Midwife, Ms C

A Report by the

Health and Disability Commissioner

(Case 12HDC00301)

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

Table of Contents

Executive summary....1
Complaint and investigation....2
Information gathered during investigation....3
Relevant standards....14
Response to provisional opinion....15
Opinion: Breach — Ms C....15
Recommendations....22
Follow-up actions....23
Addendum....23
Appendix A — Independent Expert Advice....24

Executive summary

Background

1. This report is about the care provided by midwife Ms C to her client, Ms A. Ms C first met Ms A in 2011, when Ms A was aged 16 years, and 10 weeks and 4 days pregnant. Ms C noted that Ms A had a difficult social history and had just left her partner.

2. There is no record of a birth plan having been developed. In addition, Ms C told Ms A that she might be uncomfortable attending antenatal classes and said that she would instead teach Ms A the topics that would be taught in the classes.

3. Ms C prescribed evening primrose oil capsules for Ms A to take for a week because she considered it has been shown to bring on labour.

4. When Ms A was 37 weeks and 4 days pregnant, Ms A woke in pain. She, and her partner, Mr A, called Ms C several times and were told to wait and not to go to hospital. The pain worsened, so Mr A called his mother, who came to their home and then also telephoned Ms C. Shortly thereafter, Ms A gave birth on the bathroom floor.

5. Ms C arrived after the baby was born. Ms C examined Ms A and told her she had a small perineal tear that did not require sutures.

6. Ms A experienced severe pain in her perineum, and the tear pulled open when she walked. She tied her thighs together to minimise this and, when Ms C saw she had done so, she laughed, but provided little assistance to her.

7. In addition, in the period following the birth, Ms A experienced difficulty with breastfeeding, but was not offered a referral to a lactation specialist.

8. Ms C was on leave for several days. On her return Ms C visited Ms A, who was clammy and cold, and had a fever and cramps and offensive smelling lochia.[1] Ms C prescribed one dose of metronidazole[2] and took a swab.

9. The following day Ms A went to an after-hours doctor. She was seen by an obstetrician, Dr D, who immediately admitted Ms A to hospital for IV antibiotics, EUA (examination under anaesthetic), perineal debridement and perineal reconstruction.

10. On admission to hospital, Ms A appeared unwell and had an elevated CRP[3] and white cell count. A vaginal swab taken the previous day showed a heavy growth of Streptococcus Group A (*Streptococcus pyogenes*).

[1] Lochia is the vaginal discharge for the first fortnight of puerperium (after birth), containing blood, mucus, and placental tissue.
[2] A treatment for anaerobic infections.
[3] A C-reactive protein (CRP) test is a blood test that measures the amount of a protein called C-reactive protein in the blood. C-reactive protein measures general levels of inflammation in the body. High levels of CRP are caused by infections and many long-term diseases.

11. The EUA confirmed an infected labial and perineal laceration that had failed to unite, and that a posterior vaginal wall skin flap had fibrosed onto the raw perineal edges. All infected tissue was excised, and labial and perineal reconstruction was performed.

Findings

12. Ms C failed to provide adequate antenatal advice; communicate effectively with Ms A and her supporters; attend the labour; provide adequate breastfeeding advice and support; adequately assess the perineal tear and provide appropriate treatment of the tear; and appropriately prescribe medications. The Commissioner had serious concerns about the collective number of moderate departures from expected standards in this case, and considered that, overall, Ms C's care of Ms A was seriously sub-optimal. The Commissioner found that Ms C failed to provide services to Ms A with reasonable care and skill and, accordingly, Ms C breached Right 4(1)[4] of the Code.

13. By failing to document significant events, discussions and decisions, Ms C did not meet professional standards. Ms C's inadequate and misleading records were a further breach of professional standards and, accordingly, Ms C beached Right 4(2)[5] of the Code.

14. Ms C was 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

15. Obstetrician Dr D complained about the care provided to Ms A by independent midwife Ms C. The complaint was supported by Ms A. The following issue was identified for investigation:

- *Whether Ms C provided an appropriate standard of midwifery care to Ms A.*

16. An investigation was commenced on 14 November 2012.

17. Information was obtained from the following parties:

Ms A	Consumer
Mr A	Consumer's partner
Mrs B	Partner's mother
Ms C	Independent midwife/provider
Dr D	Obstetrician/provider
The District Health Board	Provider
Midwifery Council of New Zealand	

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

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

Also mentioned in this report
Baby A
Ms E Midwifery Advisor

18. Independent expert advice was obtained from a registered midwife, Juliet Thorpe (**Appendix A**).

19. This report is the opinion of Anthony Hill, Health and Disability Commissioner.

Information gathered during investigation

Background

Maternity services in New Zealand

20. Pregnant women in New Zealand are entitled to free maternity services from midwives or general practitioners to cover their pregnancy, birth and postnatal care. To access these services, the woman must choose a Lead Maternity Carer (LMC), who is funded by the Ministry of Health to provide maternity services. LMC responsibilities are set out in the Primary Maternity Services Notice, issued pursuant to section 88 of the New Zealand Public Health and Disability Act 2000 (the Section 88 Notice). The Section 88 Notice states that the LMC is responsible for the care provided to the woman throughout her pregnancy and in the postpartum period.

Ms C

21. Ms C is an independent midwife. At the time of these events, Ms C had been practising as a midwife for approximately nine months, having graduated with a Bachelor of Midwifery. Ms C moved to the area in 2011.

22. Ms C advised that at the relevant time she had approximately 15 clients in total, and was participating in the Midwifery First Year of Practice Programme. As part of the programme, she had contact with her midwifery first year practice mentor, who was in the area where Ms C lived previously, on a weekly basis. Ms C advised HDC that she had been allocated a mentor who lived in the district, but the allocated person had been unable to fulfil the role. Accordingly, Ms C's original mentor continued as Ms C's mentor. Ms C advised that she was also well supported by her practice partner at the relevant time.

Ms C's antenatal care

Safety concerns

23. Ms C first met Ms A (then aged 16 years) in 2011 at an initial booking visit. At that time, Ms A was 10 weeks and four days pregnant. Ms C noted that Ms A had a difficult social history, including that she had just left her partner, Mr A, due to relationship difficulties. At the time of this appointment, Ms A was in the early stages of her pregnancy.

24. Ms A advised HDC that two days after she discovered she was pregnant, Family Planning referred her to Ms C because she would be sympathetic when caring for a

young mother. At that time, Ms A and Mr A were going through "a stage", and Ms A was staying with friends, who also attended the booking visit. Ms A advised that, at that time, she was distraught and, during the booking visit, said bad things about Mr A, and her friends said that Mr A had hit her, although he "hadn't really done so".

25. There was a further consultation to complete the booking visit. Ms C recorded that Ms A had moved in with Mr A and his family.

26. Ms C recorded that she had discussed postnatal support groups with Ms A, and the possibility of Ms A attending a parenting group. Ms C gave Ms A a DVD on breastfeeding, and a book containing information for young parents.

27. Ms A stated that during the course of her pregnancy Ms C followed up with regard to Ms A's safety. However, Ms A felt she did not need support as Mr A had consulted a counsellor, and they both "grew up a bit". Ms C advised that towards the end of Ms A's pregnancy, Mr A was present for almost all of Ms A's antenatal visits, but she still always asked Ms A if she was safe. Ms C stated to HDC: "I always asked her if she was safe — I was uneasy but [there was] no obvious abuse." In response to the provisional opinion, Ms C advised HDC that she only ever discussed safety issues with Ms A when Mr A was not present at the consultation or had left room.

28. Ms C said she discussed trespass and restraining orders against Mr A, but Ms A was doubtful about ending the relationship and had nowhere to go except back to Mr A because her family was not supportive of the pregnancy. Ms C said she gave Ms A information pamphlets on violence in relationships.

29. Further on in the pregnancy, Ms C wrote a referral letter to a social worker but did not action it. When HDC asked why she did not do so, Ms C responded that she was aware that Ms A was having counselling and was not keen on the referral. Ms C stated that Mr A declined the social work referral and, although she could have talked Ms A into it, she did not do so.

Antenatal classes

30. Ms A stated that Ms C told her that if she attended antenatal classes she would get "looked down on" because of her age, and Ms C said she would teach her everything a class could teach her.

31. In contrast, Ms C said she recommended to Ms A that she attend antenatal classes but Ms A was not keen. Ms C said she did not discourage Ms A, but told her that it can be difficult for "young Mums" to attend antenatal classes, and that she might feel uncomfortable. Ms C agreed that she said to Ms A that she would cover what would have been covered in the antenatal classes.

Birth plan

32. Ms C said that at the booking visit she provided Ms A with the booklet she routinely gives to all her clients, together with a copy of the printed version of a birth plan. Ms C provided HDC with a copy of the birth plan template she uses. The template has handwritten instructions for when to contact Ms C. It states:

> "**When to Contact Midwife:** if membranes rupture: if liquor is green or any 'hanging' objects ASAP. Otherwise during daylight hours. When contractions are 1:5–10mins. Stay at home as long as possible. I will come assess you at home before transferring to the Maternity Unit."

33. Ms C stated that she did not keep a copy of Ms A's birth plan.

34. In contrast, Ms A denies developing a birth plan with Ms C or being given a copy of the above template. Ms A said that Ms C told her to develop a birth plan on her own. Ms A stated that most of what she knew about pregnancy came from the internet.

35. Ms A said that when she was 36 weeks pregnant she asked about pain relief during labour, and Ms C said it would be discussed at her next visit. Ms A also stated that Ms C did not discuss the Guthrie test (heel prick test). Ms A does, however, recall that Ms C gave her booklets that set out the stages of labour.

Vitamin K

36. The MedSafe consensus statement "Vitamin K Prophylaxis in the Newborn"[6] recommends that it is the responsibility of the LMC to discuss vitamin K prophylaxis[7] and ensure that parents are aware of the recommendation that all babies receive vitamin K. It also recommends that a written record of the date, dose and method of administration of vitamin K be kept in the Child Health Record Book.

37. Ms C recalls that when developing Ms A's birth plan she did discuss with Ms A the administration of vitamin K to her baby, although Ms C made no record of the discussion(s). Ms A said that no such discussion took place. The antenatal records have no references to consent to the administration of vitamin K having been obtained. However, the midwifery notes state: "VIT K IM given."[8]

Evening primrose oil

38. Four days prior to the birth, Ms C recorded that she had prescribed evening primrose oil[9] capsules to be taken orally in the morning for a week. Ms A does not recall any detailed discussion about evening primrose oil, but recalls that Ms C said that it was a common treatment. Ms A said that Ms C did not advise her that there were any risks from taking evening primrose oil.

39. Ms C advised that she recommended Ms A take evening primrose oil because anecdotally it brings on labour, and she had seen other midwives using it.

The birth — Ms A's,Mr A's and Mrs B's accounts

Ms A

40. Ms A advised that, during the two days prior to her baby's birth she had been experiencing pains, which came and went. At 5.30am, Ms A woke in pain and went to

[6] Available from www.medsafe.govt.nz/profs/puarticles/vitk.htm.
[7] The use of vitamin K to prevent bleeding in the newborn baby.
[8] This is the date of the birth of Ms A's baby.
[9] Evening primrose oil is used in pregnancy for starting and shortening labour.

the toilet, where the mucous plug fell out.[10] Ms A said she had no idea what it was and so she conducted an internet search and ascertained that this was "the start of the beginning of labour". Ms A was then 37 weeks and 4 days' gestation.

41. Ms A returned to bed and tried to sleep, but she could not because of the level of her pain. She stated that the pain was "bad, constant with waves of intensity. The peaks were 5 to 6 minutes apart".

42. At 6am, the pains got worse and so Ms A woke Mr A and then rang Ms C. Ms A said that she told Ms C, "I have really bad tummy pain," asked whether her baby was all right, and advised that she was sitting on the toilet, as that was the only position in which she could get any relief. Ms A said that she was very concerned because she did not know whether she was experiencing labour or if there was something wrong with her baby. Ms A said that Ms C told her to call back in eight hours.

43. Ms A said that by 6.03am the pain was so bad that she again called out to Mr A, who was still in bed, and, about 5 to 10 minutes later, she telephoned Ms C for a second time. Ms A said she told Ms C about the nature of the pain and that the pain was "excruciating" and was "really, really, bad" and asked what to do. Ms A advised HDC that Ms C again said, "Call me in 8 hours. You have to put up with pain, it is only going to get worse from here."

44. Ms A said the pain felt like a knife twisting inside, and that, by that stage, Mr A was "freaking out". Ms A said that during the telephone conversations with Ms C, Ms C did not ask about whether the pain was constant or how long it was lasting, and never told Ms A to time the contractions.

Mr A

45. Mr A said that he was woken by Ms A telling him she was in "excruciating pain". Mr A said that he called Ms C and told her that Ms A was in a lot of pain, and that he was going to take her to hospital. Mr A said that Ms C did not ask him any clarifying questions, but told him not to take Ms A to hospital, and that he should wait and call back in two hours.

46. Mr A said that Ms A's pain got worse. He stated to HDC, "[Ms A] was sitting on the toilet, bent over, screaming … [the] pain was coming in waves which were very close together." Mr A said that he called Ms C again about five minutes later and told her that the pain was getting worse and that Ms A was not coping. Mr A told HDC that Ms C again told him to wait and call her back in a few hours.

47. Mr A said that he then called his mother, Mrs B, who arrived within five minutes of the call.

Mrs B

48. Mrs B said that when she arrived, Ms A was sitting on the toilet and clearly in labour, with contractions occurring a few minutes apart. Mrs B said that she told Mr A to call

[10] A plug that fills and seals the cervical canal during pregnancy. It is formed by a small amount of cervical mucus.

Ms C and tell her that she needed to come immediately because Ms A was in labour. Mrs B said that Mr A called Ms C but was told to wait and call back in a few more hours.

49. Mrs B stated that she then called Ms C herself and told her that Ms A was in established labour and that Ms A needed to come immediately. Ms A said she heard Mrs B say to Ms C, "[Ms A's] in labour" and "the pains are really bad — I haven't seen anything like this."

50. Mrs B said that Ms C told her that Ms A was "just young" and "panicking". Mrs B then hung up the telephone and went to check on Ms A. Mrs B said that by this time, Ms A was having constant contractions and was at the "point of no return".

Baby A's birth

51. Ms A said that at 6.23am she reached down and felt the baby's head. She called out to Mrs B, who looked and saw the baby's head. Mr A called Ms C and told her that the baby was coming, and Ms C said that she was on her way.

52. Ms A said that she was on her hands and knees in the bathroom and, at 6.30am, Baby A was born. Mrs B wrapped Baby A in a towel, and Ms A sat holding Baby A while waiting for Ms C to arrive.

The birth — Ms C's account

53. Ms C stated that she had a ten-minute conversation with Ms A at around 5.40am. Ms C said she told Ms A that she expected her to go into established labour over the next four to six hours, and that she would call Ms A back in around two hours' time.

54. Ms C stated that the next telephone call was from Mr A, and was about 40 minutes later. Ms C told HDC that Mr A advised her that the contractions were becoming more intense and lasting a lot longer. Ms C said she told Mr A to time the contractions for 20 minutes and then let her know the frequency and duration. She stated that she made the assumption that Ms A was in early labour.

55. Ms C said that Mr A rang back and advised the following:

> "… [Mr A] said [contractions] 5–8 minutes apart lasting anywhere from 20–90 seconds. [Mr A] said [Ms A] was feeling pressure. [I] said I was coming to assess [Ms A]. I thought she was in early labour as she was all over the place."

56. Ms C stated that as she was getting organised to go to Ms A's home she received another telephone call from Mr A to say that Ms A was pushing. Mr A passed the telephone to his mother, who said that Ms A was starting to bear down and that the baby's head had just been born. Ms C said that when she arrived at Ms A's home some minutes later, the baby had already been born.

57. Ms C's records of the telephone calls and the subsequent events are brief and do not contain the above detail. The notes do not indicate that they were made retrospectively. However, Ms C advised the Midwifery Council of New Zealand (MCNZ) the following:

> "Unfortunately I did not document times or the discussions we had over the phone, I had just jotted what the contractions were doing in my diary and this helped me interpret what I thought was going on. I then wrote a brief outline in the notes, this did not have a lot of clarification or description about my decision making, advise [sic] or discussions I had with all three people present on the phone."

58. Ms C recorded on the Labour and Birth Summary record that she was present at the birth. In response to the provisional opinion, Ms C advised HDC that it is her understanding that a birth is not complete until the delivery of the placenta. On the Labour and Birth Summary record there is only a tick box to indicate whether one is present for the birth or not. Ms C advised HDC that because she was present for the delivery of the placenta she therefore ticked the box that indicated that she was present for the birth.

Postnatal care — Immediate postnatal period

59. Ms A said that Ms C arrived at 6.40am and, after cutting the cord, assisted her to the bedroom. Mrs B said that because Ms C had not brought any scissors with her, they had to find scissors in the house to cut the umbilical cord.

60. Ms C put Baby A on Ms A's breast and assessed her perineum. Ms C noted that there was a tear but said that it was not bad, and referred to it as a "tiny tear". Ms A said that while Ms C was examining her, Ms C knocked the umbilical cord, which hurt, so she pulled away. Ms C denies that this occurred.

61. Ms A said that she felt really cold and was shaking. Ms C covered her with a blanket and then left the room, saying that she was going to fill in the clinical notes. Some time later she returned and asked whether the placenta had been delivered. Ms A said that the placenta remained inside her for about an hour, which was very uncomfortable.

62. Ms A said that Ms C then told her to push really hard, and that Ms C "grabbed the [umbilical] cord and pulled it out" and said, "Hopefully I got it all out." With reference to the placenta, the midwifery notes state: "Appears complete." Ms C denies that she pulled the umbilical cord. The records indicate that the placenta was delivered at 7.25am.

Management of tear

63. Ms A advised HDC that Ms C told her she was "OK" and that "it [was] a small tear", and gave her the option of either staying at home, in which case the tear would heal normally, or getting two to three stitches at hospital. Ms A said that Ms C told her she did not need stitches as she was "perfectly fine", but that if she wanted them, she had to go to hospital because Ms C did not have the correct equipment with her to suture the tear herself. Ms C told HDC that she did have the suturing equipment with her.

64. Ms A said that she asked Ms C directly, about three times, "Do I need stitches?" and was told, "No." Ms A advised HDC: "I would have happily had stitches if needed." Ms A said that Ms C did not talk about the risk of infection or how to deal with the tear, other than to tell Mr A that if Ms A started bleeding out, to push hard on her tummy.

65. Ms A said that she had wanted a hospital birth and, although she was offered the option of going to the hospital to have the tear sutured, she was not offered the option of having Baby A or herself checked. Ms A said that it was her preference to go to hospital. Mrs B said that she also asked Ms C if Ms A needed to go to hospital but was told, "No, everything is fine."

66. Ms C said that, at 8.15am when she reassessed Ms A's perineum, she could see that Ms A had a first degree tear, which included the clitoral hood and was 3cm at the lower vagina. Ms C stated that she recommended to Ms A that she needed sutures to repair the vaginal tear, but said she would not suture the clitoral hood herself. Ms C claimed that Ms A said she would "do anything not to have the tear sutured", and so Ms C supported her wishes. Ms C said that when Ms A asked whether she needed to go to hospital, Ms C told her "not necessarily", and so Ms A decided not to go. Ms C recorded the advice she gave Ms A to manage the tear, and that Ms A had "declined sutures".

67. Ms C said that she told Ms A to be "ladylike", and to keep her legs together and change her pads frequently. Ms C said she provided Ms A with Ural sachets.[11]

68. Ms C said that she discussed Ms A's care with Mrs B, who said she would be there all day. Ms A said that all she wanted to do was to lie down with her baby.

69. Ms C said that Ms A "seemed fine" and was not shaky, but seemed a bit shocked. At about 9am, Ms C told Ms A that she would be back later in the day and left.

Assistance with Baby A

70. Ms A said Mrs B returned later and changed Baby A and showed Ms A how to change his nappies and dress him. Ms A said that Ms C did not weigh or dress the baby. In contrast, Ms C stated that she did dress the baby. Ms C recorded in the notes that at 8.05am, Baby A was checked and weighed at 3350grams.

71. Ms A said that Ms C did not discuss with her how, or how often, to breastfeed. Ms A stated that when Ms C came back for a home visit, at around 2pm, Baby A was feeding, which Ms A found to be very painful. Ms C said that the pain was normal and that Ms A should watch the breastfeeding DVD. Ms C said that Baby A fed for 20 minutes while she was at Ms A's home.

Further assistance during postnatal period

Breastfeeding

72. Ms A said that by the third postnatal day her nipples were cracked and bleeding, and her breasts were rock-hard and sore. Initially Ms C said that there was nothing Ms A could do, but later advised her to express some milk before she breastfed.

73. On the fourth postnatal day, Ms C recorded in the notes: "[B]reast very full today, some localised redness. Ms A gave Baby A 100ml EBM via bottle discussed waiting to express due to this redness." Ms C recorded her advice that "if nipples get

[11] Ural sachets provide relief from the painful burning symptoms of urinary tract infections.

oedematous then use pump to soften, then latch baby". On the fifth postnatal day, Ms C recorded "breasts comfortable" and "nipples grazed but comfortable".

74. Ms A advised that on the fourth postnatal day she rang Ms C at 5.30pm because her breasts were so sore and Baby A was crying. Ms A said that she was crying during the telephone conversation and told Ms C that she could not latch Baby A. Ms A asked Ms C to come to help her latch him, and said that Ms C told her to "deal with it until tomorrow". Ms A said that she told Ms C that Baby A had not had a feed and was screaming, and Ms C told her to express breast milk into a metal spoon and feed him with that, and then hung up. Ms A said that she was very angry with Ms C as she was within walking distance of Ms A's home, so she rang Mr A's sister, who gave Ms A a breast pump to use. Ms A said that after that incident she lost confidence in Ms C.

75. Ms C agreed that this conversation took place but said that it was on the third postnatal day between 7pm and 9pm. Ms C advised HDC:

> "I had a good discussion with [Ms A] in regards to how to soften the areola and get the baby latched and referred her to our previous discussions and the hand out. I felt that by [Ms A's] tone she was angry that I would not 'drop' what I was doing and come assist, however I told her I would come first thing in the morning. It was hard for me to not go but after numerous discussions with my [mentor], [she] always told me that I didn't need to go at unreasonable hours. It was at the time my children all head off to bed and my own family time so this was an unreasonable request, but I was worried all night."

76. Ms C did not record the conversation. She explained to HDC that she decided not to visit Ms A because her mentor had told her not to visit if it was "unreasonable" to do so, and she thought it would be "all right" to go the following day.

77. When HDC asked why it was unreasonable to visit at that hour, Ms C said that it was because she was putting her children to bed. Ms C said she thought that if Ms A expressed some milk she would be "OK", and said she told Ms A she would call back.

78. Ms C said that the following day she gave her breast pump to Ms A, who told her that all was well and that Baby A was latching well. When Ms C was asked whether she considered referring Ms A for lactation advice, Ms C said that she told Ms A about a "Mum to Mum" group where mothers support each other. Ms C said she did not consider referring Ms A to a lactation consultant at the hospital because she "thought breastfeeding wasn't going to last".

Lump under arm

79. Ms A said that she had a lump under her arm, which became larger and more painful after Baby A's birth. Ms A recalls that Ms C advised her that if it stayed like that for a week she should go to the doctor. In contrast, Ms C advised HDC that she told Ms A that she should get it checked by the doctor immediately. Ms C gave Ms A painkillers and antibiotics, which Ms C said were to prevent infection. Ms A said that once she was taking the antibiotics the lump under her arm reduced; however, when Ms C visited she "yelled at [Ms A]" for not going to the doctor, whereas Ms A thought that she had to wait for a week before going to the doctor.

Pain in perineum

80. Ms A said that after Baby A's birth she was in extreme pain and could barely walk. Ms C told her to sit on the couch and walk only to go to bed, and that Mr A was to bring the baby to her to feed. However, because of the severity of Ms A's pain, she was unable to sit on the couch and instead sat on a plastic outdoor chair, which was less uncomfortable than the couch. Ms A said that she told Ms C about the extent of her pain, and Ms C's advice was to keep changing her pads regularly and to continue sitting for about a week.

81. Ms A said that when she took a step she could feel the tear pull open, and it was very painful when she was urinating. When Ms A told Ms C about these symptoms, Ms C asked whether Ms A had had a bowel motion. Ms A said she had not, and that she could urinate only once a day. Ms A told Ms C that she had tried to make a funnel to prevent the urine from touching the tear, and said that she could not bear the pain.

82. Ms C said that she considered that Ms A's pain was not bad initially, but that it got worse later on. Ms C thought Ms A's posture was bad, and told her to stand up straight. Ms C said to HDC: "I thought it was a bit of a show — she was a bit over the top." Ms C advised that in the first week after the birth the tear appeared to be healing, as it was not red and there was no discharge. However, in the second week, it looked different and had come apart. Ms C said she thought that Ms A and Mr A may have tried to have sex.

83. Ms A said that she tied her thighs together with her dressing gown cord so that she would not pull the wound open when she walked. When Ms C asked Ms A what she was doing, Ms A said that she kept feeling that the wound would rip open, but Ms C laughed and did not take her seriously. Ms C said to HDC: "I thought tying her legs together was excessive — quite funny." She said she did not expect Ms A to take her advice that she should keep her legs together so literally. In response to the provisional opinion, Ms C advised HDC that Ms A told her that tying her legs together made her feel more confident, which Ms C accepted. Ms C said that they both had "a bit of a giggle" about it, and she "thought that any tension in the room was broken with this 'giggle'." She noted that, in hindsight, she may have "completely misinterpreted [Ms A's] smile".

84. Ms A said that Ms C checked the tear most days, and that sometimes she just looked at it and other times she wore gloves and "poked around". Ms A said that Ms C told her that the tear was "healing fine".

85. On the eighth postnatal day, Ms C recorded that Ms A was "taking Augmentin 1000mg 3 x daily for cover against infection in perineum. Also lump in armpit is a cyst that became infected. GP would also have given the same antibiotics, so happy with plan of 7 days Augmentin." Ms C advised that she gave antibiotics to Ms A to reduce the risk of infection to Ms A's perineum, but did not seek any clinical advice or take any swabs.

Ms A's deterioration

86. Ms A said that she started to get hot and cold spells, and that Mr A stood beside her with the hairdryer, blowing cold and hot air on her. Ms A said that when she told Ms

C how she was feeling, Ms C said it was normal and that it was caused by her body getting used to post pregnancy.

87. Ms A said that she began feeling dizzy and frequently fell over, but she did not tell Ms C about this because Ms A thought it was normal.

88. Ms C said that she had a period of leave so she recommended to Ms A that she be seen by her colleague. However, Ms A refused to see her colleague, and so Ms C made no arrangements for Ms A's care while she was away.

89. Ms C returned from leave and telephoned Ms A, who advised that she was still in pain and that the lochia[12] was different but not smelling. The following day, Ms C visited Ms A, who was clammy and cold and had fever and cramps and offensive smelling lochia.

90. Ms C said that she took a swab and prescribed one dose of metronidazole. She told Mr A to collect the medication from a pharmacy. Ms C told Ms A that if the medication did not work, she would have to go to the hospital. Ms C said that she telephoned Ms A later that afternoon, at which time she was out getting the groceries, and that Ms A said she was feeling much better. Ms C did not record the conversation.

91. In contrast, Ms A said that Ms C did not suggest that Ms A should go to the hospital if she did not improve. Ms A stated to HDC that her condition was no better at that time, and "if she had told me to go to hospital I would have gone".

Consultation with doctor

92. Ms A said that she had an infection on her finger that had spread to her hand and arm, so the following day she went to the after-hours GP service. While she was there the doctor asked her why she was walking strangely, so she asked the doctor to check her perineum. The doctor then called an obstetrician, Dr D, to assess Ms A.

93. Dr D advised that after examining Ms A she organised for her to be admitted for intravenous antibiotics, examination under anaesthetic (EUA), perineal debridement and reconstruction at the hospital. Dr D stated that, on admission, Ms A appeared unwell and had an elevated CRP[13] and an elevated white cell count, which indicated infection. A vaginal swab taken the previous day showed Streptococcus Group A (*Streptococcus pyogenes*).[14] The EUA confirmed an infected labial laceration and perineum that had failed to unite, and that a posterior vaginal wall skin flap had scarred onto the raw perineal edges. All infected tissue was excised and a labial and perineal reconstruction was performed.

Hospital admission

94. Ms A was discharged on continuing antibiotics.

[12] The material eliminated from the uterus through the vagina after the completion of labour.
[13] An indicator of inflammation.
[14] A type of bacteria.

95. Ms A said that the hospital midwives tried to help her to breastfeed Baby A but, as he had been bottle fed for an extended period, he was not interested. Ms A said that if she had received that standard of assistance when Baby A was born, she would have had a better chance of succeeding with breastfeeding.

Further events

96. Ms C said that she was "gutted" when she found out how bad Ms A's tear actually was. When asked what she would now do differently in a similar situation, Ms C said that she has improved her documentation, would call an obstetrician before prescribing antibiotics, and seeks more support from her practice colleague.

97. Ms A said that after the doctors at the hospital told her that her care was not of an appropriate standard, she asked Mr A to contact Ms C to advise that they did not want her to continue as Ms A's LMC. Ms A said that Ms C offered her back-up midwife in her place and, when Mr A said that they did not want her either, Ms C became angry. In response to the provisional opinion, Ms C denied ever getting angry with a client or his or her whānau. Ms C advised that during the telephone call Mr A was very angry at her and became quite abusive. She recalls that by the end of the conversation she was upset and crying.

98. Ms A advised that the hospital midwife who took over as her new LMC was always available and provided an excellent standard of care. The midwife did not hurt her when she examined her stitches. Ms A advised that the tear has not healed completely satisfactorily, but it is no longer sore.

The District Health Board

99. The District Health Board (the DHB) conducted an investigation into the events and issued a report in March 2012. The report concluded that the midwifery care was inadequate in the following areas:

- Recognition of risk factors present and referral to appropriate agencies.
    - Risk factors: Family violence, [history] of self harm, attempted suicide, teenage mother.
- Labour and birth care — recognition of established labour and providing timely and adequate care.
- Breastfeeding support — including referral to and accessing additional support services.
- Perineal assessment and management following birth.
- Recognition and appropriate management of puerperal sepsis — including prescribing correct medication.

100. The DHB made a number of recommendations, which were reviewed in November 2012. A number of the recommendations had been completed, while others were ongoing. The DHB noted that Ms C was engaging with the MCNZ supervision programme whereby she was required to undertake additional learning with an

appointed supervisor to review her practice documentation and knowledge of skills, in accordance with the midwifery competencies and standards for practice.

Midwifery Council of New Zealand

101. On 8 May 2012, the MCNZ required that Ms C undergo a competency review before the end of June 2012. On 22 September 2012, the MCNZ considered the competency review panel's report and noted that it continued to have concerns about Ms C's competence. The MCNZ required Ms C to complete a comprehensive pharmacology and prescribing programme.

102. The MCNZ further ordered that Ms C was to practise under supervision and to meet with her supervisor on a monthly basis.

103. Ms C advised that as a result of the MCNZ recommendations she currently meets with her supervisor monthly, and her supervisor assesses her caseload and documentation, including care plans. Her supervisor then reports to the MCNZ.

Relevant standards

104. The New Zealand College of Midwives *Midwives Handbook for Practice* states:

> "Standard One:
> The midwife works in partnership with the woman …
>
> Midwives respond to the social, psychological, physical, emotional, spiritual and cultural needs of women seeking midwifery care, whatever their circumstances, and facilitate opportunities for their expression … Midwives have responsibility to ensure that no action or omission on their part places the woman at risk. Midwives have a professional responsibility to refer to others when they have reached the limits of their expertise.
>
> Standard Three:
> The midwife collates and documents comprehensive assessments of the woman and/or baby's health and wellbeing.
>
> Standard Four:
> The midwife maintains purposeful, ongoing, updated records and makes them available to the woman and other relevant persons.
>
> Standard Five:
> Midwifery care is planned with the woman."

Response to provisional opinion

105. Ms C's lawyer provided a submission on behalf of her client in response to the provisional opinion.

106. Ms C submitted that while she accepts that her documentation "let her down", she questions the findings of the provisional opinion in relation to her credibility.

107. In relation to the finding of the provisional opinion that she lacked compassion and lacked insight into her lack of compassion, Ms C submitted that she was not uncaring or lacking in compassion. She stated that she was "a new practitioner who still had something to learn about signals and cues coming from the consumer and interpreting them correctly, and responding appropriately". Furthermore, Ms C submitted that she was a newly qualified midwife who "has learnt her lessons".

Opinion: Breach — Ms C

Introduction

108. Ms A was a particularly vulnerable consumer. A number of factors indicated that she might be at risk. These factors included her experiences of family violence, her history of self harm, her youth, and her limited family support.

109. Working in partnership with the woman is key to good midwifery practice.[15] In order to work in partnership with the woman, the midwife must ensure that communication is effective, and that she is responsive to the woman's concerns or anxieties.

110. This Office has previously stated:[16]

> "[A] general issue raised by the case is the apparent failure of the midwives to listen carefully to what [Mrs A] was telling them … Providers should always treat consumers with respect and listen carefully to their concerns. This case is a reminder of why this is so important."

111. Ms C has accepted that she could have done things differently, but said that she thought Ms A was "making a fuss" and was "quite difficult". I accept that Ms C was relatively inexperienced, but, in my view, this should have suggested to Ms C that, at various stages, there was a need for her to seek additional support, in particular following the unexpected birth of Baby A at home, and when Ms A was experiencing difficulty with breastfeeding and continuing to suffer pain from her perineal tear.

Antenatal care

Safety concerns

112. My expert adviser midwife, Juliet Thorpe, advised that Ms C provided the expected number of antenatal visits. However, Ms C was on notice of a number of sensitive

[15] Competency One and Standard One contained in the *Midwives Handbook for Practice* (2008 ed.).
[16] 07HDC04325, 13 December 2008.

personal issues, including Ms A's recent relationship difficulties with Mr A. Ms C documented that she discussed postnatal support groups and parenting groups, but did not record any discussion about Ms A's safety. Ms Thorpe advised that most midwives would write separate notes, which the woman would not hold. She noted that although there was a social work referral, no further plan or follow-up was documented

113. Ms A recalls that during her pregnancy Ms C did raise safety issues. Ms A assured the HDC Investigator that, by that stage, there were no safety risks.

Birth plan

114. Ms C did not document a birth plan, including matters such as pain relief, vitamin K administration, and third stage of labour options.

115. Ms C said that she gave a birth plan to Ms A but did not keep a copy of it herself. In contrast, Ms A said that Ms C told her to draw up a birth plan on her own, and she was left to research information from the internet. Ms A stated that although pain relief was discussed at 36 weeks' gestation, Ms C said that it would be covered more fully in the following visit.

116. Although there is some mention of epidural and pain relief options in the records, there is no record of discussions about when to call if labour was suspected, or what to do should the waters break, or blood loss occur, or if the baby's movements reduced. Ms C said she gave Ms A "a handout" of what to expect. However, Ms A only recalls receiving booklets relating to the stages of labour.

117. During the antenatal period, Ms C should have discussed with Ms A and Mr A the administration of vitamin K to their baby. Ms C said that she always talks to clients about vitamin K, but there is no record that such discussion took place, and Ms A does not recall it. Furthermore, there is no record of whether Ms A consented (or not) to the administration of vitamin K to her baby.

118. As I have noted previously, "If it isn't recorded in the notes the starting point is that it didn't happen."[17] In these circumstances, I find that it is more likely than not that Ms C did not prepare a birth plan and, prior to the birth, did not discuss or obtain consent for the administration of vitamin K. By failing to prepare a birth plan and discuss vitamin K administration, Ms C did not meet professional standards. Furthermore, Ms C's inadequate records were also a breach of professional standards.

Antenatal classes

119. Ms A and Ms C provided HDC with very different accounts about the advice provided regarding antenatal classes. Ms A said that she did not attend antenatal classes because Ms C told her that young women get looked down on at such classes, and Ms C assured her that she would teach her everything covered in the classes, although she failed to do so.

[17] Hill, A., "Systems, Patients, and Recurring Themes", *New Zealand Doctor* (9 March 2011). Available at: www.hdc.org.nz.

120. Ms C agreed that she said that it can be difficult for young mothers to attend antenatal classes, but asserted that she did not discourage Ms A's attendance, and it was Ms A who did not want to go to antenatal classes. Ms C agreed that she said she would cover the material during the antenatal assessments.

121. I accept Ms A's account that the information provided by Ms C had the effect of discouraging her from attending antenatal classes. Ms C was aware that Ms A was young, inexperienced, and had little family support. In that situation, I consider it very poor that Ms C did not encourage Ms A to attend antenatal classes, especially in light of the potential for Ms A to obtain support from other mothers. In my opinion, this was not adequate care.

Evening primrose oil

122. When Ms A was 37 weeks' gestation, Ms C recommended that she take two evening primrose oil capsules in the morning each day for a week. Miss Thorpe advised me that this is not evidence based advice, and scientific evidence suggests that evening primrose oil is not recommended in pregnancy, as studies have found that it does not shorten the pregnancy or the length of the woman's labour, and is associated with an increased risk of premature rupture of the membranes, oxytocin augmentation,[18] and ventouse[19] extraction. Miss Thorpe noted that there is no documentation to indicate why Ms A, a well and healthy woman at 37 weeks' gestation, would require anything to ripen her cervix or promote labour, as she still had three weeks of pregnancy remaining.

123. In these circumstances, by prescribing evening primrose oil, Ms C failed to provide services to Ms A with reasonable care and skill.

Intrapartum care

124. At 38 weeks' gestation, Ms A went into labour.

125. Ms A said that she called Ms C at approximately 6am, advising that she had "really bad tummy pain". She then called again a few minutes later advising that the pain was really bad and constant. Ms A said that the information she had obtained from the internet did not describe labour pains as being of the type she was experiencing, and so she was concerned for the health of her baby. She said she asked Ms C whether the baby was all right, and said she was in so much pain she could not lie down. I accept Ms A's evidence that Ms C told her that the pain was only going to get worse, and that Ms A should not call Ms C again for several hours.

126. Ms C stated that she was under the impression that Ms A was in only the early stages of labour. However, Ms A is clear that she explained the severity of the pain. The accounts of Ms A, Mr A, and Mrs B are that they repeatedly told Ms C about the

[18] Oxytocin (syntocinon) augmentation is a pharmacological treatment for dysfunctional labour or to achieve induction of labour. The objective is to produce uterine contractions that effectively produce cervical change and descent of the presenting part.
[19] A ventouse is a vacuum device used to assist the delivery of a baby when the second stage of labour has not progressed adequately.

severity and nature of the pain and asked for assistance. Mrs B said that Ms C told her that "they are young and they are panicking".

127. I note that Ms C acknowledged to the MCNZ that she did not make notes of the telephone conversations at that time and just jotted notes about the contractions in her diary. She stated that she wrote only a brief outline of the conversations in the notes, and that they do not contain a description of her decision-making or the discussions she had on the telephone. Ms C's notes do not state that they were made retrospectively, nor do they indicate when they were made. However, Ms A said that after Ms C assisted her to lie on her bed, Ms C said that she was going to write her notes. If notes are made retrospectively, this should be clearly noted, as well as when the notes were made. Again, Ms C's record-keeping was below expected professional standards.

128. I consider that it is more likely than not that Ms A did tell Ms C that she was in severe pain, but Ms C thought that Ms A was exaggerating and did not take her seriously. I accept the advice of my expert that if Ms A had given the impression that she had "niggles" overnight and was just establishing into labour, it was reasonable to advise her to call back when the contractions were stronger and more regular. However, Ms A, Mr A and Mrs B all stated to HDC that they described Ms A's ongoing pain to Ms C. I therefore accept Ms A's evidence that she was experiencing constant pain, and that the extent and nature of her pain was communicated to Ms C.

129. Having accepted this evidence, I consider that Ms C's care of Ms A during the labour and birth was not of an appropriate standard.

Postnatal care

Breastfeeding support

130. During the antenatal period Ms A had told Ms C that she wished to breastfeed her baby. Ms C provided Ms A with a DVD on breastfeeding, but Ms A did not find it helpful. I note Miss Thorpe's advice:

> "When a woman births at home it is not unusual to visit more than once a day especially in the early days to ensure that the latch is correct and that the baby is feeding effectively. When a woman experiences nipple pain, as was the case with [Ms A] this would indicate to most midwives that there was a problem with the latch and attachment of the baby at the breast."

131. There is little evidence that Ms C provided effective advice to Ms A about latching Baby A to the breast. Ms A called Ms C in the evening of either the third or fourth postnatal day in a distressed state, and advised that she was unable to latch her baby, and that the baby had not fed and was crying.[20] Ms C said that she did not assist Ms A because she believed that Ms A had called at an "unreasonable hour". I note Miss Thorpe's advice that LMCs are contracted to provide midwifery support 24 hours a day and, if she could not attend, she would be expected to arrange for a colleague to attend, especially as Ms A had limited support at home. Miss Thorpe advised that

[20] As stated above, Ms A and Ms C have different recollections of when this discussion took place.

most midwives would have visited and set in place a clearly written plan for the woman to follow overnight. Furthermore, the failure to respond caused Ms A to lose confidence in Ms C.

132. I consider that Ms C failed to adequately reassure or assist Ms A. This was particularly important given that Ms C was aware that young mothers require additional support to breastfeed successfully. I note that little or no advice was given, or plans put in place. When asked whether she considered referring Ms A to a lactation consultant, Ms C said that she had told Ms A about a "Mum to Mum" group, but did not refer her to a lactation consultant because she thought that Ms A's breastfeeding would not last. When asked whether she discussed Ms A's breastfeeding with her mentor, Ms C said that the mentor advised her to "hang in there".

133. I accept Miss Thorpe's advice that Ms C provided the very basics of midwifery care, but not enough to meet Ms A's specific needs. Ms C's failure to provide adequate breastfeeding support was a moderate departure from the expected standard.

Perineal tear and healing

134. Following Baby A's rapid birth at home, Ms C examined Ms A's perineal injury and noted that it was a first degree tear that did not involve the vagina, and that it sat well together. Ms C acknowledged that she did not do a thorough examination as Ms A found the examination very uncomfortable. Miss Thorpe advised: "It is very important to do a thorough examination to ensure the extent of the tear does not include the perineal muscles or the posterior vaginal wall …"

135. Ms C said that she did not consider that it was necessary to call for a back-up midwife or a second opinion because the baby had been born in good condition.

136. Ms C said that she did not suture the tear or refer Ms A to hospital in accordance with Ms A's decision. In contrast, Ms A said that Ms C looked at the tear and told her it was a "tiny tear". Ms A said that the options she was given were to stay at home, where the tear would heal normally, or go to hospital for two to three stitches. Ms A said that she would happily have had stitches if they had been needed or if she had been aware of the risks of infection. I find that Ms C did not adequately examine Ms A following Baby A's birth.

Ongoing care of tear

137. Ms C advised Ms A to rest, keep her legs together, and use a cool pad to reduce swelling.

138. Ms A stated that she was in extreme pain, could barely walk, and was unable to sit on the couch because of her discomfort. Ms A said that Ms C checked the tear on most days, which was very painful, and that when she told Ms C the extent of her pain, Ms C told her to keep changing the pad, remain sitting, and get Mr A to bring the baby to her. Ms A said that she told Ms C that she could feel the tear pull open when she walked, and it was very painful when she urinated. Ms A said that she used her dressing gown cord to tie her legs together to minimise the pain.

139. When Ms C discovered that Ms A had tied her legs together it should have indicated to her that Ms A's distress was of concern. Instead, Ms C told HDC that she "had a bit of a giggle" about it and she "thought that any tension in the room was broken with this 'giggle'".

140. I have considered Ms C's submissions in response to my provisional opinion. However, I remain of the view that it was not appropriate for Ms C to fail to give adequate assistance and to laugh when she discovered that Ms A had tied her legs together. I remain of the view that this response was unkind and unprofessional, and it demonstrated a lack of compassion towards Ms A. Ms C, again, did not provide an appropriate standard of care.

Antibiotics

141. On the fifth postnatal day, Ms C recorded that Ms A's perineum was healing but, despite this, she prescribed a week of antibiotics to help reduce the possibility of infection, and she did not take a swab from the wound. Miss Thorpe advised that not taking a swab prior to prescribing antibiotics is a mild departure from the expected standard.

142. Miss Thorpe advised that most midwives would initially consider a lump under a woman's arm to be a blocked milk duct, or a lymph node that was swollen because of an infection of the breast, perineum or uterus. I note the differing accounts in relation to whether Ms C advised Ms A to have the lump checked by a doctor immediately or to wait for one week. In the circumstances, in the absence of any supporting documentation, I am unable to reach a conclusion about what advice was given.

143. Ms C recorded between the seventh and twelfth day after the birth that the tear was healing well. However, on the ninth day after the birth, she noted that Ms A was feeling feverish and slightly faint. Nonetheless, she did not assess Ms A for other signs or symptoms of infection.

144. On the 22nd postnatal day, Ms C recorded that Ms A's labial tear was still tender but the perineum was healing well. Ms C was then absent until the 26th postnatal day. Ms A did not want to be treated by Ms C's colleague, and Ms C made no alternative arrangements. Therefore, Ms A had no midwifery care during that period. In my view, Ms C should have suggested alternative options to Ms A, such as the contact details of the hospital midwives, or advised her to contact her GP if her symptoms worsened.

145. When Ms C returned, Ms A was very unwell. Ms C took a swab, prescribed a one-off dose of metronidazole, and planned to telephone Ms A at 5pm and see her the following day. Miss Thorpe advised that "it would be unusual to leave a woman in this condition at home and most midwives would arrange for an immediate admission to hospital for an obstetric assessment with a view to commencing intravenous antibiotics".

146. It is evident that Ms C did not, at any stage, examine Ms A's perineum adequately, and continued to believe that the tear was minor with no perineal muscle or vaginal wall involvement. Accordingly, Ms C failed to recognise the unsatisfactory perineal healing. Ms C inappropriately prescribed antibiotics and failed to take appropriate

steps when Ms A's condition deteriorated. Again, Ms C failed to provide services to Ms A with reasonable care and skill.

Conclusions

147. In my view, the care Ms C provided to Ms A was unsatisfactory. Ms C failed to appropriately complete a birth plan, including the options of pain relief. She also failed to discuss the administration of vitamin K to the baby, and did not ensure that Ms A was adequately educated about child birth, including encouraging her to attend antenatal classes. Furthermore, Ms C inappropriately prescribed evening primrose oil.

148. When Ms A and Mr A contacted Ms C for assistance in the early hours of the day the baby was born, Ms C failed to respond appropriately to the information she was given. In my view, even if it was likely that Ms A was in early labour, Ms C should have attended and provided reassurance and support, particularly in light of Ms A's youth and personal circumstances. Once Baby A was born, Ms C did not provide adequate breastfeeding advice and support. In particular, when Ms A was distressed and asked for assistance, Ms C refused to attend, advising that it was an unreasonable request.

149. Ms C failed to adequately assess Ms A's perineal tear or make appropriate assessments of its healing. Ms C prescribed antibiotics without clear rationale and without taking a swab to assess whether there was an infection, and prescribed a dose of antibiotic to a woman who, as advised by Ms Thorpe, was exhibiting very obvious signs of puerperal sepsis.

150. Ms C's records were superficial and, in some respects, misleading. She recorded that she had attended the birth when she did not do so, and failed to note the fact that she had attended only the delivery of the placenta. She did not indicate that the records of the telephone calls she received while Ms A was in labour were made retrospectively.

151. Miss Thorpe advised that a number of these various failures were moderate departures from the expected standard.

152. I have considered Ms C's response to the provisional opinion, however I remain concerned that Ms C appears to lack insight into her lack of compassion toward Ms A and her inadequate clinical competency. When interviewed by HDC staff she was asked what she would do differently should a similar situation arise. Her response was that she has improved her documentation, would call an obstetrician before prescribing antibiotics, and now seeks more support from her practice colleague.

153. In my view, Ms C: failed to provide adequate antenatal advice; failed to communicate effectively with Ms A and her supporters; failed to attend the labour; did not provide adequate breastfeeding advice and support; did not assess the perineal tear adequately and provide appropriate treatment of the tear; and did not prescribe medications appropriately. I have concerns about the collective number of moderate departures from expected standards in this case, and consider that, overall, Ms C's care of Ms A was seriously sub-optimal. I find that Ms C failed to provide services to Ms A with reasonable care and skill and, accordingly, Ms C breached Right 4(1) of the Code.

154. By failing to document significant events, discussions and decisions, by recording that she attended the birth when she only attended the delivery of the placenta, and by not recording that she made her notes retrospectively, Ms C did not meet professional standards. Ms C's inadequate and misleading records were a breach of professional standards and, accordingly, I find that she breached Right 4(2) of the Code.

Recommendations

155. I recommend that Ms C:

- apologise to Ms A. The apology is to be sent to this Office by **26 July 2013** for forwarding to Ms A;
- organise a special Midwifery Standards review through New Zealand College of Midwives, particularly focused on her documentation;
- reflect on her failings in this case and provide a written report to HDC on her reflections and the changes to her practice she has instigated as a result of this case;
- undertake further training with regard to vitamin K consent, administration and record-keeping and provide HDC with evidence of this training;
- ensure that all her clients have written care plans, and arrange an audit of her current clients to confirm that she has done so;
- undertake further education and training on documentation and care plans in conjunction with the New Zealand College of Midwives; and
- undertake further training on communication with clients in conjunction with the New Zealand College of Midwives.

156. Ms C should provide a report to this Office by **20 December 2013** confirming her compliance with the recommendations of this report, including confirmation of her attendance at the agreed workshops or confirming her enrolment at the relevant upcoming workshop, and providing a copy of her documentation audit report. Ms C should provide a further report to this Office by **30 May 2014** confirming her compliance with the remainder of the recommendations of this report.

157. I recommend that the Midwifery Council of New Zealand review Ms C's compliance with the recommendations made by the DHB, and also the recommendations in this opinion, and report to HDC on the review by **20 December 2013**.

Follow-up actions

158.
- Ms C 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 New Zealand Midwifery Council, the New Zealand College of Midwives, and the District Health Board, and they will be advised of Ms C's name.

- 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

The Director of Proceedings decided to issue proceedings In the Human Rights Review Tribunal against the midwife.

The Director brought proceedings against Ms C. Ms C was found to be in breach of Rights 4(1), 4(2) and 4(4) of the Code for failures in midwifery care provided to Ms A. Ms C failed to develop a sufficient birth plan, provide adequate information to Ms A about the labour process and caring for a newborn, and appropriately document her care of Ms A. She failed to attend the birth of Ms A's baby when birth was imminent, failed to adequately examine Ms A for perineal damage, refer Ms A to a medical practitioner for examination and assessment of Ms A's perineal damage and failed to appropriately manage Ms A's puerperal sepsis. In addition, Ms C prescribed anti-biotics without a clinical rationale (for example test results) and failed to adequately respond to Ms A's requests for assistance with breastfeeding.

Issues relating to damages and costs were resolved between the parties by negotiated agreement.

Appendix A — Independent Expert Advice

"I have been asked to provide further midwifery advice to you, the Health and Disability Commissioner, regarding the midwifery care provided by midwife [Ms C] for [Ms A].[21]

I am an independent midwife who has been registered for twenty two years and has been providing an independent midwifery service to the women of Christchurch for twenty years. I also have a Masters Degree in Midwifery. I am an active member of the New Zealand College of Midwives (NZCOM) and have been a midwifery reviewer for the Canterbury/West Coast region NZCOM Standards Review Committee for over twelve years. I have also worked for the New Zealand Midwifery Council on Competence Review Panels and Professional Conduct Committees, as well as providing midwifery advice to ACC. I am currently an appointed member of the Health Practitioners Disciplinary Tribunal.

I have read and agreed to follow the Commissioners Guidelines for Independent Advisors.

I have also closely **reread** the following information prior to writing this advice.

Supporting Information

1. [Dr D's] letter to the New Zealand College of Midwives
2. Letter to [the] Midwifery Council, from Dr D
3. Investigation by the DHB into a reportable event with regard to [Ms C's] care of [Ms A] written by [the] Midwifery Advisor, the DHB
4. [Ms C's] letter to [Ms E], Midwifery Advisor, Midwifery Council regarding the complaint
5. NZCOM Legal Advisor [Ms C's lawyer] letter to [Ms E], Midwifery Council
6. [Ms A's] maternity notes

My preliminary advice was completed in August 2012. I have subsequently been provided with the following additional information on which to review this case.

1. [Ms C's] record of her clinical experience during her midwifery education, including her academic transcript
2. A birth plan template and a pregnancy and parenting booklet.
3. Her Midwifery Standards Review Certificate and Professional Development Plan (23/04/12)
4. Letter to [Ms C] from [Ms E] at the Midwifery Council notifying her of the Competence Review Panel's decisions (27/09/12)
5. Letter to … HDC investigator, from [the] Chief Medical Officer at the DHB (21/11/12).
6. Letter to Mr Anthony Hill (HDC) from [Ms C] (6/12/12)

[21] Miss Thorpe provided preliminary advice to the Commissioner prior to the investigation commencing. Only her advice provided during the investigation is reproduced here

7. Transcript of interview with [Ms C] conducted by [HDC Investigators] (1/03/13).
8. Transcript of interview with [Ms A] conducted by [HDC Investigators] (1/03/13).
9. Transcript of phone call interview with [Mr A] conducted by [HDC Investigator] (15/03/13)
10. A provisional report by the Health and Disability Commissioner (15/03/13)

Advice requested.
The purpose of this advice is to enable the Commissioner to determine whether there are concerns about the care provided by [Ms C] and whether the care provided was appropriate and met the expected standards of midwifery care.

In particular:
1. Please comment generally on the standard of care provided by [Ms C].
2. What standards apply in this case?
3. Were those standards complied with?

I have also been asked where there are two versions of the facts, to provide advice in each situation. I will go through the advice I have already provided and where there have been any changes to my opinion due to the new information, I will write in italics.

The appropriateness of the care provided to [Ms A] during the antenatal period. In particular:

- **the advice given to [Ms A] in relation to her history of abuse**
- **the advice [Ms C] provided [Ms A] about antenatal classes**
- **the management of the birth plan.**

History of abuse.
There is clearly documented on the [date of first meeting with Ms A], recent history of abuse from [Ms A's] partner [Mr A] but no plan put in place for [Ms A] with regard to this. [Ms C] documents at the next visit that she has discussed postnatal support groups, [a parenting group] and a referral to a dietician due to [Ms A's] absence of weight gain. This appears reasonable but doesn't address the previous abuse and any discussion about [Ms A's] safety where she is currently living. This is of concern as [Ms A] is living in the house with her previously abusive partner and his parents. It may be that the parents were providing guidance at this home but there is no documentation indicating this. Some women in abusive relationships request that details of the abuse is kept out of their notes, for fear of it being read by their partner. What most midwives would do in this situation is to write separate notes which the woman does not hold. I did not see any evidence of this. By the end of the pregnancy it appears that [Ms A] and [Mr A] were living alone together. There was a social work referral but no further plan or follow-up documented.

[Ms A] states that [Ms C] followed up during the pregnancy with regard to her safety but that she did not feel that she needed to access supports as they both 'grew up a bit' (March 2013).

[Ms C] states that she did not action the social work referral as she was aware that [Ms A] and [Mr A] were already having counselling through [...] and that [Ms A] was not keen on another referral.

In my original report I stated that failure to refer had been a mild departure from the expected standard but it appears that [Ms A] was already receiving help from an agency and [Ms C] was supporting her wishes. This appears to be reasonable care and meets the acceptable standard, in particular — ***Standard Five: midwifery care is planned with the woman (NZCOM 2008).***

Where she did not meet the Standards was [Ms C's] lack of documentation with regard to the conversations she had with [Ms A] about her safety and this appears to be something that has been addressed at her DHB review and her Midwifery Standards Review resulting in her needing to complete an NZCOM documentation workshop (booked for March 2013).

In this situation [Ms C] did not meet the expected standards and in particular — ***Standards Three and Four: the importance of collating purposeful and on-going updated records (NZCOM 2008).***

*[Ms C] has stated that she has made changes to her documentation following this experience. She says '****I agree that my documentation was not of an appropriate standard. I believe my documentation has improved to an appropriate standard as a result of this process'. (6/12/12)***

Antenatal classes and the birth plan.
[Ms C] stated that they had discussions about what to expect when the baby is born and some discussions around labour *(March 2013).* There is no birth plan. There is mention of epidural and pain relief options *in the midwifery notes* but no discussions around, for example: when to call if labour is suspected, what to do if waters break or blood is passed, if baby's movements were reduced, support for the labour and postnatal period, third stage, vitamin K.

There is also mention on [date] at 37 weeks of the use of evening primrose oil capsules and that [Ms A] should take 2 every day in the morning for a week. This is not evidence based advice and I am not sure why it was recommended other than anecdotal suggestions that it may help to ripen the cervix. The scientific evidence suggests that it is not recommended in pregnancy as studies have found that it does not shorten the pregnancy nor the length of a woman's labour and is associated with an increased risk of premature rupture of the membranes, oxytocic augmentation and ventouse extraction (Dove & Johnson 1999, Ernst 2002). There was no documentation to indicate why [Ms A], a well healthy woman at 37 weeks, would require anything to ripen her cervix, as she still had 3 weeks of her pregnancy to go.

In [Ms C's] most recent statement (March 2013) she says with regard to evening primrose oil 'Anecdotally it brings labour on...had seen other midwives using it…I hadn't researched any side effects'.

I am concerned about recommending evening primrose oil to a young healthy woman with no rationale in the notes as to why this was suggested. This advice would not be supported by the NZCOM (NZCOM Consensus Statement, Complementary Therapies, 2009). *It does not meet the standards and in particular* ***Standard Seven****:* ***the midwife ensures that her practice is based on relevant and recent research.***

[Ms C] has subsequently stopped prescribing evening primrose oil as a result of this experience.

Overall I found the documentation to be lacking in advice or any clear plans for [Ms A] to follow, especially with regard to signs of labour, when and why to call etc. [Ms C] states that she discussed these details with [Ms A] but most midwives would write a 'check-list' for women to easily access and refer to when in labour.

The antenatal care was adequate but I do not feel that it met all of [Ms A's] needs and this may have contributed to the lack of understanding when she went into labour, resulting in the unattended birth.

*Having read the additional material for this further opinion I don't believe I need to change my overall assessment of the issues above. With regard to antenatal classes however, [Ms C] said that she recommended them to [Ms A] but did mention to her that '****she may feel uncomfortable****'. From [Ms A's] point of view this was certainly the message that she received but was reassured by [Ms C] that she would provide her with the necessary information if she chose not to attend classes.*

*[Ms A] believes that she did not receive that information. From my understanding of the statements I have read, [Ms A] did not feel that [Ms C] had discussed very much with her at all. She says in her statement '****She said she would teach me everything the class would be taught but never got to that stage because the baby was born early'.***

[Ms A's] baby was born at 38 weeks which is not early. Full term is any time from 38–42 weeks gestation. In the Handbook for Practice (NZCOM 2008) there are decision points which clearly outline the expected time frames for discussions with women. From 16 weeks on there is an expectation that midwives begin discussing the details of the birth plan so that there is time to look at various information sources so women can make their own decisions (pg 21, NZCOM 2008). [Ms A] does not appear to feel that she was given the information she was hoping to receive within the time frame expected. If that is the case then [Ms C] did not meet the standards required.

In particular:

Standard Two: the midwife shares relevant information, including birthing options and is satisfied that the woman understands the implications of her choices.

Standard Three: acknowledges the individual nature of each woman's pregnancy in her assessments and documentation.

Standard Four: maintains purposeful, on-going, updated records and makes them available to the woman.

Standard Five: provides information from her knowledge and experience — demonstrates in the midwifery care plan an analysis of the information gained from the woman.

In [Ms C's] statements she said that she gave [Ms A] a handout of what to expect. The handout that I have received with the other documents does not outline anything about labour. There is no check list for when labour begins, when to call or any information about Vit K, third stage etc.

She said that she gave [Ms A] a birth plan. The birth plan template I received has nothing completed in it except for ***'When to Contact Midwife: membranes rupture, if liquor green or any hanging objects ASAP. Otherwise during daylight hours. When contractions are 1:5–10 mins. Stay at home as long as possible. I will come and assess you at home before transferring to the Maternity Unit'.***

These instructions are vague and confusing. Contractions can be every 2 minutes and mildly uncomfortable, they may also be every 10 minutes and excruciating. No labour is the same and every woman's experience of labour is unique to them so it is certainly not helpful to be prescriptive. By 'hanging objects' does she mean umbilical cord, mucous, blood clots? This comment is obscure and undefined. Contact during daylight hours indicates that [Ms C] was not available if [Ms A] had concerns in the night time which is unfortunate when many labour calls happen at night.

There is nothing from the extra material that I have received that makes me believe that [Ms C] had prepared [Ms A] well for her imminent labour and birth. She did not meet the Standards as mentioned above (Stds 2, 3, 4 and 5).

I believe that the antenatal care and documentation of such, was a ***moderate*** *departure from the expected standard.*

Labour Care

- **Whether the advice provided to [Ms A] and her support people was reasonable in the circumstances?**

[At 38 weeks], [Ms A] goes into labour. There appear to be discrepancies between when and how often [Ms C] was called during that morning but it is apparent that the communication between both parties was not clear. [Ms C] was under the impression that [Ms A] was in the early stages, yet with hindsight we know that she was in advanced labour and close to birthing. It was not unreasonable for [Ms C] to believe that this was early labour. Most women having their first baby experience on average 12–18 hours of regular contractions before they are ready to birth their baby (NICE 2007). [Ms C] was under the impression that [Ms A] had had 'niggles' overnight and was just establishing into labour.

In [Ms C's] statement she says she was called at 0540hrs and that [Ms A] did not indicate 'any undue pain or stress' so [Ms C] said she would ring back in two hours and 'I said to ring back if membranes ruptured or stronger contractions' (March 2013).

To advise [Ms A] to call back when the contractions were stronger and more regular was reasonable. [Ms A] and [Mr A] state that they requested her attendance earlier and it is likely that had [Ms C] realised that the labour was so advanced, she would have attended when first called. It is sometimes hard to gauge what is happening in a labour over the phone and a midwife relies on the information she receives from the woman and her family. [Ms C] mentioned that she spoke to [Ms A] for ten minutes and that [Ms A] didn't have a contraction over that time. This would indicate to most midwives that the woman was in early labour.

[Ms C] then stated that there was a second call 40 minutes later when she spoke with [Ms A's] Mum who said [Ms A] was feeling pressure and [Ms C] said she was 'on her way'. If this was the case then [Ms C] provided prompt appropriate care of the expected standard (March 2013).

In [Ms A's] statement however she says they called [Ms C] at 0600hrs, 0610hrs, 0617hrs, 0622hrs and each time they called she said they would have to wait for a few hours (March 2013). Even if a midwife believed that the woman was in early labour, to be called so many times in such a short period would indicate that this family was not coping and required midwifery support and assessment. Certainly in this version of events the advice to call back when the contractions get stronger and 'I will come in six hours' was entirely unreasonable. If the family had called [Ms C] that frequently and she did not see the need to attend [Ms A], then this would have been a ***moderate*** *departure from the expected standards. In particular:* ***Standard 6 — Midwifery actions are prioritized and implemented appropriately with no midwifery action or omission placing the woman at risk.***

- **Please comment on the content of the notes and the failure to indicate that they were made retrospectively.**

[Ms C] has documented in the midwifery notes three phone calls at 0546, 0630 and 0631. This matched her version of events but she has subsequently stated that they were written in retrospect. This was not indicated in the notes. This is unfortunate as we do not know exactly when they were written and their accuracy would rely on [Ms C's] memory of the events. Contemporaneous notes are the expected standard. Phone logs should be kept and be updated as soon as possible after the actual event and the details of any conversations written in the midwifery notes. It is understandable that when a midwife has to attend a woman urgently the notes are not an immediate priority but most midwives would jot down brief notes at the time to refer to later. The fact that the midwifery notes weren't written contemporaneously makes it difficult to verify [Ms C's] account of the events.

As mentioned previously, [Ms C] has attended a documentation workshop which would have addressed these issues and as she noted in her letter to Mr Hill ***'I now endeavour to write much clearer more in depth notes'*** *(December 2012).*

When she arrived she provided reasonable care in that she assessed the condition of the baby, [Ms A's] blood loss, the birth of the placenta etc. It is unfortunate that she did not call a second practitioner for help and advice. Most home birth midwives would still call a second midwife to attend so that if there were any concerns with either mother or baby in the immediate postnatal period, there was an extra pair of skilled hands available. As a new practitioner this is particularly important.

[Ms C] notes that she would now always have a second midwife present at a home birth. However the immediate postnatal care appears to have met the expected standard other than the examination and assessment of the perineal injury which I will address later.

The appropriateness of the advice [Ms C] provided [Ms A] in relation to breastfeeding.

I cannot find any discussion in the antenatal notes with regard to breastfeeding other than under breastfeeding history, 'will breastfeed'. It is well documented in the research that some teenage mothers struggle with breastfeeding and need extra support and education to continue to feed their baby the breast (Hunter 2008, Mossman et al 2008). When a woman births at home it is not unusual to visit more than once a day especially in the early days to ensure that the latch is correct and that the baby is feeding effectively. When a woman experiences nipple pain, as was the case with [Ms A], this would indicate to most midwives that there was a problem with the latch and attachment of the baby at the breast (Lawrence and Lawrence 2005). At the second postnatal visit [Ms C] notes that [Ms A's] breasts are full but there is no plan for [Ms A] as to how to manage this and no mention of how the baby is latching or ?nipple tenderness. At the third visit she notes that 'breasts are full today, nipples tender' but there is no mention of a discussion around latching or what might be causing the tenderness. When [Ms A] called [Ms C] that evening (7–9pm) to say she was unable to latch her baby, [Ms C] did not offer to visit her and I believe that this was a **moderate** departure from the expected standard of care. I am also very concerned that her mentor suggested that she did not need to visit at an 'unreasonable' hour. As an LMC, [Ms C] is contracted to provide midwifery support 24 hours a day. If she could not attend then I would expect her to arrange for a colleague to attend, especially as [Ms A] had limited support at home. This would have been a crucial time in [Ms A's] breastfeeding experience. Most midwives would have visited and set in place a clearly written plan for the woman to follow overnight. If [Ms C] had attended and provided useful advice, it is possible that [Ms A] may well have continued to have breastfed.

It appears from the new information that [Ms C] has reflected on this and made significant changes to her practice as a result. For example: ***'I make myself more available to my clients for breast feeding support now, ensuring my visits coincide with the baby's feeding times' (Dec. 2012.)*** *She has a rural mentor and a Midwifery Council appointed supervisor who [are] both near her now which is also pleasing to see.*

By Day 3 [Ms A] had red painful breasts and tender nipples and was feeding her baby expressed breast milk with a bottle. There was some advice with regard to softening

the breast with a pump to aid the latch but no follow up plan if this was not effective. Although [Ms C] visited regularly during this time it appears from the documentation that there was little or no advice given or plans put in place. The ongoing nipple tenderness was not addressed and by Day 4 [Baby A] was completely bottle-fed and by Day 12 was having formula. I believe that this was a moderate departure from the expected standard.

I do not know what services are available in [the area] for breastfeeding support but most midwives would have referred their client who was unable to breastfeed in the first postnatal week to a lactation consultant, or another midwife, if the extent of their expertise was not enough for their client. The NZCOM Standard 6 was not met in this case — Midwifery actions are prioritized and implemented appropriately with no midwifery action or omission placing the woman at risk. In particular this standard refers to the responsibility of a midwife 'to refer to the appropriate health professional when she has reached the limit of her expertise' (p.11, NZCOM 2008).

[Ms A] showed her desire to breastfeed by making an attempt to re-establish her milk supply when in hospital with puerperal sepsis and it is unfortunate that this was not successful.

I am of the opinion that [Ms C] provided the very basics of midwifery care but not enough to meet the specific needs of this teenage mother and was a **moderate** departure from the expected standard.

The appropriateness of the care and advice [Ms C] provided [Ms A] in relation to the management of the perineal tear.
When [Ms C] examined [Ms A's] perineal injury she noted that it was a first degree tear and did not involve the vagina and that it sat well together. In her letter to [Ms E] she acknowledged that she did not do a thorough examination as [Ms A] found it very uncomfortable. She said that the tear extended 3 cms and also involved a labial tear, the clitoral hood and the forchette. It is very important to do a thorough examination to ensure the extent of the tear does not include the perineal muscles or the posterior vaginal wall, and I don't believe that [Ms C] did this. Whether this was due to inexperience or because she did not want to cause [Ms A] any additional pain it was unfortunate as it appears that the tear was likely to have been more extensive than she thought. This would have been the best time to seek a second opinion and [Ms C] has subsequently changed her practice to include a second practitioner, as the result of this experience. [Ms A] said that she was not sutured because [Ms C] did not carry any suturing equipment and [Ms C] says she didn't suture as this was [Ms A's] wish. Whatever the reason the assessment of [Ms A's] wound was less than satisfactory.

*In [Ms A's] statement she said **'I asked her three times. I asked her directly "do I need stitches"? She said "No". I would happily have had stitches if needed'.** [Ms A's] version of events tells me that if [Ms C] had felt that stitches were required then [Ms A] would have had them. If this is the correct version then it would seem that as mentioned above that [Ms C] had not made an accurate assessment of the perineal injury for if she had she would have sutured it.*

This does not meet the standards and in particular ***Standard 6 — Midwifery actions are prioritized and implemented appropriately with no midwifery action or omission placing the woman at risk.***

[Ms C] says in her statement ***'I recommended that she needed sutures. Talked about the tear. She ([Ms A]) said that she would do anything not to have it sutured. I supported her'****. If this was the correct version of events it was reasonable to not suture if [Ms C] believed that the tear was superficial.*

She said, however, that she recommended sutures so she was aware that the tear was of some significance. In her letter to [Ms E] (April 2012) she acknowledged that she ***'wanted to suture to ensure it healed well together … I wanted to be more authoritative and tell her that she needed sutures but I couldn't'****.*

This does not meet the expected standard of care and in particular ***Standard 6 — the midwife has the responsibility to refer to an appropriate health professional when she has reached the limit of her expertise.*** *This would have been the perfect time to call for a second opinion from a colleague but she didn't. Most midwives would see this as a* ***moderate*** *departure from the expected standards.*

[Ms C] now states that she ***'will take back up to any births, regardless of the situation'*** *(Dec. 2012)*

[Ms C] clearly wrote in [Ms A's] notes how she should care for the area. That she would need to rest, to keep her legs together and to use a cool pad to reduce the swelling. From [Dr D's] letter it appears that [Ms A] told her that she took this literally and tied her legs together. There is no mention of this in the midwifery notes.

There is no mention of [Ms A's] perineum again until Day 3 when [Ms C] notes 'perineum tender, visualised, no discharge or infectious signs. Skin tag on lower forchette still looks bruised. Healing well tho. Try and stay sitting and relaxed this week to help heal'. I am not sure what she means by the lower forchette but the advice was reasonable. She checked the area again on Day 4 and noted that it looked much better and discussed hygiene when toileting. This is reasonable care.

On Day 5 she says that the perineum is healing but prescribes a week of antibiotics 'to help reduce infection'. She does not take a swab from the wound and I am unsure as to why she would prescribe antibiotics unless she felt there was an underlying infection. A swab would have provided useful information. The results would have determined whether there was an infection and if the drugs prescribed were the most appropriate. Not taking a swab prior to prescribing antibiotics would be a **mild** departure from the expected standard.

There is a discussion about a swollen lump in [Ms A's] arm pit. At this stage she has stopped breastfeeding so most midwives' first thought would be a blocked milk duct or a swollen lymph node due to an infection of the breast, perineum or uterus. [Ms C] says that the lump was an infected cyst and that the GP would have prescribed the same antibiotics but I believe most midwives would have sought a second opinion

with this clinical picture. I believe that this is a **mild** departure from the expected standard.

[Ms C] examined [Ms A's] perineum at Day 7 and then at Day 12 and notes on both days that it is healing well. Previously on Day 9 she notes that [Ms A] is feeling feverish and slightly faint. This is not a normal condition at 9 days following birth and once again I would be assessing for any other signs or symptoms of infection and possibly seeking a second opinion to determine if the current management plan is working and examine her perineum more closely. [Ms C] did not do this and I see that as a **mild** departure from the expected standard.

By Day 17 [Ms A's] labial tear is still tender but [Ms C] says the perineum is healing well. She does not note whether she has visualized it that day but by Day 21 [Ms A] has become very unwell. She is clammy and cold and has had a fever all day. Her lochia smells offensive. [Ms C] has a look at [Ms A's] perineum and says that the labia is not swollen but that there is a discharge present and [Ms A] is tender in her groin. She takes a swab and prescribes a one off dose of metronidazole and plans to phone her at 5pm and then see her again the next day. It is clear that [Ms C] has not appreciated the serious nature of [Ms A's] condition. It would be unusual for a midwife to leave a woman in this condition at home and most midwives would arrange for an immediate admission to hospital for an obstetric assessment with a view to commencing intravenous antibiotics.

It is also apparent that [Ms C] did not examine [Ms A's] perineum closely enough at any of the postnatal visits. I can only assume that because she believed it was a minor tear, with no perineal muscle or vaginal wall involvement, she did not need to be more thorough in checking. However with the clinical picture that presented it would be important to work out where the source of the infection was coming from and [Ms C] did not do this. She failed to recognise unsatisfactory perineal healing. This was a **moderate** departure from the expected standard.

Whether it was appropriate for [Ms C] to go on leave without organising any follow-up for [Ms A].
From my reading it would appear that [Ms C] took a week off [...] when [Ms A's] baby was 17 days old. Most midwives would be visiting once a week after the first two weeks so it was not inappropriate for [Ms C] to be away for a week as long as [Ms A] had the contact details of [Ms C's] colleague. In her letter to [Ms E] (April 2012) she said ***'She was aware of how to get in touch with [my colleague], as [my colleague] had my phone and would be available to [Ms A] at any stage'****. It would have been good to have seen this plan documented in the midwifery notes but once again the notes were of a poor standard. However, the back-up appears to have been arranged and there is nothing in [Ms A's] statement to say that this was a concern for her.*

In Summary.
Throughout this opinion I have found mild and moderate departures from the expected standard of care required of an LMC midwife. However it must be noted that [Ms C] has reflected on this experience and is addressing the professional requirements of Standards Seven and Eight.

Standard Seven — the midwife is accountable to the woman, to herself, to the midwifery community and to the wider community for her practice.

Standard eight — the midwife evaluates her practice (NZCOM 2008).

In particular it appears that [Ms C] has recognised her own learning needs and has found opportunities to have these met. She says 'I have made extensive efforts to engage my peers and health professionals to reassure them of my willingness to learn from this incident and to identify where my skills need addressing'. The investigation completed by the the DHB set out a very comprehensive list of recommendations which included everything from attending a workshop in perineal assessment and suturing through to developing more effective ways of accessing support and resources in her obstetric and midwifery community. The Midwifery Council noted [the DHB] education programme and also recommended a Competence Review to investigate [Ms C's] practice systems and to assess her knowledge concerning decision making throughout the antenatal, labour and birth, and postnatal periods. It also suggested looking in particular at postnatal infections and [Ms C's] prescribing practices.

[Ms C] made submissions to the Competence Review Panel on the 21st June 2012. The Midwifery Council noted that it continued to have concerns about her competence so set in place that she attends compulsory education and that she may only practice as a midwife under supervision. The supervision includes monthly case reviews.

Finally, I am not sure what further action HDC would take. [Ms C] has a detailed education/supervision plan in place and has noted that she has thoroughly reflected on this case and made significant changes to her practice as the result.

I hope this helps you further in your assessment of this case.

Regards, Juliet Thorpe, Midwife

References

Hunter 2008. Teenager's experience of postnatal care and breastfeeding. British Journal of Midwifery, 16 (12): 785–790.

Lawrence R, Lawrence R 2005. Breastfeeding: a guide for health professionals (6th edn), Mosby, St Louis.

Mossman M, Heaman M, Dennis C et al. 2008. The influence of adolescent mothers breastfeeding confidence and attitudes on breastfeeding initiation and duration. Journal of Human Lactation 24 (3): 268–277.

National Institute for Health and Clinical Excellence (NICE) 2007. Intrapartum care. Clinical guidelines. NICE, London.

National Institute for Health and Clinical Excellence (NICE) 2008a. Antenatal care. Routine care for the healthy pregnant woman. Clinical guidelines. NICE, London.

National Institute for Health and Clinical Excellence (NICE) 2008b. Guidelines on Induction of Labour. NICE, London.

New Zealand College of Midwives (NZCOM) 2008 Handbook for practice. NZCOM, Christchurch, NZ

New Zealand College of Midwives (NZCOM) 2009 Consensus Statement-Complementary Therapies. NZCOM, Christchurch, NZ