Midwife, Ms B

A Report by the

Health and Disability Commissioner

(Case 14HDC00452)

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

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Executive summary

1. In 2013, Ms A (aged 26 years at the time of these events) became pregnant with her first child.

2. Because Ms A's original midwife was going on leave, Ms A transferred her care to community-based midwife Ms B.

3. Ms A's pregnancy progressed normally until 39+6 weeks' gestation, when she presented for a routine antenatal check. During this appointment, Ms A was noted to have a raised blood pressure of 140/100mmHg. Urinalysis was recorded as negative. Ms A was noted to weigh 84kg — a 2kg weight gain since she was weighed seven days earlier — and to have "mild" oedema. Upon further questioning, Ms A advised that she had experienced visual disturbances two weeks previously and again on one occasion in the days preceding the appointment. Ms B and the student midwife assisting her, Ms D, discussed the signs and symptoms of pre-eclampsia with Ms A and advised her to contact Ms B if she experienced these symptoms or noticed a decrease in fetal movements. Despite Ms A's presentation and her report of visual disturbances, Ms B did not recommend to Ms A that she consult with a specialist, or take additional steps to assess Ms A for pre-eclampsia, such as arranging for blood tests and further urinalysis.

4. The following day, at 9.41am, Ms A sent a text message to Ms B stating that she had experienced headaches and further visual disturbances that morning. At 12.30pm, Ms B telephoned Ms A and left a message, asking Ms A to let her know if she experienced any more "symptoms". Ms B did not arrange to assess Ms A urgently in response to the symptoms she had reported.

5. Later that day, at 8.46pm, Ms A sent a text message to Ms B advising that she was experiencing contractions. Ms B subsequently telephoned Ms A and arranged to meet her at the delivery suite at the public hospital, when her contractions became closer together.

6. At 11.30pm, upon arrival at the delivery suite, Ms D and Ms B carried out an assessment, noting that Ms A's blood pressure was 167/97mmHg. Ms B did not carry out any further assessment in response to Ms A's raised blood pressure at that time, such as blood or urine testing. All other observations of Ms A and the baby were recorded as normal. Ms B continued to monitor the fetal heart rate until about 12.40am, when Ms B and Ms D left the room to admit Ms A onto the computer system.

7. Ms B and Ms D later returned to Ms A's room, at which time Ms A reported feeling faint. At that point, her blood pressure was noted to be 170/108mmHg. Ms D, on direction from Ms B, went to consult with the on-call registrar, Dr C, about Ms A's condition, including her blood pressure.

8. Dr C took over care of Ms A, monitoring her closely for pre-eclampsia, commencing a magnesium sulphate infusion for seizure prevention, and giving labetalol to treat her high blood pressure.

9. Ms A gave birth to Baby A at 2.58am. Baby A was well, with apgars of 9, 10 and 10. Ms A continued to be managed for the symptoms of pre-eclampsia in the postnatal period, and was eventually discharged approximately a week later.

Findings

10. Ms B failed to identify and respond appropriately to Ms A's developing pre-eclampsia. Accordingly, Ms B failed to provide services to Ms A with reasonable care and skill and breached Right 4(1) of the Code of Health and Disability Services Consumers' Rights (the Code).[1]

11. Criticism is also made about Ms B's failure to advise Ms A appropriately about the use of text message communication in relation to urgent matters, Ms B's lack of communication with Ms A regarding her condition during labour, and Ms B's comments to Ms A regarding another professional.

12. Ms B will be referred to the Director of Proceedings in accordance with section 45(2)(f) of the Health and Disability Commissioner Act 1994 for the purpose of deciding whether any proceedings should be taken.

Complaint and investigation

13. The Commissioner received a complaint from Ms A about the services provided by a community-based lead maternity carer (LMC) midwife, Ms B. The issue identified for investigation was:

The appropriateness of the care provided to Ms A by Ms B during 2013 and 2014.

14. An investigation was commenced on 14 October 2014.

15. The parties directly involved in the investigation were:

Ms A	Consumer/complainant
Ms B	Provider/community-based LMC midwife

16. The following parties were also involved:

Dr C	Obstetric registrar
Ms D	Student midwife
Ms E	Complainant/consumer's mother
Mr A	Complainant/consumer's partner
Dr F	Obstetric house officer

Also mentioned in this report:

Dr H	Obstetric consultant

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

17. Independent expert advice was obtained from a midwife, Mary Wood (**Appendix A**).

Information gathered during investigation

Background

18. Ms A was aged 26 years at the time of these events. In 2013, she became pregnant with her first child.

19. Ms A transferred her care to community-based LMC midwife Ms B, because her original LMC midwife had advised that she would be on leave around Ms A's due date.

Ms B

20. Ms B qualified as a midwife in 2008 and has been working as a registered midwife since 2009. At the time of these events, Ms B worked in a group of midwives.

Monday, 39+6 weeks' gestation

21. Ms B saw Ms A regularly throughout the antenatal period, and her pregnancy progressed normally until Ms A was 39+6 weeks' gestation, when she presented for a routine antenatal check with Ms B. A student midwife, Ms D, who was working with Ms B as part of a nine-week elective midwifery placement for her final year of midwifery training, was assisting Ms B during that appointment.

22. At the appointment, Ms A was noted to be feeling well, and she reported good fetal movements. The midwifery records from the consultation, written by Ms D, document that Ms A's urinalysis[2] was negative. However, Ms A's blood pressure (BP) was noted to be 140/100mmHg, which is high, and a significant increase from her booking BP of 110/60mmHg. Ms A was noted to weigh 84kg — a 2kg weight gain since she was last weighed seven days earlier — and to have "mild" oedema.[3] Ms D documented that she and Ms B had a discussion with Ms A "around BP", and that Ms A reported "having seen spots" over the last couple of days, as well as two weeks earlier, which Ms A reported to occur when she was resting and as lasting only a few seconds.

23. Ms A told HDC that at the time of the appointment, she reported to Ms B and Ms D that she had been having headaches and black dots in her vision for the previous two weeks, but had put this down to it being summer and hot. Ms A said that she had experienced headaches throughout her pregnancy.

24. In a statement to HDC, Ms D said that she recalls taking Ms A's BP twice during the appointment (although only one reading is documented), and that Ms A had told her

[2] A test that screens the urine for the presence of proteins (an indicator of pre-eclampsia or possibly infection) and glucose (an indicator of gestational diabetes).
[3] Fluid retention causing the affected tissue to become swollen.

that she had been busy at home staining her deck and thought she may have been overdoing things as she had been seeing stars.

25. Ms B told HDC that during the appointment Ms A told them that two weeks previously, "on a really hot day", she had been staining her deck and had seen spots but "reported no other symptoms" since that day. Ms B also said that at the time of the appointment Ms A said she was feeling well. Ms B told HDC that while she cannot recall exactly what she was thinking at the time, she "must have decided that as the visual disturbances were being explained by [Ms A] as happening on an occasion which she explained was a couple of weeks earlier, that [she] would make [Ms A] fully aware of the relevant symptoms of pre-eclampsia[4] and the need to contact [her] should anything occur which suggested pre-eclampsia. … [She] had to make the decision then on the material before [her] with a woman, who, but for the raised blood pressure appeared perfectly normal."

26. Ms D said that they discussed the signs and symptoms of pre-eclampsia with Ms A at this appointment. In the midwifery records, Ms D documented:

> "Had discussion with [Ms A] around the symptoms of pre-eclampsia and for her to contact the midwife immediately if she was to experience these or if she noticed a decrease in fetal movements."

27. Ms D then documented that a stretch and sweep[5] was attempted but that the cervix was noted to be in a posterior position, 1–2cm dilated, 1cm in length,[6] and "mid-soft", and that a stretch and sweep could not be carried out.

28. Ms A was advised to rest and drink fluids to remain hydrated, and they discussed management if she did not go into spontaneous labour in the next two days.

29. Ms A agrees that they discussed the signs and symptoms of pre-eclampsia, and that she was advised to contact Ms B "immediately" if she experienced these symptoms again, but said that she did not really understand how serious it was.

Tuesday

30. Ms A documented her recollections of the events, including her text communication with Ms B on Tuesday morning. Consistent with these recollections, Ms A's telephone records confirm that she sent a text message to Ms B's telephone informing her that she had experienced further visual disturbances and headaches. The text message, sent at 9.41am, stated:

> "Good morning [Ms B]; did we end up getting a time that I have to go up to hospital for the checks tomorrow? Have had headaches and a few times had the

[4] Pre-eclampsia is a condition in pregnancy that is normally characterised by high blood pressure and increased protein in the urine. Other symptoms include swelling (especially in the hands, face and feet), headaches, and visual disturbances. Pre-eclampsia, if not treated, may have serious effects on the mother and baby.
[5] A procedure that involves the clinician introducing a finger into the opening of the cervix and using a circular motion to separate the membranes from the uterus.
[6] During labour the cervix opens (dilates) and becomes thinner (effacement) in preparation for delivery.

> spots in the eyes mostly this morning but baby moving around well. Might just be more aware of them now??? Had a few bouts of watery discharge heavier than normal too … "

31. Ms B's telephone records confirm that a text message was received from Ms A's number at 9.41am. Ms B told HDC that she does not recall receiving that text message from Ms A; however, she stated: "I accept that if [Ms A] phone records show a text to my number one must have been sent but it does not take much to work out that there may be a hundred reasons why I didn't pick up a text message (e.g. phone on charge, or in my bag, in the next room, or in the car during a visit to a client)." Ms B's telephone records show that multiple text messages and telephone calls with various telephone numbers were sent and received from and to her telephone between approximately 10am and 2pm.

32. Ms A said that at 2.30pm, Ms B left a message on her telephone voicemail, advising that if she experienced any more symptoms, to let Ms B know. A summary of the outgoing activity from Ms B's telephone shows that she made a telephone call to Ms A's telephone number at 12.30pm. Ms B's telephone records confirm that the call lasted 1.32 minutes.

33. Despite this, in a statement to HDC, Ms B said that she does not recall having any contact with Ms A until 8.45pm. Ms B stated:

> "[Ms A] texted and rang me fairly regularly but I have no recollection of a text or of a phone call that day before 20.46pm complaining about symptoms of pre eclampsia but if I had received such a text I would have tried to contact her as soon as I picked it up."

34. Ms A said that later that afternoon she began experiencing contractions. At 8.46pm, Ms A's telephone records show that she sent a text message to Ms B stating that she was experiencing contractions that were 10 minutes apart. Her text message states:

> "… [H]aving contractions 10mins apart. Been happening for a few hours but not progressing much. Will ring u if they get closer."

35. Ms B told HDC that following the receipt of this text message she telephoned Ms A and advised her to go to the delivery suite at the public hospital. Ms B's telephone records show that she made an outgoing call to Ms A's telephone number at 8.49pm. The call lasted 4.33 minutes.

36. In contrast, Ms A said that Ms B told her to wait to go to the delivery suite until her contractions were closer together. Ms A said that she was still experiencing headaches and spots in her eyes at the time. She said that Ms B did not ask her any questions about her symptoms, and that the only discussions she had with Ms B related to the frequency of her contractions.

37. Ms A said that she remained at home, and when she felt that the contractions were becoming closer together she decided to go to hospital. Ms A said that her partner, Mr A, called Ms B and they agreed to meet at the hospital for further assessment. Ms B's

telephone records show that Ms A telephoned Ms B at 10.34pm. The call lasted 1.17 minutes.

Arrival at delivery suite

38. At approximately 11pm, Ms A arrived at the delivery suite. Ms A recalls that Ms B was already there. Ms A was accompanied by Mr A, and her mother, Ms E. Ms D arrived a short time later.

39. Ms D documented in the clinical records that Ms A reported that she had been experiencing contractions since 6.26pm, that Ms A's contractions were now at a rate of four every 10 minutes, and that she was in established labour.

40. Ms A said that upon arrival on the delivery suite she showed Ms B her sanitary pad, "which had light, odd coloured (green) liquid discharge". Ms A said that she was concerned that this was meconium.[7]

41. Ms E recalls Ms A being concerned about the discharge that was on her pad. Ms E cannot recall whether Ms B ever sighted the pad, but does remember Ms B being quite dismissive of Ms A's concerns, telling her just to throw the pad in the bin. Ms E said that she did not see the pad herself.

42. Ms B agrees that Ms A showed her a pad, but told HDC that there was no meconium present, so she was unconcerned. This is not documented. Later that evening, at 11.30pm, Ms D performed a vaginal examination and recorded that Ms A's membranes were intact.

43. At 11.12pm, a CTG[8] was commenced. Ms D noted that the fetal heart rate (FHR) was in the "130's" with respect to beats per minute (bpm).[9] She also documented Ms A's observations, noting that her BP was 167/97mmHg, temperature 36.5°C, pulse 67 bpm, and oxygen saturation 97%.[10]

44. Ms D told HDC that she recalls that, on arrival, Ms A "appeared to be labouring well and her partner and mother were present with her for support".

45. Ms B told HDC that she informed Ms A of her high BP reading at that time, advising her that it was "probably due to being in labour and tired". Ms B told HDC that Ms A never mentioned to her that she had been experiencing any signs of pre-eclampsia at the time of her arrival on delivery suite. Furthermore, Ms B said: "[Ms A] (an intelligent, educated and very forthright woman) knew the symptoms of pre-eclampsia. I was not aware of the presence of any other symptoms of pre-eclampsia." Ms B said that Ms A had passed urine just prior to arriving on the delivery suite and, therefore, she (Ms B) could not carry out a urinalysis.

[7] The first faeces passed by a baby. Sometimes this can occur before or during labour and can be an indication of fetal distress.
[8] Cardiotocograph.
[9] Normal FHR is generally considered to be between 120–160bpm.
[10] The concentration of oxygen in the blood. Normal levels are between 95–100%.

46. Ms A denies being asked to provide a urine sample. She said that she could have produced a sample, had she been asked. In addition, she does not recall being told that she had a high BP reading at that time. Similarly, neither Ms E nor Mr A recall any discussion regarding Ms A's BP, nor do they recall her being asked to produce a urine sample.

47. There is nothing documented in the clinical records in relation to whether Ms A was asked to produce a urine sample at that time, or of any discussion with Ms A.

48. At 11.25pm, Ms D documented that Ms A was using Entonox[11] to assist with pain relief during contractions.

49. At 11.30pm, Ms D performed a vaginal examination, noting that the cervix was 3–4cm dilated and 60% effaced. The baby was in a head down position with the presenting part at station –2[12] and 3/5 palpable, indicating that the head had entered the pelvic cavity but was not yet fully engaged.

50. At 11.45pm, Ms D documented that Ms A had vomited and was relaxing on the bed with CTG monitoring continuing.

51. At 11.57pm, the CTG trace was discontinued. The FHR was noted to be 125bpm, with the overall interpretation being normal.

52. The FHR continued to be monitored intermittently using a hand-held Doppler.[13] At 12.13am, the FHR was noted to be 125bpm. At 12.40am the FHR was 127bpm. Ms A was noted to be sitting on a Swiss ball and had reported feeling cold.

53. Ms B told HDC that she and Ms D then left the room to admit Ms A onto the computer system. Ms B said that the staff office is approximately 15–20 steps from the room Ms A was in, and recalls that they advised Ms A, her partner and mother about the emergency bell and how to use it if they required assistance while she and Ms D were out of the room. Ms D told HDC that, prior to leaving the room with Ms B, Ms A "appeared to be labouring well" on the Swiss ball, and that they left "after ensuring [Ms A] was comfortable".

Return to Ms A's room

54. Ms A told HDC that she recalls being left in the room while Ms B and Ms D went to admit her onto the computer system. Ms A does not recall how long she was left in the room, but said that a little while after Ms B left, she began to feel faint and recalls that her mother left the room to find Ms B, and returned a short time later with her.

55. Ms E thinks that they may have been left in the room for about an hour, and said that when Ms A began to feel faint she left the room to find Ms B. Ms E said that she found Ms B in an office down the corridor, and that Ms B followed her back into Ms A's room. Mr A cannot recall the time very well, but also thinks that they were left for

[11] A mixture of oxygen and nitrous oxide used for pain relief.
[12] Fetal station describes the position of the baby's head in relation to the ischial spines of the pelvis. Station –2 means that the head is 2cm above the ischial spines.
[13] A hand-held ultrasound transducer used to measure the FHR.

about an hour, and that Ms E left the room to find Ms B when Ms A started feeling faint.

56. Ms B and Ms D's accounts of these events differ slightly from Ms A's and Ms E's accounts. Both Ms B and Ms D recall that after they had admitted Ms A on the computer system they spontaneously returned to Ms A's room to find her looking very pale, and that Ms A reported feeling faint.

57. Ms B recalls asking Ms A why she had not called for help earlier, and that Ms A reported to have only just begun experiencing the symptoms.

58. The clinical records show entries by Ms D at 12.40am and 1.05am, which appear to be before and after she and Ms B admitted Ms A on the computer system. The clinical records at 1.05am state:

> "Returned to room after admitting [Ms A] on hospital system. [Ms A] reported feeling faint on entering room."

59. Ms B said that she immediately instructed Ms D to attach a BP cuff on an automatic BP machine, whilst she positioned Ms A on the bed with the bed head lowered and began to administer oxygen to Ms A.

60. Ms A's BP was noted to be 188/106mmHg. Ms D told HDC that she recognised that this was high and left the room to get a manual BP monitor. Ms D said that she returned immediately and retook Ms A's BP, which was 170/108mmHg. Ms A's oxygen saturation was noted to be 99%, her pulse 77bpm and temperature 36.7°C. The FHR was noted to be 120–130bpm.

61. Ms A, Ms E and Mr A all told HDC that after Ms B and Ms D returned to the room, and Ms A's BP had been taken, the emergency alarm was raised. They all said that at no stage did Ms B explain what was happening. Ms E said that it was not until the doctor arrived that they had any understanding of what was wrong. Ms A and Mr A also commented that as soon as the doctor arrived, they felt that everything was under control.

62. In contrast, Ms B said that an emergency call was not made at that time. Both Ms B and Ms D recall that they had a discussion about what to do, and the decision was made for Ms D to leave to consult the obstetric registrar. Ms D stated:

> "I can recall at that time feeling concerned about how quickly things had changed from when we last saw [Ms A] prior to leaving the room to admit [Ms A] on the hospital system. [Ms B] encouraged me to consult with the O&G [obstetrics and gynaecology] Registrar about [Ms A's] present condition and blood pressure readings, and following brief discussion with [Ms A] around the rationale for a prompt consultation [Ms A] indicated that she was happy for this to occur."

63. Ms D said that she left Ms A's room and made her way to the obstetric registrar's office, but the registrar was not there. She said that she was informed by the senior house officer (SHO), Dr F, who was in the office, that the registrar, Dr C, was not far

away. Ms D said that as she was talking to Dr F, Dr C arrived. Ms D then outlined the facts of the situation to Dr C and Dr F. Ms D said that both Dr C and Dr F immediately went to assess Ms A.

Obstetric assessment

64. At 1.20am, Dr C and Dr F arrived in Ms A's room. Dr C told HDC that, on arrival in the room, she was immediately very concerned about Ms A, as she looked very unwell, appearing shaky and pale and reporting feeling faint and nauseous. Dr C assessed Ms A. The clinical records note that Ms A's reflexes were brisk, and her BP was 179/87mmHg and her pulse 70–80bpm.

65. At 1.25am, Dr F documented that a CTG commenced upon her and Dr C's arrival in Ms A's room was recording an FHR of 100–110bpm. Dr C told HDC that, due to her concerns regarding fetal and maternal welfare, she elected to summons assistance via the emergency bell, as she needed immediate assistance with Ms A's management. The on-call anaesthetist was also called. Dr F told HDC that two core midwives attended within a few minutes. At 1.27am, the anaesthetic registrar was noted to be present. Dr C told HDC that, with the assistance of the core midwives and the anaesthetic registrar, two IV lines were inserted and blood samples obtained. An IV catheter was inserted.

66. Ms A said that Dr C was very assertive and to the point in her assessment and questioning of Ms B. Ms A recalls Dr C asking why a urine sample had not been done, and that Ms B became quite defensive and blamed Ms D.

67. Dr C told HDC that she cannot recall any details of what was discussed with Ms B upon arrival in the room, but stated:

> "I recall feeling dissatisfied that [Ms B] did not seem to appreciate or recognise that [Ms A] had severe pre-eclampsia and was extremely unwell. Most importantly I was unhappy that urgent medical attention was not sought when routine basic observations were clearly abnormal. CTG had not been commenced which is indicated when baseline observations are abnormal. The LMC also informed me when reviewing [Ms A's] antenatal record that her blood pressure had been 140/100 at her last antenatal visit and no referral for secondary assessment has been made at this stage."

68. Dr F commented in her statement to HDC that despite the initial BP being significantly elevated, further tests and assessments were not completed as she would have expected. Dr F stated that, in her view, Ms A's elevated BP was an obstetric emergency, and her "feeling during this event" was that Ms B failed to recognise this.

Ongoing care — management of developing pre-eclampsia

69. Following Dr C's initial assessment, Ms A was managed for pre-eclampsia. At 1.30am, Dr C spoke to the obstetric consultant, Dr H, who agreed with the planned management of administering magnesium sulphate for seizure prevention, for an artificial rupture of membranes (ARM) to be performed, a fetal scalp electrode (FSE) to be attached, and an indwelling urinary catheter (IDC) to be inserted.

70. At 1.46am, an ARM was performed, and thin meconium was noted. Ms A continued to be monitored closely by Dr C and Dr F for pre-eclampsia. Throughout this time, Ms A's BP remained unstable, and urinalysis showed the presence of 3+ protein, which is high.[14] Despite management with magnesium sulphate, Ms A's BP remained high and, at 2.54am, following a discussion with Dr H, a bolus of IV labetalol[15] was administered. Baby A was born via normal vaginal delivery at 2.58am. Baby A was well, with apgars of 9, 10 and 10.

Post-delivery management

71. Following the birth of her baby, Ms A continued to be monitored closely and managed for severe pre-eclampsia. She was stabilised with magnesium sulphate, and midwifery care was handed back to Ms B by the obstetric team.

72. At 3am, further labetalol was administered, and Ms A was noted to be bleeding. Dr C performed uterine fundal massage, and commenced a Syntocinon[16] infusion. The bleeding settled, with an estimated blood loss of 500ml.

73. At 3.12am, Ms A's BP was 130/70mmHg. At 3.32am, a further 200ml of blood was expressed on fundal pressure.

74. At approximately 5.20am, Ms A experienced a further gush of blood, and Dr C was called to attend. Ms A's BP and pulse rate remained stable. Ms A was noted to have lost a total of 1000ml of blood. Close monitoring continued and Ms A remained stable.

75. Ms B and Ms D left the hospital at approximately 6.15am.

Following days

76. In the following days, Ms A continued to be monitored and treated for pre-eclampsia.

77. Ms B visited Ms A in hospital on Wednesday and Thursday, but was later contacted by hospital staff, who advised that Ms A no longer wanted Ms B as her LMC.

78. A few days later, Ms A was assessed as stable and discharged home with Baby A.

Incident report

79. Following these events, Dr C completed an incident report in which she outlined the events and noted:

> "I felt that the LMC did not recognise that the patient was rapidly deteriorating and that the hypertension constituted an obstetric emergency and that she should have summoned help immediately."

80. The DHB subsequently carried out a review of the events, which included meeting with Ms B and Ms D. Following the meeting, the DHB recommended that Ms B write

[14] The presence of 3+ protein is potentially a sign of pre-eclampsia.
[15] Medication for the treatment of severe hypertension.
[16] A synthetic version of the hormone oxytocin, which stimulates contraction of the uterus.

reflective notes of the events and undertake further training relating to management in emergency situations. However, it is noted that Ms B indicated that she is confident in her knowledge of pre-eclampsia.

Midwifery Council of New Zealand

81. Following notification of this complaint, the Midwifery Council of New Zealand (the Council) undertook a competence review and found that Ms B failed to meet the required standard of competence in some areas of her practice. The Council ordered Ms B to undergo a full formal assessment against the Competencies for Entry to the Register of Midwives and a suitable remedial programme of education to be put in place. Ms B's registration to practise as a midwife has been suspended pending the outcome of this assessment.

Further comment from Ms A

82. Ms A said she is concerned that Ms B failed to monitor her adequately during her labour, particularly in relation to the signs and symptoms of pre-eclampsia. In addition, Ms A said that at no time did she ever really understand the significance of her symptoms. She said that despite telling Ms B about her symptoms, such as visual disturbances, Ms B just kept saying to contact her if they got worse or continued.

83. Ms A said that while she was aware that she should call Ms B if there was an emergency, Ms B never gave her any information about what kind of information she should communicate by text message and when she should call her.

84. Ms A told HDC that she recalls that in one of the postnatal visits at the hospital Ms B "bagged out" the emergency team, stating that Dr C turned the birth into an unnecessary drama.

Further comment from Ms B

85. In relation to what information she provides women in the antenatal period about when and how to contact her, Ms B told HDC that she usually advises her clients verbally that they can text message her for non-urgent matters, but that they should ring, not text, if the matter is urgent.

86. Ms B said that she tried to be professional at all times. She said that she expressed an "honest opinion" about Dr C to Ms A, stating that Dr C shouted instructions at her, which she considered "undermined the reassurance I was trying to give".

87. Furthermore, Ms B stated:

> "When she [Ms A] asked about what happened I was in a very difficult situation. I was being questioned about why my approach had been different to [Dr C's]. I had to give an answer. I had to be honest. I tried to explain, I was trying to keep the situation calm whilst [Dr C] was reacting to the fulminating pre-eclampsia. [Ms A] interpreted that as a criticism when it was supposed to be an honest explanation of our different approaches."

Response to Provisional Opinion

Ms B

88. Ms B's response to the provisional opinion has been incorporated into the report where appropriate.

Ms A

89. Ms A advised that she did not wish to make any further comment in response to the information gathered section of the provisional opinion.

Opinion: Breach — Ms B

Monday — routine antenatal check

90. Ms B saw Ms A for a routine antenatal check. Student midwife Ms D was also present for this appointment.

91. During the appointment, Ms D documented that Ms A's BP was 140/100mmHg, which is high, and a significant increase from her booking BP of 110/60mmHg. Ms A was also noted to have had a 2kg weight gain since her previous weigh seven days earlier, and to have "mild" oedema. The midwifery records document that urinalysis was negative at that time. On further discussion, Ms A told Ms D and Ms B that she had been seeing spots and/or stars in her vision.

92. There is some discrepancy between Ms A's, Ms B's and Ms D's accounts about how frequently they recall Ms A's visual disturbances being reported. Ms B told HDC that Ms A had reported having had spots in her vision while staining her deck on a "really hot day" two weeks earlier, but that she had had no other symptoms since then. Ms D told HDC that Ms A told them that she thought she may have been overdoing things as she had been "seeing stars". Ms A said she told Ms B and Ms D that she had been experiencing headaches, and black dots in her vision, over the previous two weeks, but that she had put this down to it being summer and hot. The midwifery records documented by Ms D at the time of the consultation state that Ms A reported having "seen spots over the past couple of days on one occasion and again two weeks ago", which Ms D documented to have occurred at rest and resolved within a few seconds.

93. In light of the midwifery records, I accept that Ms A reported experiencing visual disturbances on two separate occasions, the first time two weeks earlier and then again on one occasion in the days preceding. There is no comment in the midwifery records regarding whether Ms A was experiencing headaches, or if she was asked about headaches.

94. Ms D documented that she and Ms B discussed the symptoms of pre-eclampsia with Ms A and advised her to contact the midwife immediately if she experienced any such symptoms or if she noticed decreased fetal movements. Ms A agrees that she was informed of the symptoms of pre-eclampsia and that she was advised to contact Ms B

immediately if she experienced any of these symptoms again. However, Ms A said that she did not really understand the significance of that information.

95. The Ministry of Health 2012 *Guidelines for Consultation with Obstetric and Related Medical Services* (the Referral Guidelines) that applied at the time required the LMC in cases of "Gestational hypertension" ("[n]ew hypertension presenting after 20 weeks with no significant proteinuria[17]")[18] to recommend consultation with a specialist. In the case of "Pre-eclampsia" ("BP of ≥140/90 and … 2+ protein on a dipstick testing"), the Referral Guidelines required the LMC to transfer care to a specialist.[19]

96. Ms B told HDC that given that the symptoms of pre-eclampsia were discussed with Ms A during the appointment, the possibility of pre-eclampsia was clearly something she was considering. Ms B said that while she cannot recall why she did not take any further action at that appointment, such as consulting with a specialist or arranging for further blood testing or further urinalysis, she would have made her decision "on the material before [her] with a woman, who, but for the raised blood pressure appeared perfectly normal".

97. My independent midwifery expert, Mary Wood, advised that a BP reading of 140/100mmHg is "significant", particularly taking into account Ms A's booking BP of 110/60mmHg. In Ms Wood's view, Ms B's failure to recommend a consultation with obstetric services or to arrange blood and further urine testing, and to arrange for a follow-up appointment in the following days to recheck Ms A's BP, was a "moderate departure from acceptable midwifery care". Ms Wood commented that, while Ms B discussed the possibility of pre-eclampsia, "without any diagnostic tests such as bloods and PCR [protein-creatinine ratio], clinical judgement is very limited". I accept Ms Wood's advice.

98. Ms Wood also referred to Ms A's 2kg weight gain and oedema, and suggested that while oedema is a common feature of a normal pregnancy, rapid development of generalised oedema is a red flag that should alert the clinician to screen for pre-eclampsia. Ms Wood also advised that pathological oedema includes "weight gain of 2 kg or more in 1 week". In view of Ms Wood's advice, I am concerned at the lack of attention or recognition by Ms B of Ms A's weight gain as an additional warning sign of pre-eclampsia.

99. The Referral Guidelines make it clear that, at a minimum, in light of Ms A's high BP of 140/100, Ms B ought to have recommended a consultation with a specialist to Ms A.

[17] The presence of abnormal amounts of protein in the urine.
[18] Code 4009, Referral Guidelines.
[19] Code 4022 of the Referral Guidelines defines pre-eclampsia as: "BP of ≥ 140/90 and/or relative rise of > 30/15 mmHg from booking BP **and** any of:
1. proteinuria > 0.3g/24 hours; or protein/creatinine ratio ≥.3, or 2+ protein on dipstick testing
2. platelets < 150 x 10/9/l
3. abnormal renal or liver function
4. imminent eclampsia"

100. Furthermore, in the circumstances, given the potentially serious consequences of pre-eclampsia, Ms B should have taken additional steps to assess Ms A by arranging for blood tests, further urinalysis, and a follow-up appointment to recheck Ms A's BP. This was particularly important given that Ms A reported experiencing visual disturbances on two separate occasions, the first time two weeks earlier and then again in the days preceding the final antenatal check-up.

Management on Tuesday

101. At 9.41am on Tuesday, Ms A sent a text message to Ms B stating that she had "had headaches and a few times had the spots in the eyes mostly this morning but baby moving around well. Might just be more aware of them now??? …" Ms B told HDC that she does not recall having received that text message and, while she accepts that Ms A's telephone records show that a text message was sent to her at 9.41am, Ms B said that, "it does not take much to work out that there may be a hundred reasons why I didn't pick up a text message (e.g. phone on charge, or in my bag, in the next room, or in the car during a visit to a client)".

102. After sending the text message, Ms A said that the next contact she had with Ms B was at 2.30pm, when Ms B left a message on her voicemail advising her that if she experienced any more symptoms, to let her know. In contrast, Ms B told HDC that she did not have any contact with Ms A until 8.46pm. However, Ms B's telephone records show that she made a telephone call to Ms A's telephone number at 12.30pm, which lasted 1.32 minutes.

103. Taking into account all the above information, I accept that there may have been a delay in Ms B picking up Ms A's text message. However, I consider it more likely than not that Ms B received Ms A's text message some time between 9.41am when it was sent and 12.30pm when she telephoned Ms A, given that Ms B's telephone records show that she was active on her telephone from approximately 10am, and given that she telephoned Ms A at 12.30pm.

104. Having accepted that it is likely that Ms B did receive Ms A's text message some time between 9.41am and 12.30pm, I find Ms B's subsequent actions concerning. When Ms B received Ms A's text message she should have taken immediate action to arrange for an urgent assessment. Ms A had had a raised BP the previous day, and had been reporting visual disturbances at least twice in the preceding two weeks (as well as again that morning). Ms A had also reported suffering from headaches, and has told HDC that this was something she experienced throughout her pregnancy. I note Ms Wood's advice that "[g]iven that [Ms A's] blood pressure had been significantly increased the previous day, it is my opinion that with the presence of symptoms such as headache and visual disturbance, an urgent assessment was indicated". I also note Ms Wood's view that this failure would be considered a "serious departure from expected standards of care". I accept that advice. As noted above, where a woman presents with signs and symptoms of pre-eclampsia, further assessment is needed to fully assess the woman and to comply with the Referral Guidelines.

105. In my view, Ms B failed to act appropriately when she received Ms A's text message, by failing to carry out an urgent assessment for pre-eclampsia, and then, if appropriate, arranging for transfer to a specialist.

Text communication

106. I am also concerned at Ms B's acceptance of text messages from Ms A that communicated important clinical information regarding her symptoms. I note that Ms B said that she always verbally advises women to communicate urgent information to her by telephoning, rather than by text message. However, Ms A said that she was never advised not to use text message for communicating information.

107. In my view, given that Ms A chose to use text messages to communicate information to Ms B in this case, I do not accept that Ms B made it clear to Ms A that any information other than simple administrative tasks, such as arranging a clinic appointment, needed to be communicated verbally.

108. The Midwifery Council of New Zealand *Code of Conduct* (2010) states:

> "Text messaging can be an unreliable method of communication, with message transmission delayed at times or messages open to misinterpretation. While women may use texting to contact a midwife, midwives must consider the appropriateness of using text communications and ensure that their communication with women occurs through reliable methods such as telephone. All communication with women should be appropriately documented."

109. Ms Wood advised that "it is [her] opinion that text messaging should be confined to administrative aspects such as appointment changes". I accept Ms Wood's advice.

110. In my opinion, Ms B should have made it clear to Ms A that any information other than simple administrative tasks needed to be communicated verbally. I am concerned that this does not appear to have occurred.

Admission to hospital

111. When Ms A arrived at the hospital she was met by Ms B and Ms D. Ms D carried out an assessment of Ms A, including taking her BP reading, which was 167/97mmHg.

112. There is no comment in the clinical records as to whether the BP reading of 167/97mmHg was identified as being high. CTG monitoring was discontinued at 11.57pm. Ms D told HDC that at 12.40am, Ms A "appeared to be labouring well" on a Swiss ball, and that she and Ms B left the room together "after ensuring [Ms A] was comfortable", in order to admit Ms A onto the computer system.

113. Ms A, Ms E and Mr A all told HDC that they were never advised of the high BP reading.

114. Ms B told HDC that she attributed the high BP reading to Ms A being in labour. Ms B said that at that time Ms A never mentioned any other symptoms, and she was not aware of Ms A having experienced any other symptoms, and "was aware that [Ms A] (an intelligent, educated and very forthright woman) knew the symptoms of pre-

eclampsia". There is no evidence that Ms B asked Ms A whether she was experiencing any symptoms such as headaches, epigastric pain or visual disturbances, despite Ms A having reported both headaches and visual disturbances earlier that day.

115. Ms B also told HDC that Ms A had passed urine just prior to Ms B arriving on delivery suite, so she had been unable to carry out a urinalysis. However, Ms A told HDC that she was not asked by Ms B to produce a urine sample at that time, and could have done so if she had tried. Ms E and Mr A also have no recollection of any discussion about obtaining a urine sample. Consistent with these recollections, there is no documentation in relation to any discussion about Ms A providing a urine sample. Therefore, I consider it more likely than not that Ms B did not request a urine sample from Ms A at that time. In my view, Ms B should have done so in the circumstances.

116. I note that Ms A recalls being concerned that she had meconium on her pad at the time of her arrival on the delivery suite. Ms B states that she recalls sighting the pad and there was no meconium. I note that the clinical records state that Ms D carried out a vaginal examination at 11.30pm and recorded her finding that Ms A's membranes were intact and no liquor was noted. I am unable to make a finding as to whether there was meconium present at the time of Ms A's admission. At 1.46am, Ms A's membranes were ruptured, and thin meconium liquor was noted.

117. Ms A, Ms E and Mr A said that they did not understand the seriousness of the situation until Dr C arrived. Ms A and Mr A both commented that once Dr C arrived, they felt that things were under control.

118. Ms Wood agreed that BP can increase during labour, especially if it is measured through a contraction, but stated that "this would not negate the necessity to recheck it", particularly in light of the fact that [Ms A's] BP had been significantly raised the day before. Ms Wood advised that it would be her expectation that, despite the progress of Ms A's labour being good, "at the least, [Ms A's] blood pressure should have been rechecked within 15–30 mins", in light of the previous high BP reading. Ms Wood advised:

> "A urine sample to check for protein would have been useful also but [Ms A] had voided prior to the arrival of [Ms B]. It would seem that there was no further attempt to collect a urine sample until [Ms A] was catheterized by the obstetric registrar."

119. Ms Wood further advised: "At the time the initial blood pressure of 167/97 was documented, there is no mention of other symptoms such as headaches, epigastric pain or visual disturbances." Ms Wood noted that despite Ms A's significantly increased blood pressure, there was "no documentation about any questioning about further symptoms of pre-eclampsia noted nor laboratory testing arranged to test for developing pre-eclampsia, nor was [Ms A's] blood pressure rechecked until some time later when she became unwell".

120. I note that Ms Wood considered that, in the circumstances, Ms B's actions would be viewed as a moderate departure from expected standards of care. I accept Ms Wood's advice.

121. In my view, the Referral Guidelines make it clear that, where a pregnant woman presents with a BP at or above 140/90, further testing for pre-eclampsia is required. I have observed the importance of obtaining the information necessary to comply with the Referral Guidelines in a recent case regarding the management of a woman presenting with a raised BP.[20]

122. In my opinion, Ms B failed to monitor Ms A adequately. When Ms A was assessed as having high BP at the time of her admission, Ms B should have, at the very minimum, reassessed Ms A's BP within 15–30 minutes. Although Ms B remained in the room for over an hour, she did not arrange for further urgent blood tests or attempt to obtain a urine sample. She then later left the room for at least 25 minutes without questioning Ms A regarding any other symptoms, such as headaches, epigastric pain or visual disturbances, to ascertain whether Ms A was developing pre-eclampsia. In my opinion, by failing to respond adequately to Ms A's high BP at the time of admission, particularly given her history, which was known to Ms B at that time, Ms B failed to provide services to Ms A with reasonable care and skill.

123. I am also concerned by Ms B's lack of communication with Ms A and her support people regarding Ms A's condition, including her high BP. As noted by Ms Wood, "an explanation of what was occurring should have been ongoing to [Ms A] and her family throughout as the situation unfolded …". I accept Ms Wood's advice. It is clear that Ms B underestimated the seriousness of the developing pre-eclampsia, and that this had an impact on the information she provided Ms A and her support people.

Professionalism

124. Ms A told HDC that when she saw Ms B postnatally, Ms B was unprofessional and "bagged off" Dr C. Ms B said that she gave Ms A an "honest opinion" about Dr C, stating that she felt that Dr C "undermined the reassurance [she] was trying to give". Furthermore, Ms B commented that when asked about what happened and why her approach had been different from Dr C's, she gave an "honest opinion", explaining that she was trying to keep the situation calm while Dr C was trying to manage the severe pre-eclampsia. Ms B commented that "[Ms A] has interpreted this as a criticism when it was supposed to be an honest explanation of our different approaches".

125. Ms B had an important role in supporting Ms A and providing reassurance. As noted by Ms Wood: "An atmosphere of panic and/or conflict in a labour room in situations such as this is always unhelpful for everyone, the woman, her family and the staff involved."

126. In relation to Ms B's subsequent comments about Dr C, Ms Wood commented:

> "While it is important to discuss events in detail with the woman and her family in the days following a stressful birth, personal comments regarding specific staff members who were involved, is in my opinion, unwise and could be seen as unprofessional. Conflict issues between professionals should be discussed in the first instance, between them, possibly with a support person present."

[20] See Opinion 13HDC00952, 23 June 2015 at para 89.

127. I note Ms Wood's view that Ms B's comments would be considered a mild departure from expected standards of care. I accept Ms Wood's advice.

128. I accept that Ms B did not intend to criticise Dr C, but that it was interpreted as such by Ms A. I trust that Ms B will reflect on her behaviour and the potential impact it can have on the woman and her care.

Conclusions

129. Overall, I have serious concerns about the care Ms B provided to Ms A. There were a number of missed opportunities for Ms B to identify and respond appropriately to Ms A's developing pre-eclampsia.

130. First, during a routine antenatal appointment, Ms A was noted to have a raised BP, a 2kg weight gain from seven days earlier, and mild oedema. Ms A then disclosed that she had been experiencing visual disturbances two weeks earlier and then again on one occasion in the days preceding the appointment. However, Ms B failed to assess Ms A adequately, or to recommend to Ms A that she consult a specialist.

131. Then, the following day, when Ms A sent a text message to Ms B advising that she had again been experiencing visual disturbances that morning and had also been experiencing headaches, Ms B failed to assess Ms A urgently.

132. Finally, when Ms A arrived at the hospital later that evening in labour and was noted to have a BP of 167/97mmHg, Ms B failed to carry out any further assessment, such as arranging for blood or urine testing. At the very least, Ms B should have re-tested Ms A's BP after 15–30 minutes. Instead, Ms B remained in the room for over an hour without carrying out such an assessment, and then left the room for at least 25 minutes. Ms Wood advised that Ms B's failure to take any action at that time was a moderate departure from accepted standards. It was not until Ms A reported feeling faint on Ms B's return to the room, that Ms B re-checked Ms A's BP and then sent Ms D to consult with the on-call registrar about Ms A's condition.

133. I note Ms Wood's comment that although pre-eclampsia is a relatively rare condition (occurring in about 8% of first pregnancies), it is a disorder that can worsen quickly, "which is the reason why signs of pre-eclampsia should never be underestimated or ignored". Midwives should take prompt and effective action when women develop signs and symptoms of pre-eclampsia, in order to ensure early intervention and management to minimise the risk to the mother and baby. Ms B failed to do so in Ms A's case, which is seriously concerning. I conclude that Ms B failed to provide services to Ms A with reasonable care and skill and breached Right 4(1) of the Code.

134. I am also concerned about Ms B's failure to advise Ms A appropriately about the use of text message communication in relation to urgent matters, Ms B's lack of communication with Ms A regarding her condition during labour, and Ms B's comments to Ms A regarding another professional.

Recommendations

135. The Midwifery Council of New Zealand will be asked to provide a report to this Office outlining the outcome of its formal assessment and any further performance assessment and/or restrictions on Ms B's practice it decides to take.

Follow-up actions

136.
- Ms B will be referred to the Director of Proceedings in accordance with section 45(2)(f) of the Health and Disability Commissioner Act 1994 for the purpose of deciding whether any proceedings should be taken.
- 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 the District Health Board, and they will be advised of Ms B's name.
- A copy of this report with details identifying the parties removed, except the expert who advised on this case, will be sent to the New Zealand College of Midwives.
- A copy of this report with details identifying the parties removed, except the expert who advised on this case, will be placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

Addendum

137. The Director of Proceedings filed a charge before the Health Practitioners Disciplinary Tribunal. Professional Misconduct was made out and a number of conditions were placed on Ms B's practice (should the Midwifery Council lift her suspension) including supervision for no less than 18 months.

Appendix A: Independent midwifery advice

The following expert advice was obtained from a registered midwife, Mary Wood:

"My name is Mary Wood. After completing a diploma in Comprehensive Nursing at Carrington Polytechnic (now Unitec) in 1989 I completed a diploma in midwifery at AUT in 1990. I then completed a Bachelor of Health Science Midwifery at AUT in 2001. I worked as a midwife in [a delivery unit in a hospital] from Jan 1991 until September 1991, after which I began working [as an independent midwife]. I worked as a full time self employed midwife [until 2013]. In April 2013 I began working part time as an Associate Clinical Charge Midwife in [a birthing suit at a hospital], where I am responsible for the management of the labour ward, co-ordinating, teaching and supporting staff and responding to emergency situations. Currently I combine a part time self employed caseload with my part time work at the hospital. As a self employed midwife, I work in a practice of (currently) 12 midwives, each of whom carry their own caseloads. I provide midwifery care for women throughout pregnancy, from positive pregnancy test through until six weeks after the birth of the baby, delivering either at home or [in hospital]. I provide midwifery care for women in both low, moderate and high risk pregnancies.

I have read and agree to follow the HDC 'Guidelines for Independent Advisors' and I have no conflicting interests either professional or personal in this case.

I have reviewed the documentation provided by the HDC including:

[Ms A's] Complaint
[Ms B's] response
[Ms A's] clinical records
Relevant [phone] Texts
The Clinical Maternity notes from [the public hospital]

You have asked me to provide preliminary advice regarding the standard of midwifery care provided by [Ms B] to [Ms A], prior to and during her labour and birth [in 2014].

This was [Ms A's] first pregnancy, and the clinical notes demonstrate that her pregnancy progressed normally until [term], when she presented for a routine antenatal check with blood pressure of 140/100. Her urine was clear on dipstick. It is noted that she had a weight gain of 2 kg during that week, but the notes describe her to have only mild oedema. The midwifery notes record a discussion about high blood pressure and pre-eclampsia during this visit, and [Ms A] revealed that she had been having visual disturbances during the previous two days, and on one occasion two weeks before. There is no mention of headaches in the written notes at this time, and it is noted that '[Ms A] reports feeling well in herself'. [Ms B] goes on to write in the clinical notes that she discussed the symptoms of pre-eclampsia with [Ms A], which I believe would have included a discussion about headaches.

[Ms B] did not arrange for blood and urine testing nor arrange for a follow up blood pressure check later that day or the following day. She did not consult at that time. She states in her letter that it was a matter of clinical judgement.

Advice requested (i)

The Guidelines for Consultation with Obstetric and Related Medical Services (Referral Guidelines) recommend consultation with obstetric services with blood pressure above 140/90 and transfer of care with blood pressure above 150/100. Although [Ms B] did discuss pre-eclampsia with [Ms A] at this visit she did not arrange for blood and urine testing nor did she consult the local obstetric service. [Ms A] felt that [Ms B] appeared to be clinically well at that time, although [Ms A] was describing visual disturbances. With blood pressure of [140]/100, blood tests and a urine PCR were indicated as well as consultation with the local obstetric service.

I could find no plan for follow up arrangement to specifically recheck [Ms A's] blood pressure in the notes, just a comment about post dates check [two days later].

I consider this a moderate departure from an acceptable standard of care. [Ms A] was aware of the possibility of pre-eclampsia and discussed the possibility with [Ms B], but without any diagnostic tests such as bloods and PCR, clinical judgment is very limited. Women can develop severe pre-eclampsia and remain without symptoms until the disease is advanced, which is why blood pressure and urine are checked at every antenatal visit. I do consider that urgent blood and urine testing should have been arranged and that [Ms A's] blood pressure should have been monitored more closely. In the area that I work I would expect a woman to be admitted to the antenatal service in hospital with blood pressure of 140/100, so that blood pressure/urine testing, diagnostic testing and obstetric review could be undertaken.

Somanz Guidelines for the Management of Hypertensive Disorders of Pregnancy (2008) recommend that blood pressure over 140/90 should be confirmed by repeated readings over several hours. They note that edema is not included in the diagnostic features of pre-eclampsia as it is a normal and common feature of normal pregnancy, but rapid development of generalized edema should be noted as a warning sign and alert the clinician to screen for pre-eclampsia. The clinical notes record that [Ms A] had gained two kilo during the week prior to seeing [Ms B] on [Monday]. '*Pathological oedema is defined as a generalized accumulation of fluid of greater that 1+ pitting oedema after 12 hours of bed rest or weight gain of 2 kg or more in 1 week, or both' Pairman, Tracy, Thorogood, Pincombe, 2010 pg 806*

NZCOM Handbook for Practice / Standards of Midwifery Practice

Standard Six: Midwifery Actions are prioritized and implemented appropriately with no midwifery act or omission placing the woman at risk.

** The midwife identifies deviations from the normal, and after discussion with the woman, consults and refers as appropriate'*

The following morning [Ms A] states that she texted [Ms B] at 0940 to advise her that she was experiencing visual disturbance and headache. [Ms B] phoned in response to that text at 1430 but did not arrange to see her at that time.[21] Given that [Ms A's] blood pressure had been significantly increased the previous day, it is my opinion that with the presence of symptoms such as headache and visual disturbance, an urgent assessment was indicated.

At 2046 [Ms A] texted [Ms B] to advise her that she was having contractions and then phoned her at 2130 to advise her that her contractions were stronger and closer. She then made her way to the hospital.

[Ms B] states that she received a text from [Ms A] at 2046 on [Tuesday] advising her that she was having contractions 10 mins apart and she advised her to go to hospital at that time. She states that she does not recall any phone calls or texts from [Ms A] that day, prior to that time.

The phone records indicate a text from [Ms A] to [Ms B] at 0941 that morning and the transcription includes comments about her having headaches and visual disturbances as well as bouts of watery discharge. A further text at 2046 that evening is recorded regarding contractions coming every 10 mins and stating that [Ms A] would phone [Ms B] when the contractions became stronger.

Advice requested (iv)

The difficulty with the use of text messaging is that there can be delays in transmission. The Midwifery Council Code of Conduct 2010 points out that '*Text messaging can be an unreliable method of communication, with message transmission delayed at times or messages open to misinterpretation. While women may use texting to contact a midwife, midwives must consider the appropriateness of using text communications and ensure that their communication with women occurs through reliable methods such as telephone'.*

Texting has become part of reality for midwives today, with many women using texting as their preferred initial contact method. However, as stated above the risk of misinterpretation and delays in messaging make it important that midwives phone women in response to text messages. It is my opinion that text messaging should be confined to administrative aspects such as appointment changes, and that clinical matters, especially as regards symptoms of concern during pregnancy should be responded to via direct telephone conversation.

Advice requested (v)

The [phone company] documentation provided highlights texts sent by [Ms A] to [Ms B]. It does not detail communications from [Ms B] to [Ms A]. As a result, there is [Ms A's] statements about sending texts to [Ms B] and [Ms B's] statements about not receiving texts or calls. Further documentation from the phone companies may be useful.

[21] Ms B's telephone records show that this call was made at 12.30pm.

[Ms A] was admitted to the labour ward at 2300 that night in established labour. The hospital clinical notes record that a CTG (continuous fetal monitoring) was commenced at 2312 and a full set of observations were performed at that time, which revealed blood pressure of 167/97. [Ms A] was using entonox for pain relief at that time. A vaginal examination confirmed that she was in established labour. The CTG was normal and was discontinued at 2357 to enable her to mobilize more freely. At 0105 [Ms B] documents that on returning to the room following admitting [Ms A], she found [Ms A] feeling faint. The notes state that the 'bed was lowered' which I assume means that the bed was flattened so [Ms A] could be placed in a left lateral position. Blood pressure was recorded at 188/106 electronically and 170/108 manually. At this time the obstetric registrar and SHO was called to attend.

The obstetric registrar [Dr C] and the SHO were present at 0120, at which time [Ms A's] reflexes were noted to be brisk. An IV line was commenced, urgent bloods were taken and at this time the emergency bell was used to call for assistance from the core midwifery staff. After discussion with the on call consultant ([Dr H]) a magnesium sulfate bolus was given for seizure prevention, (followed by a maintenance infusion) an indwelling urinary catheter was inserted and a sample of urine was obtained for dip stick analysis (3+ protein was present) and sent to the lab for urine PCR.

At 0146 Dr C then performed a vaginal examination during which she ruptured the membranes and thin meconium liquor was noted. At 0225 [Ms A] was fully dilated and her baby was born in good condition at 0258. [Ms A] then had a post partum hemorrhage of an estimated 1000ml.

Advice requested (ii)

[Ms A's] admitting blood pressure was again noted to be significantly increased (167/97). Women's blood pressure can be elevated during labour, especially if it is recorded during a contraction. However, given that there had been significantly elevated blood pressure noted the day before, I would expect that urgent bloods should have been taken at this time, and consultation with the obstetric service should have occurred. Although the progress of [Ms A's] labour was good, blood pressure at this level, especially in light of the increased blood pressure from the day before should have raised concern, and it is my opinion that at the least, [Ms A's] blood pressure should have been rechecked within 15–30 mins. A urine sample to check for protein would have been useful also but [Ms A] had voided prior to the arrival of [Ms B]. It would seem that there was no further attempt to collect a urine sample until [Ms A] was catheterized by the obstetric registrar.

At the time the initial blood pressure of 167/97 was documented, there is no mention of other symptoms such as headaches, epigastric pain or visual disturbances. I would have to assume from this that these questions were not asked. In my experience, in situations such as this, there is questioning about the presence of other symptoms and their presence/lack of presence are documented.

While midwives are taught to test for hyper-reflexia, I would expect that if a woman's blood pressure was high enough to be considering this, the obstetric service should already have been summoned. In my experience it is normally the obstetrician or registrar who do this. I would not expect this to be done by an LMC midwife.

Advice requested (iii)

[Ms B's] memory about [Ms A's] blood pressure upon admission to the labour ward does not match the clinical notes, and this does suggest to me that she was not concerned at the time. This could also be why her blood pressure was not rechecked. She states in her response that she informed [Ms A] that the blood pressure was likely to be 'due to being in labour and being tired'. While it is true that blood pressure can be elevated during labour as I have mentioned already, I am not aware of tiredness causing blood pressure to rise significantly.

As regards the amniotic fluid, [Ms B] states that the fluid was clear and there was no meconium present, while the clinical notes document that when the membranes were ruptured there was thin meconium present. She also states in her response letter that '*Thick meconium is a cause for concern, I know this. If there was meconium, it was light meconium and therefore nothing to worry about'*. The presence of any meconium liquor is a warning sign that the baby may have experienced an episode of distress, and normally continuous fetal monitoring is commenced as a result. [Ms A's] baby showed no signs of fetal distress from the CTG trace included in the documentation and was born in good condition. In fact, in the majority of cases when meconium is found to be present it has been my experience that the baby is born in good condition. Conversely, I have seen babies born in poor condition when no meconium was present. However, the presence of meconium in liquor prior to birth is considered a risk factor or warning sign whether it is thin or thick meconium.

[Ms A] states in her complaint that [Ms B] told her that the hospital staff and in particular [Dr C] the Obstetric Registrar, had turned her birth into an unnecessary drama and that the reaction of the team was over the top.

[Ms B] states that she did express the view that she believed that the registrar had undermined the reassurance she was trying to give, and created what she considered a damaging air of panic rather than calm. She goes on to comment that she would have expected [Ms A] would have welcomed frank and honest views about what had occurred. Earlier in her response letter, [Ms B] comments that the registrar 'completely took over' after some disagreement about which blood pressure machine to use. [Ms B] states that she was trying to keep [Ms A] calm and that her 'actual labour was progressing well and her baby was fine'. She also describes [Ms A's] comment in her complaint that she had developed severe pre-eclampsia mid labour and that somebody must have given her that information.

[Ms A's] labour did progress rapidly and her baby appeared to be well throughout the developing situation, but [Ms A] did develop severe pre-eclampsia during her labour. It would be my expectation that an explanation of what was occurring

should have been ongoing to [Ms A] and her family throughout as the situation unfolded, rather than something that 'someone' had informed her of after the birth or the following day. She had significant protein in her urine (3+), reduced urine output, her highest recorded blood pressure was 233/144 just prior to the birth and she was demonstrating brisk reflexes.

It would seem from reading the documentation that [Ms B] was trying to keep the birth as normal as possible, but underestimated the seriousness of the developing severe pre-eclampsia. [Dr C] was trying to deal with a serious obstetric emergency, that is, a possible impending eclamptic seizure event, which can be life threatening.

An atmosphere of panic and/or conflict in a labour room in situations such as this is always unhelpful for everyone, the woman, her family and the staff involved. While it is important to discuss events in detail with the woman and her family in the days following a stressful birth, personal comments regarding specific staff members who were involved, is in my opinion, unwise and could be seen as unprofessional. Conflict issues between professionals should be discussed in the first instance, between them, possibly with a support person present.

Midwifery Council of New Zealand / Accountability

The public and midwifery profession expect that midwives:

** work in partnership with professional colleagues, ensuring that the woman's interests remain paramount*

Inter-professional relationships:

Through their conduct, Midwives ensure that:

- *They interact with their colleagues in a fair and respectful manner.*
- *They must not make malicious or unfounded criticisms of colleagues that may undermine women's trust in the care or treatment they receive or in judgment of those treating them.*

Guidance Statements:

Midwives need to be aware that their behaviour towards other professionals can pose a risk of harm if it impacts on the care that women receive. Criticisms of colleagues may undermine the woman's trust in the care they receive or in the judgment of those treating them. It is vital that all members of the health care team work in a way that is conductive to safe care for the woman and this means that midwives must be aware of the way in which they communicate.

Conclusion:

[Ms A] presented for a routine antenatal appointment at term with significantly increased blood pressure, which was not rechecked initially, nor was a follow up plan made to recheck it. She also reported experiencing visual disturbances during the previous two days. No blood or urine laboratory testing was arranged to check for developing pre-eclampsia nor was there any discussion with the local obstetric service. I consider this is a moderate departure from expected standards of care as I have discussed above.

The following day text communication from [Ms A] to [Ms B] described developing symptoms (visual disturbance and headache) but this message was not responded to. [Ms B] states she has no memory of receiving this message but phone records from [Ms A's] phone company confirm that this message was sent. Records from [Ms B's] telephone company may be helpful in determining when and what messages were sent and received. If the text at 0940 from [Ms A] to [Ms B] was received I would consider failure to respond to this text with a phone call to arrange an urgent review for pre-eclampsia a serious departure from expected standards of care.

[Ms A] was admitted to the labour ward that night in established labour and again her blood pressure was found to be significantly increased. There is no documentation about any questioning about further symptoms of pre-eclampsia noted nor laboratory testing arranged to test for developing pre-eclampsia, nor was [Ms A's] blood pressure rechecked until some time later when she became unwell. I consider this a moderate departure from expected standards of midwifery care as I have discussed above.

I consider negative comments about [Dr C's] obstetric management by [Ms B] made to [Ms A] the following day does not meet that standard of care expected by Midwifery Council. I would consider this a mild departure from expected standards of care as it reflects negatively upon the professionalism of [Ms B] and was unhelpful to [Ms A].

[Ms A] developed severe fulminating pre-eclampsia during the labour and birth of her first child. [Ms B] is correct in her statement that she did not cause it, could not have prevented it, was not responsible for it nor can she be blamed for it. However, she failed to take any steps to ensure [Ms A] was not developing a serious complication of her pregnancy in that she ignored the warning sign of significantly increased blood pressure and visual disturbances the previous day and when [Ms A] was admitted to hospital in labour.

Pre-eclampsia is a condition that complicates around 8% of first pregnancies. It can be subtle initially in that the woman can remain feeling well until she is seriously unwell. It is a disorder that can worsen very quickly, as it did in this case, which is the reason why signs of pre-eclampsia should never be underestimated or ignored.

It is a potentially life threatening disorder that can have serious effects on both mother and child and it is the reason blood pressure and urine are checked at every antenatal check, especially after 20 weeks of pregnancy.

References:

Midwifery Council of New Zealand, *Code of Conduct*, 2010.

Midwifery; Preparation for Practice Second Edition, Pairman, S. Tracy, S, Thorogood, C. Pincombe, J. 2010, Elsevier Australia.

NZ College of Midwives, Midwives Handbook for Practice.

Somanz: Society of Obstetric Medicine of Australia and New Zealand, Guidelines for the Management of Hypertensive Disorders of Pregnancy 2008"

Further advice from Mary Wood

"***Advice requested (i)***

Regarding the blood pressure concerns, I stand by my original report in that BP of 140/100 recorded at the final antenatal appointment on the 24/02/14 was significant, and the failure to arrange blood and urine laboratory testing, any follow up appointment in the following days to re check it nor any obstetric consultation was a moderate departure from acceptable midwifery care. [Ms A's] blood pressure was not slightly raised but significantly raised, especially as her previous blood pressure recordings had been in the range of 110/60 to 120/80.

I don't know how it would be possible to judge the significance of blood pressure of 140/100 in circumstances such as this, without blood and urine testing as women with pre-eclampsia can remain symptom free until they are extremely unwell.

The guidelines recommend consultation with blood pressure of 140/100 and transfer of care at 150/100.

Advice requested (ii)

I stand by my comments regarding [Ms A's] blood pressure of 167/97 upon admission to the labour ward at 2300 the following day. It is certainly true that blood pressure can be raised during labour, especially if it is recorded during a contraction. However, in this case it appeared that no consideration was given to the raised blood pressure from the day before, and her admission blood pressure was not re checked until she became symptomatic some 2 hours later.

My original report records that thin meconium was noted to be present when the membranes were ruptured by the obstetric registrar [Dr C] at 0146, not on admission.

Conclusions comments

My comment was '***If*** *the text at 0940 from [Ms A] to [Ms B] was received I would consider failure to respond to this text with a phone call to arrange an urgent review for pre-eclampsia a serious departure from expected standards of care.'* The documentation I have reviewed demonstrate that three text messages were sent from [Ms A] phone at 0941 to [a telephone number] which I am assuming is [Ms B's] mobile phone number. It is not clear to my mind whether [Ms B] received these texts however. Texting as I discussed in my original report is unreliable and should not be used for important messaging.

There is a product I use called 'Diskaid' which allows me to download and print off text messages from my mobile phone. It may be useful for [Ms B] to investigate the use of this or a similar product to record her text messaging with women for the future.

Regarding the use of my term 'ignored' as being unfair in my assessment of this case. On the previous day when [Ms A] presented with blood pressure of 140/100, [Ms B] recognized that this was high and discussed it with [Ms A], but her decision was to do nothing about it. She stated that it was a matter of clinical judgment. I am unsure how

one can make a clinical judgment without blood and urine testing (PCR) in situations such as this, as you would be making clinical decisions without a full picture. I can't think of another word other than 'disregard' that I could have used here.

[Ms A's] systolic blood pressure of 140 was not what concerns me as much as her diastolic blood pressure of 100. Again the following day when [Ms A] presented with increased blood pressure of 167/97 in labour, there appeared to be no consideration given to further checking or testing until [Ms A] became symptomatic. I certainly agree that a woman's blood pressure can increase due to the stress of labour, but this would not negate the necessity to recheck it if the initial recording was high. The only way to know would in fact to be to recheck the blood pressure."