## Antenatal and postnatal care provided by a midwife (12HDC01474, 11 April 2014)

Community-based midwife  $\sim$  Lead maternity carer  $\sim$  Referral  $\sim$  Growth  $\sim$  Post-natal care  $\sim$  Rights 4(1), 4(2)

A woman complained about the care she received during her pregnancy and following the birth of her baby.

When she became pregnant with her first child, she engaged a community-based midwife as her Lead Maternity Carer (LMC).

At 35 weeks' gestation, the LMC noted no growth of the fetus for one week, and the woman was referred for an ultrasound scan. The LMC recommended that the woman have the scan within the next week. One week later, the scan was performed and it revealed abnormalities that required urgent referral to the hospital. The LMC was informed of the scan results. A midwife at the hospital then contacted the LMC and asked that the woman come into the hospital that day for blood tests. The LMC subsequently sent the woman a text message asking her to go into hospital if she could.

Although the woman did not understand the urgency of the request, she went into hospital later that day and was subsequently admitted for monitoring. The baby was delivered two days later by Caesarean section and admitted to the Neonatal Intensive Care Unit.

The LMC saw the woman in hospital twice following the birth. The woman was then seen by the back-up midwife at home because her LMC was on leave. When the LMC returned from leave a visit was arranged but later cancelled by the LMC. The woman subsequently transferred her care to another midwife.

It was held that the LMC failed to recognise the need to refer the woman for a scan in a timely manner when the baby's growth stopped. Following the receipt of the scan results, the LMC failed to respond to the urgency of the situation and, as a result, did not adequately communicate to the woman the need for urgent follow-up. The LMC also failed to provide adequate postnatal care that met the woman's needs. The series of failures in the care provided by the LMC suggested a pattern of suboptimal care, breaching Right 4(1).

By failing to maintain adequate contemporaneous antenatal records, record her postnatal visits and any discussions and decisions in relation to ongoing management, the LMC failed to meet the standards set by the Midwifery Council of New Zealand and also breached Right 4(2).