestational age babies so that appropriate referrals and management can be implemented if required.

91. RM Eadie advised that the failure to assess the fetal growth regularly and appropriately was a moderate departure from expected practice. I accept this advice and consider that the fetal growth was not monitored adequately.

Perineum

92. RM C stated that when she visited Ms A on 28 Month8 Ms A did not disclose any pain from the graze/laceration of her perineum and was mobile. RM C said that she did not offer to inspect Ms A's perineum because Ms A told her that her PV loss had settled and she had no concerns. However, RM C said that on reflection, she considers that she should have offered to inspect Ms A's perineum. I agree.

Conclusion

93. I find that RM C failed to obtain Ms A's previous medical, surgical and obstetric history, failed to communicate with Ms A adequately about her shortened cervix, failed to assess the fetal growth adequately, and failed to offer to inspect Ms A's perineum. Accordingly, I find that RM C did not provide services to Ms A with reasonable care and skill and breached Right 4(1)[13] of the Code of Health and Disability Services Consumers' Rights (the Code).

Professional conduct — adverse comment

94. Ms A and RM C both agreed that RM C brought up a personal matter during an appointment. Ms A was concerned that RM C had breached her confidentiality.

95. Ms A said that RM C referred in a negative manner to a midwife who worked for the public hospital maternity unit.

96. RM C said that the conversation related to Ms A's previous partner, who had been 'seeing' RM C's friend/colleague. RM C said that Ms A's confidentiality was not breached and none of her information was ever shared with colleagues outside the maternity service.

97. RM C stated:

[12] Using a tape measure to check the distance between the pelvic bone and the top of the uterus.
[13] Right 4(1) states: 'Every consumer has the right to have services provided with reasonable care and skill.'

> 'I only mentioned it because I wanted her to be aware that my colleague was my friend and I wanted to give her the opportunity to bring up any concerns she may have felt to be uncomfortable.'

98. Ms A was also concerned that RM B and RM C discussed her with others after they were no longer her midwives.

99. I am unable to make findings as to what exactly occurred, but I take this opportunity to remind RM C of the need to conduct herself in a professional manner and maintain professional boundaries.

Care of Baby A

Weighing baby — breach

100. On 28 Month8 RM C reviewed Baby A. He weighed 2,570g and had lost 295g since his birth. RM C recorded that Baby A was alert, no jaundice was present, and he had good output and good wet nappies. Ms A was breastfeeding and topping up the baby with formula by bottle. RM C recorded that the reason for the topping up was that Baby A had lost 10% of his birth weight. RM B and RM C also stated that Ms A was giving top-ups because she had sore nipples, although the records document: '[N]ipples are comfortable.' Despite these contradictions, it appears that the midwives were aware that Ms A had sore nipples.

101. RM C accepts that she should have re-weighed Baby A a few days after this visit. She said that usually she would re-weigh a baby in 2–3 days' time if the baby had lost weight in the first week. RM Eadie advised that given the weight loss, it would be expected that the midwives would review the baby in 2–3 days to ensure that no further weight loss had occurred, rather than wait for a whole week, as was the case here. She said that the failure to check in earlier to assess Baby A's weight and Ms A's breastfeeding, given Ms A's sore nipples, reflects a mild to moderate departure from expected practice. I accept this advice.

102. RM C said that a referral to the community lactation service would have been appropriate, but because of the time of year, the service was closing for the holidays. RM C added: 'We cannot say that Ms A and baby would have been seen by the lactation consultant, but the referral could have been made.' I agree that RM C should have made the referral at that time.

103. I find that by failing to re-weigh Baby A and make a referral, RM C failed to provide services to Baby A with reasonable care and skill and breached Right 4(1) of the Code.

Opinion: RM B

Care of Ms A — breach

Assessment of fetal growth

104. There was no assessment of the fetal growth prior to 32 weeks' gestation. RM Eadie stated that the recommendations are to assess growth from 26–28 weeks.

105. Ms A was sent for growth scans at 32 and 36 weeks' gestation. The anatomy scan on 13 Month4 showed a mild dilated renal pelvis of the fetus's right kidney, and it was recommended that Ms A have a follow-up scan at 32 weeks' gestation. The growth scan at 36 weeks may have been because RM B thought that the baby was small when she saw Ms A at 35 weeks' gestation, although she did not record that in the notes or on the GROW chart.

106. Ms A's GROW chart shows only two SFH measurements, which were plotted at 33 weeks' gestation and 38 weeks' gestation. RM Eadie advised that there is an expectation that midwives use the GROW chart as a tool to detect small for gestational age babies so that appropriate referrals and management can be implemented if required. The aim is that from 26–28 weeks' gestation the SFH is measured every 2–3 weeks and plotted on the GROW chart, and if the SFH plots below the 10th centile, initial management is to refer the woman for a growth scan and plot the estimated fetal weight on the GROW chart.

107. RM Eadie advised that the failure to assess the fetal growth regularly and appropriately was a moderate departure from expected practice. I accept this advice and consider that the fetal growth was not monitored adequately.

Fundal height

108. RM B said that at the 35-week appointment on 26 Month7 she was concerned about the baby's growth, so she ordered a growth ultrasound scan. However, she failed to record that concern or the reason for the scan.

109. RM B did not measure Ms A's fundal height at that appointment, which RM Eadie advised was a moderate departure from expected practice. I accept this advice.

Perineal tear

110. On 21 Month8 RM B examined Ms A's perineum. Ms A found the assessment painful and would let RM B check her only briefly, so RM B was unable to examine Ms A properly. RM B noted: 'I could only see labial grazes, no perineal tears seen. [Ms A] told me to stop checking and that she felt fine! Offered to use entonox but she declined.' RM B recorded that she told Ms A that the grazes were superficial and did not need sutures, and there was no bleeding.

111. RM Eadie advised that as part of routine postnatal care, it is expected that there is an assessment of the perineum. She said that as the immediate post-birth assessment of the perineum was challenging and it was not inspected thoroughly, there would be more need to check it later. She advised that if a visual inspection was not offered subsequently, this would be a mild to moderate departure from expected practice. RM Eadie noted that in order to undertake a thorough assessment, this procedure is often quite painful for women, but it is necessary as some tears to the vaginal walls and labia minora are not easily visible, and left undetected can result in bleeding, infection, and haematomas.

112. Ms A said that RM B told her that she did not have a tear, and she was not checked again. There is no record that a later offer to reassess the perineum was made. I accept Ms A's account that there was no further offer to check her perineum.

113. RM Eadie advised that if RM B felt that she had not made a thorough assessment, she should have documented that and made clear that there was a small labial graze and that she was unsure whether there was additional trauma. RM Eadie stated that this would have been preferable because the documentation implies that there was only a labial tear/graze and no other trauma, yet RM B did not actually know this to be the case. RM Eadie stated that this reflects a mild departure from expected practice. I accept this advice.

114. Ms A stated that on 24 Month8 she was in immense pain and could not urinate and she presented at the public hospital ED. She was examined by the ED doctor, who told her that she had a tear from her urethra to her perineum that had become infected. She said that she also had a haematoma on her lower labia that had to be drained, and a catheter was inserted to remove 1.3 litres of urine that had accumulated, as her urethra was blocked.

115. The hospital records (albeit brief) state that Ms A presented with urinary retention and pain and was found to have an infected vaginal tear and a haematoma, which a general surgeon drained.

Conclusion

116. For failing to measure the fundal height and failing to examine Ms A's perineum adequately and document that she was unsure whether there was additional trauma, I find that RM B failed to provide services to Ms A with reasonable care and skill and breached Right 4(1) of the Code.

Unprofessional conduct — adverse comment

117. On 15 Month9 RM B visited Ms A. Ms A raised her concerns and mentioned that she was not happy with her care and said that the midwives had been negligent. RM B stated that Ms A was aggressive and would not let her explain.

118. In contrast, Ms A told HDC that she remained calm and attempted to raise her concerns about her aftercare and her son's care. She said that RM B was immediately defensive, began to run her down, and said that everything was her own fault. RM B stated, 'I don't have to put up with this shit, find yourself a new midwife,' and left the house.

119. RM B admitted to having said 'I do not need to put up with this shit' but stated that she was shocked by Ms A's aggression.

120. RM Eadie advised that RM B's language, and presumably her behaviour, were unprofessional, although it was clearly a very challenging situation for RM B.

121. RM B agreed that she responded to Ms A in an unprofessional manner on the visit of 15 Month9. RM B said that she had not expected the 'hostile and aggressive behaviour' from Ms A. However, RM B made no apology for her behaviour.

122. I am unable to make any findings about Ms A's manner because of the different accounts of RM B and Ms A. However, it was incumbent on RM B to defuse the situation in a respectful manner and, if that was not possible, to leave. It was unprofessional for her to have used the language described.

Care of Baby A

Referral — adverse comment

123. On 5 Month9 (day 15), RM B weighed Baby A. His weight was then 2,770g. RM Eadie stated that there was a very reassuring 200g weight gain in a week, but Baby A was still below his birthweight. She noted that the Referral Guidelines (MOH 2012) recommend a consultation with the Paediatric Service if babies have not re-gained their birth weight by two weeks of age. However, no referral was made. RM B said that this was missed because Ms A and Baby A were discharged early from LMC care on day 15. In addition, I note that RM B has said that she did organise for Ms A to have care provided to her by the hospital midwives and gave a thorough handover of events. In my view, these factors combined mitigated the absence of a referral on her part.

124. RM Eadie advised that the failure to refer was a mild to moderate departure from expected practice. I accept this advice.

Tongue tie — adverse comment

125. It was recognised shortly after birth that Baby A had a tongue tie. RM Eadie advised that not all tongue ties will pose a problem for the baby and consequently not all tongue ties require treatment. On the third postnatal visit (day 2), RM B documented that since the baby was breastfeeding well and there was no maternal pain or nipple trauma associated with breastfeeding, then the plan was to continue breastfeeding. RM B planned to make a lactation consultant referral but delayed that because there would be no lactation consultant working over the holiday period.

126. RM Eadie stated that based on the assessment at the time, the care regarding Baby A's tongue tie was appropriate, although the lactation consultant referral should have been done immediately.

127. However, RM B failed to communicate with Ms A effectively about the situation and the normal process for a tongue tie/frenotomy review. I agree with RM Eadie that had RM B done so, this may have prevented some of the misunderstandings that became evident. I am critical of RM B's communication with Ms A.

RM C and RM B — other comment

128. Several other issues illustrate the poor communication between Ms A and the midwives, as discussed below.

Maternal weight gain

129. Ms A was concerned that her low weight gain in pregnancy was ignored. At the booking visit she weighed 69.9kg. RN Eadie advised that there would not be a need to weigh her regularly at antenatal visits in the absence of any other concerns, but the records indicate that Ms A's weight was monitored regularly. At the end of her pregnancy, Ms A weighed 74.7kg. RM

Eadie advised that the approach to weight was acceptable, but the overall weight gain was less than would be expected for a woman with Ms A's body mass index (BMI).

130. RM C and RM B said that Ms A did not disclose concerns about vomiting and food intake during her pregnancy, and she was not receiving any medication for this problem. However, I note that at a visit on 17 Month8 Ms A raised concerns about having been vomiting throughout her pregnancy. Ms A said that this visit was with a locum midwife (although the entry in the records does not include any extra initials at the end). Ms A raised the same concern when she was seen that day at the public hospital.

131. I am unable to make a finding as to whether Ms A raised concerns about vomiting before 17 Month8. If she did not do so, I find that RM C's and RM B's approach to Ms A's weight was acceptable practice. However, I find it concerning that in that case, Ms A felt able to discuss this issue only with the locum midwife on 17 Month8 and with the staff at the hospital. In my view, this points to a fractured relationship between RM C and RM B and Ms A.

132. Ms A stated that her antenatal assessments were very short and that there were very limited discussions. She said that this, combined with the number of times she saw a locum, contributed to her inability to form a therapeutic relationship with her midwives.

133. RM C and RM B stated that their appointments usually last 20–30 minutes, and if Ms A had been concerned, she could have raised that at the time. I find this response concerning. Ms A was a first-time mother who needed support. In my view, RM C and RM B should have communicated effectively with Ms A and checked whether she had concerns, rather than expecting her to raise them.

Changes made

134. RM C has completed a fetal growth training course.

135. RM C is now very aware of documentation and looking further into obstetric history at booking visits. She is also very aware of the importance of communication and partnership.

136. RM B has completed the 'Suturing for midwives' course run by the New Zealand College of Midwives.

137. RM B has completed several education workshops and assessments as a part of the Midwifery Council competency programme, including the GAP assessment and 8hr GROW workshop, 'Suturing for midwives', breastfeeding education, and the PADA (perinatal anxiety and depression Aotearoa) workshop.

138. RM B has decided to take a break from midwifery work and to have a career change.

Recommendations

139. I recommend that within three weeks of the date of this opinion, RM C provide a written apology to Ms A for the breaches of the Code identified in this report. The apology should include the changes to practice made by RM C since the complaint. The apology is to be sent to HDC for forwarding to Ms A.

140. I recommend that within three weeks of the date of this opinion, RM B provide a written apology to Ms A for the breach of the Code identified in this report. The apology should include the changes to practice made by RM B since the complaint. The apology is to be sent to HDC for forwarding to Ms A.

141. I recommend that should RM B return to midwifery practice, within three months of the date of obtaining her practising certificate she undertake additional education on record-keeping, 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 HDC.

142. I recommend that within three months of the date of this opinion, RM C undertake additional education on record-keeping, 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 HDC.

Follow-up actions

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

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

145. A copy of this report with details identifying the parties removed, except the independent advisor on this case, will be sent to Health NZ, the New Zealand College of Midwives, and the Midwifery Council of New Zealand and placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

Appendix A: In-house clinical advice to Commissioner

The following advice was obtained from RM Isabelle Eadie:

'**C21HDC00115: Advice [Ms A]**

Overview
[Ms A] was in her third pregnancy (two early miscarriages previously) and booked with [the maternity service] for her maternity care. Her named LMC was [RM C], though [RM C] and [RM B] work together and jointly provided care to [Ms A], with assistance from locum midwives when needed. [Ms A] booked very early in pregnancy at 8 weeks' gestation. [Ms A] had a history of depression and anxiety and also had a LETTZ procedure in the past, although this was not documented in the antenatal notes during the booking visit. [Ms A] had a relatively uncomplicated pregnancy, though her baby was diagnosed with an A1 renal tract abnormality during the anatomy scan, which remained stable throughout the pregnancy (management is an ultrasound when baby is 3 months old). At a repeat scan at 36 weeks, [Ms A's] baby was breech and she was referred for an obstetric review and underwent a successful ECV (when baby is turned from breech to head down). [Ms A] went into spontaneous labour at 38 weeks and had a normal vaginal birth of her baby boy in good condition. As part of routine practice, [Ms A's] perineum was checked for any tears, a small labial graze/tear was identified that was not bleeding and was not sutured. On the 4th postnatal day, [Ms A] was seen by staff in the Emergency Department at the hospital and treated for a haematoma and urinary retention. [Ms A's] baby was diagnosed with a tongue tie after birth and a frenotomy and subsequent lactation consultant referral was done approximately 2 weeks post birth. [Ms A's] last visit with [the maternity service] was … at 15 days postnatal, at this point, due to a breakdown in the relationship between [Ms A] and the midwives she was discharged early from their care.

I have been asked to comment upon the following aspects of care provided to [Ms A] by [RM C and RM B]: Adequacy of antenatal care including management of her shortened cervix; Adequacy of postnatal care including management of baby's tongue tie; The documentation Management of the perineal trauma; The discharge process.

Adequacy of antenatal care including management of her shortened cervix
[Ms A] had her first antenatal booking visit at 8 weeks' gestation and was seen regularly throughout her pregnancy. In her complaint emailed to Midwifery Council, [Ms A] alludes to being seen by locum midwives more frequently than by [RM B] or [RM C]. From the antenatal clinical notes, it appears that every visit was with her LMCs, since they are the named practitioner. In their response to HDC … [RM B] and [RM C] explain that the computer system does not allow for the locum midwives' names to display because they do not have a login for the system, but that [Ms A] was seen five times by [RM C] and twice by [RM B] and twice by the locum midwife who does write her initials at the end of the clinical notes. The frequency of antenatal visits was appropriate. Review of the antenatal record shows that expected assessments of maternal and fetal wellbeing were conducted, with the exception that the GROW chart has not been used

consistently. In New Zealand there is an expectation to use the GROW chart as a tool to detect small for gestational age babies in order that appropriate referrals and management can be implemented if required (NZFMN 2014). The aim is that from 26–28 weeks' gestation the symphis fundal height (SFH) is measured every 2–3 weeks and plotted on the GROW chart, if the SFH plots below the 10th centile, initial management is to refer for a growth scan and plot the estimated fetal weight on the GROW chart (NZFMN 2014). [Ms A's] GROW chart only shows two SFH measurements plotted at 33 and 38 weeks, which is when she was seen by the locum midwife. However, I note that [Ms A] was sent for growth scans at 32 and 36 weeks. It is not clear from the antenatal notes why she was sent for growth scans, but in their letter, [RM C and RM B] explain that when she was seen at 35 weeks, [RM B] thought the baby was small which is why she sent her, although there is no SFH plotted on the GROW chart at this visit and nothing written. It is not evident why she had a growth scan at 32 weeks, perhaps it was done as part of the routine follow up scan of the baby's renal tract. Ultimately it would appear that there was no assessment of fetal growth prior to the 32 weeks' scan, despite recommendations to assess growth from 26–28 weeks (NZFMN 2014) and no documented measurement of the SFH on the GROW chart by [RM C and RM B] at any point. The fact that they had generated a GROW chart and plotted the estimated fetal weights implies they are familiar with its purpose but have not used it appropriately. Failure to regularly and appropriately assess fetal growth reflects a moderate departure from expected practice.

[Ms A] reported that her antenatal assessments were very short; 10 minutes and that there was very limited discussions. [RM B and RM C] disagree, stating that appointments usually last 20–30 minutes and the antenatal notes document information discussed with [Ms A] that would be expected. [Ms A] says that the discussions documented did not take place. I cannot comment further upon this.

[Ms A] was concerned that her weight gain in pregnancy was ignored. [Ms A's] weight was documented during the booking visit and she had a healthy weight and body mass index (BMI), therefore there would not be a need to weigh her regularly at antenatal visits in the absence of any other concerns. It is not clear what her total weight was by the end of the pregnancy, [Ms A] claims she had only put on 4.9kg, which is less than would be expected for a woman with her BMI (MOH 2014), but I find that the emphasis upon weight in pregnancy is focused upon women with high BMIs; the MOH (2014) guideline does not provide information pertaining to women with normal weight and minimal weight gain. However, at her visit at 30 weeks on 22nd [Month6], there was a comment in the antenatal record that normal weight gain in pregnancy was discussed, and at that point she had gained 5 kg, which would be appropriate.

[RM B and RM C] wrote that [Ms A] did not disclose concerns with vomiting and food intake during her pregnancy and that she was not receiving any medication for this problem. Therefore, I find that their approach to [Ms A's] weight was acceptable practice.

During the booking visit it is normal to enquire about the woman's previous medical, surgical and obstetric history. [Ms A's] previous first trimester miscarriages were documented as was her history of depression, but not her gynaecology details, including her "shortened cervix". In her complaint, [Ms A] refers to a previous colposcopy, in their response, [RM B and RM C] refer to a LLETZ procedure, it is not clear if [Ms A] had actually had a LLETZ procedure or not. The significance is that a colposcopy looks at the cervix, where as a LLETZ procedure involves removing a part of the cervix which can have implications in pregnancy such as an increased risk of preterm birth. Regardless, nothing pertaining to [Ms A's] cervix was documented. [RM B and RM C] cannot confirm or refute if the information was shared with them, but do apologise that it was missed which meant that [Ms A] did not have an obstetric consultation to discuss this as recommended in the "Referral Guidelines" (MOH 2012). If the information had been discussed and [RM B and RM C] failed to document it and offer appropriate management and referral, this would reflect a mild to moderate departure from expected practice. As noted by [RM B and RM C], during the anatomy scan, [Ms A's] cervical length was measured and was 36mm, which is normal. At her appointment at 33 weeks, [Ms A's] "shortened cervix" was discussed with the locum midwife and appropriate safety netting advice was given about signs of preterm labour. At her 36 weeks' growth scan, at [Ms A's] request the cervical length was measured. This scan showed that the cervical length was 14mm. The scan report recommends obstetric referral, but in their response, [RM B and RM C] wrote *"The scan showed … a cervical length of 14mm at 36.1 weeks, because [Ms A] is over 28 weeks pregnant and close to term this information is irrelevant, and often common [in] women who are coming up term. [Ms A] was told that if her cervical length is short, nothing will be done about it."*

I spoke with an obstetrician about this because cervical length is not normally measured at this late gestation and there are no guidelines about an acceptable length or recommended management and I was advised that from her perspective no action would be required and that in her opinion the request to measure it should have been declined. At this 36 week scan, baby was found to be in a breech position. [Ms A] was referred for obstetric review at the hospital and was offered and accepted an ECV. [Ms A] wrote that during this consultation, the obstetrician reviewed the 36 week scan report and noted the cervical length and raised his concerns to [Ms A] that this information had not been highlighted in the referral by her midwives. However, as noted by [RM B and RM C], there is nothing in the obstetrician's documentation pertaining to concern about [Ms A's] cervical length, probably because at the time she was seen by the obstetrician, she was already 37 weeks pregnant. In her complaint, [Ms A] recounts her first admission to the hospital when she was seen and assessed by a hospital midwife. The hospital midwife telephoned [RM B] to update her, and [Ms A] wrote *"Yet again, my shortened cervix being undocumented. I was told I was 4cm dilated and I could go home to continue my laboring. I decided to go home not realizing my shortened cervix posed a great risk …"* I would like to reassure [Ms A] that the risk associated with a shortened cervix is preterm birth, but at this stage that was no longer a concern. It was appropriate management to suggest that [Ms A] went home and her "shortened cervix" posed no risk.

With the exception of referring [Ms A] for review of her "shortened cervix", other appropriate and timely referrals were made by the midwives. [Ms A] feels her midwives did not follow up with her after her hospital admissions, but there needs to be some onus upon women to take responsibility for keeping their LMC updated.

Adequacy of postnatal care including management of baby's tongue tie

[Ms A] and [Baby A] were seen by the midwives on day 0 and day 1 in the hospital, then day 2, day 7 and day 15 at home, which was the last postnatal visit due to the breakdown in the relationship between [Ms A] and [RM B and RM C]. The documentation depicts routine postnatal assessments of mum and baby were carried out by the midwives. [Baby A's] tongue tie was detected very early. Not all tongue ties will pose a problem for baby and consequently not all tongue ties require treatment (MOH 2020). On the 3rd postnatal visit (day 2), it is documented in the notes that since baby is breastfeeding well and there is no maternal pain or nipple trauma associated with breastfeeding then the plan was to continue. [RM B] planned to make a lactation consultant (LC) referral but would delay this since there would be no LC working over the [holiday] period. In their response, [RM B and RM C] explain that in [the area] a frenotomy is not done immediately after birth in the hospital but that there needs to be a LC review and the LC will then refer the baby to a midwife trained to do frenotomy or to an ENT doctor, and that at the time, there was only one community LC working in the area who was likely to not be available during the holiday period. Based upon the assessment at the time, care regarding [Baby A's] tongue tie was appropriate, though as acknowledged by the midwives in their response, the LC referral should have been done immediately. It appears, as alluded to in their response, that they had not communicated the situation and the normal process for a tongue tie/frenotomy review effectively to [Ms A], had they done so, this may have prevented some of the misunderstandings that became evident. Ultimately, [Ms A's] aunt who is trained in frenotomy carried out this procedure based upon her assessment that it was necessary. On day 7 [Baby A] was weighed and had lost 10% of his birth weight. It is normal for babies to lose some weight. [RM C] documented that he was breastfeeding well, and had good output and that [Ms A] had already started to give baby some formula top-ups. However, in the postnatal notes it is written that the top-ups were because [Baby A] had lost weight, but in their response letter, [RM B and RM C] say that [Ms A] was giving top-ups because she had sore nipples, yet in the postnatal notes it is documented that the "*nipples are comfortable".* It is not clear whether [Ms A's] sore nipples were discussed and if advice was given at the time, but this is what would be expected. The feeding plan was appropriate, but as acknowledged in their response, given the weight loss it would be expected that the midwives would review baby in 2–3 days to weigh again to ensure no further weight loss, rather than waiting a whole week which was the case here. Failure to check in earlier to assess [Baby A's] weight and the breastfeeding given [Ms A's] sore nipples reflects a mild to moderate departure from expected practice. On day 15, the subsequent postnatal visit, [Baby A] was weighed again and was 2770g, which reflects a very reassuring 200g weight gain in a week, however, he was still below his birthweight. The "Referral guidelines" (MOH 2012) recommend a consultation with paediatrics if babies have not re-gained their

birth weight by two weeks. I appreciate that this was the last visit which ended very badly, and that [Baby A] was gaining weight, but there is nothing to suggest in the documentation or their response letter that a referral was made. This reflects a mild to moderate departure from expected practice.

As part of routine postnatal care, it is expected that there is an assessment of the perineum. On the 1st postnatal visit it is documented that the "grazes are comfortable", but nothing to suggest that the perineum was visually inspected. Given that the immediate post-birth assessment of the perineum was challenging and it was not thoroughly inspected, there would be more need to check it later. Had [Ms A] declined to have her perineum inspected postnatally, this would be her prerogative and I would expect this to be documented, but if a visual inspection was never offered, as I believe was the case here, then this reflects a mild to moderate departure from expected practice. However, when [Ms A] contacted [RM B] by phone on the 3rd postnatal day late at night worried about perineal pain and unable to pass urine, [RM B] did provide appropriate advice suggesting that [Ms A] attend the Emergency Department (ED) for review.

The documentation

I found the documentation was appropriate.

Management of the perineal trauma

It is usual practice to inspect the vagina and perineum for signs of trauma following birth. In order to undertake a thorough assessment this procedure is often quite painful for women, but it is necessary as some tears to the vaginal walls and labia minora are not easily visible, and left undetected can result in bleeding, infection and haematomas. [RM B] documented a small labial tear/graze which was not bleeding and which she felt did not require suturing, but the response letter suggests that a thorough assessment was not made; *"In hindsight offering for having her legs to be up in stirrups would have helped to check her perineum adequately …".* In their letter, [RM B and RM C] describe [Ms A] closing her legs together, this is a very common response from women because the procedure is very uncomfortable, but prevents the midwife from making a thorough assessment. [RM B] did say that she offered Entonox to [Ms A] for pain relief whilst she did the examination, but that this was declined and that [Ms A] asked her to stop and [RM B] respected this request. [RM B] felt that there was nothing more she could do, though in their letter they acknowledge that she could have sought assistance from a colleague which would have been a good option. In her complaint, [Ms A] suggests that [RM B] emphatically proclaimed that there were no other tears, but ultimately, if [RM B] felt she had not made a thorough assessment, she should have documented this and made clear that there was a small labial graze and that she was unsure if there was additional trauma. This approach is far preferable because the documentation implies that there was *only* a labial tear/graze and nil other trauma, yet [RM B] did not actually know this to be the case. This reflects a mild departure from expected practice.

When [Ms A] presented to the ED on the 3rd postnatal day, a haematoma was identified and treated. In her complaint, [Ms A] describes that the attending doctor informed her

she had a *"major tear from her urethra to her perineum",* unfortunately there is nothing in the ED clinical notes to confirm this, but I did find that the ED notes were woefully lacking of any information pertaining to her diagnosis and treatment during that visit, so I cannot confirm or dispute [Ms A's] claim. As noted in their response letter, a haematoma can arise even in tears that have been recognized and sutured.

The discharge process

On the 15th postnatal day, [RM B] visited [Ms A] and during this visit, [Ms A] raised concerns she had with the care she had received from [her] midwives. This discussion did not go well. [RM B] reported that she felt threatened and unsafe, [Ms A] reported that [RM B] became very defensive and *"began to run me down*". Ultimately, [RM B] told [Ms A] "*I do not need to put up with this shit"* and left, telling [Ms A] that she would need to find another midwife. I cannot comment further on their conversation, suffice to say that [RM B's] language, and presumably her behavior was unprofessional, and I note that in their response letter she makes no apology for her conduct, though it was clearly a very challenging situation for [RM B]. Midwifery care extends up to 6 weeks postpartum, with most midwives discharging women and babies from their care between 4–6 weeks, so [RM B] terminated care early. However she did telephone the midwifery manager at [the public hospital] the next day to organize ongoing care for [Ms A] and [Baby A]. A discharge letter was also sent to [Ms A's] GP and to Tamariki Ora which included information pertaining to the referrals that had been made for a hearing test for [Baby A] and follow up scans of his hips and renal tract. This aspect of the discharge was managed appropriately.

Summary

There are aspects of care provided by [RM B and RM C] which reflect mild to moderate departures from expected practice; failure to assess fetal growth, failure to refer [Ms A] for an obstetric consultation regarding treatment to her cervix (if this information was shared with them), failure to accurately document the perineal assessment after birth, failure to adequately assess the perineum postnatally, failure to refer [Baby A] when he had not regained his birthweight by two weeks and [RM B's] unprofessional behavior during her final visit with [Ms A], though she did feel unsafe. However, the clinical notes and their response letter portray that the majority of the care provided by [RM B and RM C] was appropriate and I question whether [Ms A] always shared information with them which will impact upon the advice and care provided to her. I also find that [Ms A] has some misconceptions about aspects of care and I don't know whether she voiced these at the time which would have enabled the midwives to explain things more effectively. I think there were likely problems with communication on the part of [Ms A] and [RM B and RM C].

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