Midwife, Ms B

A Report by the

Health and Disability Commissioner

(Case 12HDC01474)

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

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Executive summary

1. In October 2011, Ms A became pregnant with her first child. Ms A engaged a midwife, Ms B, as her Lead Maternity Carer (LMC).

2. Ms B saw Ms A regularly throughout the antenatal period.

3. When Ms A was 35 weeks' gestation, Ms B noted that there had been no growth of the baby for the previous two weeks. Ms A was referred for a growth scan, and Ms B recommended that Ms A have the scan within the next week. Ms B documented the details of this consultation and recommendation for a scan in a retrospective entry recorded a week later, on the day the baby was born.

4. The growth scan revealed an abnormal collection of fluid in the fetal abdomen, reduced amniotic fluid suggesting a possible renal abnormality, and obstruction of the vessel joining the kidney and bladder. The results and the need for an urgent referral to hospital were communicated to Ms B by a radiologist, and a copy of the scan report was sent to the hospital at Ms B's request.

5. Ms A later contacted Ms B by telephone but was told not to worry. A midwife at the hospital then contacted Ms B and requested she ask Ms A to go to the hospital that day for blood tests. Ms B sent Ms A a text message asking her to go to hospital that day, if she could. Ms B did not document this request.

6. Although Ms A did not realise there was any urgency in going to the hospital for testing, she went later that day. Ms A was subsequently admitted for monitoring, which continued over the next two days.

7. Ms A underwent a Caesarean section, and the baby was admitted to the Neonatal Intensive Care Unit (NICU).

8. Ms B saw Ms A in hospital twice following the birth. Although there is no documentation relating to Ms B's first visit, Ms A confirmed that Ms B visited her briefly while she was on the ward. On the second visit, Ms B made an entry in Ms A's clinical records instructing staff to notify her back-up midwife, Ms C, if Ms A was discharged over the weekend, as Ms B was on leave between Friday and Monday. Ms A was discharged from hospital on Friday.

9. Ms C saw Ms A at home on Sunday. Following Ms B's return from leave on Monday, Ms B sent a text message to Ms A on Thursday to arrange a visit. On Friday Ms A sent a text message to Ms B advising her that she no longer needed her services and had found a new midwife.

10. Ms B did not document any of her postnatal contacts with Ms A.

Decision

11. In my view, the care Ms B provided to Ms A was unsatisfactory. Ms B failed to recognise the need to refer Ms A for a growth scan in a timely manner when the baby's growth stopped.

12. Following receipt of the scan results, Ms B failed to respond to the urgency of the situation and, as a result, did not adequately communicate to Ms A the need for urgent follow-up.

13. Ms B also failed to provide Ms A with adequate postnatal care that met her needs.

14. In my view, the series of failures in the care Ms B provided to Ms A suggest a pattern of suboptimal care. As a result, Ms B breached Right 4(1) of the Code of Health and Disability Services Consumers' Rights (the Code).[1]

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

Complaint and investigation

16. The Commissioner received a complaint from Ms A about the care she received during her pregnancy and following birth. The following issue was identified for investigation:

> *The appropriateness of the care provided to Ms A by Ms B during her pregnancy in 2011/2012.*

17. An investigation was commenced on 4 June 2013.

18. The parties involved in the investigation were:

Ms A	Consumer/complainant
Ms B	Provider, LMC midwife
Ms C	Provider, back-up midwife

19. Independent expert advice was obtained from a midwife, Ms Stephanie Vague (**Appendix A**).

[1] Right 4(1) of the Code states: "Every consumer has the right to have services provided with reasonable care and skill."
[2] Right 4(2) states: "Every consumer has the right to have services provided that comply with legal, professional, ethical, and other relevant standards."

Information gathered during investigation

Background

20. In late 2011, Ms A (who was 29 years old at the time of these events) became pregnant with her first child.

21. Ms A engaged a midwife, Ms B, as her Lead Maternity Carer (LMC). Ms A saw Ms B for a booking visit, and was seen regularly thereafter throughout the antenatal period.

Ultrasound scans

22. Ms A had a first trimester ultrasound scan. Because the nuchal translucency[3] could not be assessed properly, a further scan was recommended in a week's time. This was carried out, and was normal.

23. A second trimester anatomy ultrasound scan was performed and was normal.

Growth measurements

24. Ms B commenced fundal height measurements[4] when Ms A was 26 weeks' gestation. Measurements were initially normal and equal to the weeks of gestation.

25. Ms A said that on a number of occasions she asked Ms B to refer her for a growth scan because she was concerned about the baby's growth and wanted to confirm the baby's sex, but Ms B kept refusing, until Ms A "insisted" on a further scan when Ms A was 35 weeks' gestation.

26. Ms B advised HDC that Ms A requested a growth scan when she was 33 weeks' gestation, and that she advised Ms A that one was not clinically indicated at that time. Ms B stated:

> "I advised [Ms A] that I did not think this was clinically indicated. Baby was moving well according to her reports, the fundal height was within acceptable parameters and baby was definitely growing each week. I reassured [Ms A] that we would keep a close eye on matters. [Ms A] appeared to accept my advice and did not raise the matter further."

27. This discussion is not documented in the patient records.

Assessment

28. At 35 weeks' gestation, Ms B noted that there had been no growth in the fundal height for the past two weeks and requested an ultrasound scan. The contemporaneous records from this consultation state: "[W]ell for scan as [sic] [Ms A's] request."

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[3] The clear space in the tissue at the back of the baby's neck, which can help assess whether the baby is at risk of Down syndrome and some other chromosomal abnormalities.

[4] The distance from the pubic bone to the top of the uterus. This measurement is done through abdominal palpation and assists in the assessment of the baby's size, growth rate, and position.

29. Ms B made a retrospective note[5] which stated:

> "Fetal growth no change for 2 week. For scan. Form given. Other assessment within normal. Will see after scan."

30. In a statement to HDC, Ms B advised that, when she saw Ms A at 35 weeks, she noted that the baby had not grown for two weeks and referred Ms A for a growth scan. Ms B said that she recommended that Ms A have this scan within the next week. Ms B stated that she "saw no immediate need to perform a growth scan [on that day]" because "[a] single instance of measurement of non reassuring fundal-symphysis height at 35 weeks was not indicating any urgent scan [sic], given that baby was active and no maternal complications occurred". In addition, she advised that, because it was a Saturday,

> "[i]t was not possible to arrange a scan for [Ms A] in the community and so a referral to hospital was required. I did not think it was necessary to admit a woman to hospital over the weekend to check baby size, given that the baby was active and the mother had no medical complications."

31. Ms B noted that Ms A's previous scan at 20 weeks' gestation did not suggest a need for a further follow-up scan.

32. In relation to her assessment of Ms A at this time, Ms B advised HDC:

> "At the abdominal palpation [at 35 weeks], I had carefully felt the abdomen. I did not suspect low amniotic fluid levels at that time and it is not always possible to diagnose this on palpation alone. The fluid may also have reduced more markedly in the period between that palpation and the intervening scans."

Ms A advised HDC that Ms B never told her that her baby had stopped growing. Ms A recalls that it was not until after she had been admitted to hospital that Ms A said anything to her about the baby not growing or that she had reduced amniotic fluid.

Ultrasound scan

33. A week later (Friday), Ms A had an ultrasound scan, which revealed an abnormal collection of fluid in the fetal abdomen, reduced amniotic fluid suggesting a possible renal abnormality, and obstruction of the vessel joining the kidney and bladder. The report recommended "[u]rgent referral to [hospital] for further assessment".

34. The radiologist rang Ms B to advise her of the scan's findings. Ms B advised HDC that she was carrying out midwife visits in the community at the time of the radiologist's call and asked for a copy of the ultrasound report to be faxed to her office and the hospital.

[5] This record was made after Ms B had been notified of the results of the scan.

35. Shortly after Ms B's telephone call from the radiologist, Ms A telephoned Ms B to follow up the results of the ultrasound scan. Ms A advised HDC that, following the scan, the radiologist told her that, in light of the findings, she would probably need to go into hospital but advised her to go home to await further instructions from her midwife. Ms A said that she went home and waited approximately three hours. Because she had still not heard from Ms B, Ms A called her to ask about the scan results and whether she needed to go to hospital. Ms A said that Ms B told her not to worry, that one scan is not enough to draw any conclusions, and that they would do another scan in one week's time.

36. Ms A said that she asked Ms B specifically whether she needed to go to hospital. Ms A informed HDC that Ms B told her that a copy of the scan report had been faxed to the hospital, and it was up to the hospital clinicians to decide what would happen next. Ms A said that Ms B told her that, because it was a Friday, nothing would be done over the weekend, and if Ms A needed to go to hospital this would not happen until Monday.

37. Ms B told HDC that, at the time of Ms A's telephone call, she had not reviewed the radiology report. Ms B said that she would have tried to reassure Ms A and advised her that it was possible that further tests would need to be done.

38. Ms B said that she then received a telephone call from a hospital midwife asking her to advise Ms A that she needed to undergo a blood test that day at the hospital. Ms B said that she immediately called Ms A's mobile phone, but there was no answer. She then sent Ms A a text message advising her to go to the hospital for a blood test. Ms B stated:

> "I believe at that stage there was no immediate attention required from hospital other than blood test prior to the medical team having read the scan result. I do not agree with [Ms A] that I had said to her 'not be sent to hospital this week, wait until next week'."

39. Ms A denies that Ms B called her on her mobile phone. She advised that, approximately an hour and a half after her earlier telephone conversation with Ms B, she received the following text message from Ms B:[6]

> "Hi [Ms A] can u call me … or my cellphone as you need to go to hospital to do blood test if u can today. [Ms B]"

40. Ms A told HDC that there was no sense of urgency and she thought that if she waited until the next week to have the blood test done, this would be "OK". However, she decided to go into the hospital to get the blood test done that day.

41. Ms B stated to HDC:

[6] Ms A has provided HDC with a copy of the screen dump of the text message.

> "I believe I did not delay referring [Ms A] to hospital and I had fulfilled my role as [Ms A's] LMC when [Ms A's] care became complicated. I am sorry that I did not explain clearly enough to [Ms A] over the phone when her pregnancy suddenly developed complications that care might be transferred however I was not privy to the clinical picture at that time."

Admission to hospital

42. When Ms A presented to the hospital, a blood test was conducted. Ms A was then seen by the obstetric registrar, who explained to Ms A and her husband the scan findings and consequent need for the baby's postnatal admission to NICU for monitoring, imaging and possible surgery.

43. Ms A was subsequently admitted to hospital for monitoring. Steroids were commenced to help mature the baby's lungs, and a plan was made to deliver the baby two days later, on Sunday, by Caesarean section.

44. At 10pm on Friday, Ms B went to the hospital to provide support to Ms A and to interpret for Ms A's husband, who does not speak English very well.

45. At 10.15pm, the on-call Senior Medical Officer (SMO) reviewed Ms A and noted that the CTG[7] was showing a baseline fetal heart rate (FHR) of 170bpm (beats per minute) with decelerations of up to one minute down to 165bpm with contractions.[8] Ms A was then transferred to the delivery suite and CTG monitoring continued, which was noted to be "much more reassuring". Consideration was given to delivering the baby that night.

46. Monitoring continued overnight, and the decision was made to delay the Caesarean section. At 2.30pm Ms A was noted to be experiencing mild contractions, one every ten minutes. At 2.50pm, the neonatal team noted:

> "[A]s baby is currently well + contractions not progressed then it is best to continue to wait and allow steroids to work … if possible to wait until Mon before delivery to maximise steroids and have more staff available for care and decision making. If CTG becomes concerning then delivery is clearly a better option."

Ongoing midwifery input

47. Ms B returned to the hospital the following day to continue to provide support to Ms A. On Saturday at 12.30pm Ms B documented in the records: "LMC [Ms B] into room to support [Ms A]."

48. Ms A advised HDC that she felt that her Caesarean section kept on being bumped for more urgent cases, and said that one of her friends questioned Ms B about this. Ms A recalls Ms B telling her that she had not paid to go privately, and that this was the public system and she would have to wait her turn. Ms A also recalls Ms B saying

[7] Cardiotocography — the electronic monitoring of the fetal heart rate and rhythm.
[8] The normal baseline (mean) FHR is between 110–160 bpm.

that, as Ms A was now under secondary care, Ms B was no longer getting paid to visit her and was there out of kindness.

49. Ms B advised HDC that she recalls Ms A becoming anxious, and she asked Ms B to talk to the medical team about whether they could perform the Caesarean section sooner. Ms B said, "I explained to [Ms A] that the reason for no immediate operation at present was as recorded by the Dr and the Drs had to prioritise needs and resources in the public hospital system." This conversation is not recorded in the clinical records.

50. Monitoring of fetal well-being continued, and all observations remained within normal limits.

51. On Sunday at 10.50am the SMO reviewed Ms A and documented:

> "NICU very busy at present and because [the] baby has an unknown level of neonatal support needed it would be much preferred if could defer until tomorrow am (after round) unless clinical concerns dictate that needs delivery prior."

52. Later that day, the CTG showed that the fetal heart rate had become tachycardic,[9] with a baseline up to 175bpm with accelerations and no decelerations. The clinical records document that Ms A was becoming very upset, and that staff attempted to reassure her. At 5.10pm, the registrar documented:

> "[Patient] very anxious. Worried about hypoxia. Crying. Said Drs said she would be delivered Friday, can't understand the change of plan. Explained steroid cover needed initially [and] now NICU very full [and] unwilling to deliver."

53. It was decided to discontinue the CTG until 6pm, then recommence and, if the baby was still tachycardic, the case would be discussed again with NICU staff.

54. At 6pm, the CTG was re-started, and the registrar noted that the tachycardia had worsened. The consultant was informed, and the decision was made to proceed with a Caesarean section. This was carried out at 7.26pm, on Sunday.

Postnatal care

55. Ms A's baby was transferred to NICU for ongoing management.

56. Ms A remained on the postnatal ward for five days. Ms B advised HDC that she saw Ms A on the ward on the day following the birth, at approximately 2pm. Ms B noted that Ms A was recovering well. Ms B then saw the baby in NICU. This consultation is not documented in the clinical records. Ms A recalls Ms B visiting, but stated that this was very brief and that Ms B spoke to her mainly about other matters, not about how Ms A was coping.

[9] Increased FHR >160.

57. Ms B advised HDC that she saw Ms A again on Thursday at approximately 11.30am. Ms B noted that Ms A was recovering well, was expressing milk 3–4 hourly, and was on regular pain relief. Ms B documented: "[P]lease call back up [midwife] Ms C from this Friday is [sic] [Ms A] is discharge [sic] home or any other concerns." Ms B advised that she then went on leave, returning the following Monday.

58. Ms A was discharged from hospital on Friday, and Ms C was informed. The baby remained in NICU.

Ms C

59. Ms C's diary documents, on the day following discharge, that Ms A was in NICU but that Ms C had "missed her there staff said she left 10mins ago". According to retrospective notes written by Ms C the day prior to discharge, Ms C was unable to arrange another visit on the day following discharge.

60. Ms C saw Ms A at her home on the second day following her discharge (Sunday). In her retrospective record, Ms C documented that Ms A had told her that "she was OK, not getting enough rest going to and from hospital/home and unable to follow confinement practices as originally planned". Ms C also documented: "Home confinement for 1 month, was worried about effect of that. Reassured her that not everyone does it, and are healthy and fine." Ms C advised HDC that she documented contemporaneous records in Ms A's midwifery notes. She stated that, as she was the back-up LMC, she left both the original and the carbon copy of those notes with Ms A. Ms C told HDC that she expected Ms B to remove the carbon copy at her next visit. However, Ms B did not see Ms A again and Ms A has since lost her records. In light of this, Ms C told HDC she submitted a retrospective record of her visit with Ms A when asked to by Ms B.

61. In response to the Provisional Opinion, Ms C explained that when she visited Ms A, Ms A was making two trips per day to visit her baby in hospital and "was genuinely concerned that her health would be compromised in old age because she was leaving the house each day and not following [the custom] of confining herself to her home for a month". Ms C further stated, "The comments I made to Ms A were intended to reassure her that her health in old age would not be compromised by leaving her home to visit her baby."

62. Ms C stated: "It was not my intent to dismiss [her] cultural custom as being false, but to reassure a very distressed mother that it was alright to visit her baby at the hospital."

63. Ms A advised HDC that she does not recall her consultation with Ms C clearly, but said that she does not have any concerns about the care provided to her by Ms C.

Ongoing postnatal care

64. Ms A advised HDC that, following her discharge, she continued to visit the baby each day in NICU. Ms A said that following Ms B's return from leave Ms B kept postponing arranged visits. Ms A said that eventually she gave up and transferred her care to the hospital midwives.

65. Ms A provided HDC with a copy of a text message she sent to Ms B at 9.32am on the 11th postnatal day, which reads, "Hi [Ms B], this is [Ms A]. We are going to hospital soon. Be there about 10. May meet u there." At 2.14pm Ms B responded, "[A] lady in labor last nite. I can not c u today but may see u at hospital tomorrow after 11. Thanks. [Ms B]."

66. Ms B advised HDC that she attempted to see Ms A in NICU the following day but Ms A had left by the time she arrived. Ms B said that she then sent a text message to Ms A to organise another time to see her but Ms A responded that she had found a new midwife.

67. Ms B did not document any of these contacts with Ms A. In a statement to HDC she said that it is her usual practice to document home visits in the baby's Wellchild book but that, because the baby was in NICU, she did not have a chance to document anything.

68. Ms B provided HDC with a copy of her diary page from the 13th postnatal day, on which she has documented only Ms A's name.

69. Ms B stated to HDC:

> "I accept that the documentation I used was not sufficiently comprehensive to cover some of the more important issues, such as the care plan for [Ms A], emotional issues and discharge plan. I realise this is an important and valuable lessen [sic] that I have learned from this case."

70. Furthermore, Ms B stated:

> "I accept that the documentation in this case does not meet the [Midwifery] Council's criteria and is not able to demonstrate my midwifery rational [sic] of how and why I provided care to [Ms A], especially when the woman's situation is not straight forward.
>
> I recognise that my documentation is an area of my practice that needs to be improved."

Changes made by Ms B

71. Ms B advised that she now ensures that she documents all postnatal visits in the midwifery notes. She said she plans to attend a one-day documentation course and to become more familiar with the computer programme for the customised growth charts.

72. Ms B said that this case has taught her about the importance of communication. She stated:

> "I have also learned from this case that effective communication between professionals, such as midwife colleague, Doctors, and Lab or radiologist staff, social worker, and the woman and her family. I am not the only one providing care to her and her baby and team work through good communication is essential."

73. Ms B advised that she is now more vigilant about referring a woman if she is unsure about anything, and more readily seeks collegial support.

Relevant standards

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

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

75. 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."

Opinion: Breach — Ms B

Antenatal care

Prior to 35 weeks' gestation

76. Ms B saw Ms A regularly throughout the antenatal period. The baby's growth was assessed at each visit from 26 weeks' gestation. A nuchal scan and an anatomy scan were performed. In her complaint to HDC, Ms A advised that during the antenatal

period she had asked a number of times whether she could have a growth scan because she was concerned about the growth of the baby. She also advised that she requested a scan because she wanted to check the baby's sex, but Ms B had refused to refer her for a scan.

77. In her statement to HDC, Ms B advised that, during the appointment at 33 weeks' gestation, Ms A requested that she be referred for a growth scan. Ms B advised HDC that she told Ms A that she did not consider that a scan was clinically indicated at that stage, as the baby was growing well and was within normal limits. Ms B said that she reassured Ms A that she "would keep a close eye on matters".

78. I note the advice of my expert advisor, midwife Ms Stephanie Vague, that the growth of Ms A's baby was within normal limits until Ms A reached 35 weeks' gestation. I accept that, prior to this point, there was no clinical reason to refer Ms A for an additional ultrasound scan.

Request for scan — 35 weeks' gestation

79. When Ms A was 35 weeks' gestation, the fundal height measurements indicated that there had been no fetal growth for the previous two weeks. Ms A stated that during this appointment she "insisted" that Ms B refer her for a scan. Ms B subsequently requested an ultrasound scan. The contemporaneous records from this consultation state:

> "[W]ell for scan as [sic] [Ms A's] request."

80. Ms B made a retrospective note following receipt of the scan results, which stated:

> "Fetal growth no change for 2 week. For scan. Form given. Other assessment within normal. Will see after scan."

81. Ms B advised that, when she saw Ms A at this appointment, she noted that the baby had not grown for two weeks, and so she referred Ms A for a growth scan. Ms B said that she recommended that Ms A have this scan within the next week. Ms B stated that she "saw no immediate need to perform a growth scan [that day]" because "a single instance of measurement of non reassuring fundal-symphysis height at 35 weeks was not indicating any urgent scan, given that baby was active and no maternal complications occurred". In addition, Ms B advised that, because it was a Saturday, "it was not possible to arrange a scan for [Ms A] in the community and so a referral to hospital was required". She further stated, "I did not think it was necessary to admit a woman to hospital over the weekend to check baby size, given that the baby was active and the mother had no medical complications." Ms B noted that Ms A's previous scan at 20 weeks' gestation did not suggest a need for a further follow-up scan.

82. Ms Vague advised me that, as there had been no growth for the previous two weeks, "[i]t would generally be expected that a scan would be needed within a few days". If this could not be done privately within that timeframe, Ms A should have been referred to the hospital for a comprehensive assessment of the baby with a scan and fetal monitoring.

83. The contemporaneous records support Ms A's recollection that the referral was made at Ms A's insistence. It is evident that Ms B did not, at that time, consider a growth scan needed to be done with any urgency. This is concerning. In my view, by failing to recognise the need to refer Ms A for a growth scan in a timely manner and make the necessary arrangements for it to be conducted, Ms B breached Ms A's right to have services provided to her with reasonable care and skill.

Management of ultrasound scan results

84. One week after Ms B made the referral, Ms A had the ultrasound scan. Following the scan, the radiologist contacted Ms B by telephone to advise her of the results and recommend that Ms A be urgently referred to hospital. Ms B advised HDC that, upon receiving this information, she asked the radiologist to fax a copy of the report to the hospital and to her office. Ms B said that she did not contact Ms A because she was carrying out home visits in the community at the time.

85. Ms A then telephoned Ms B to ask for the results of her scan. Ms A told HDC that she made this telephone call because the radiologist had told her to go home and wait for her LMC to contact her with a management plan. Ms A said that she waited for about three hours and, because she had not heard from Ms B, she decided to contact Ms B directly. Ms A said that Ms B told her not to worry, that one scan does not mean anything, and that they would probably just do another scan in a week's time.

86. A short time later, Ms B was contacted by the hospital midwife, who asked that Ms A be sent to hospital immediately for a blood test. In a statement to HDC, Ms B stated:

> "I believe at that stage there was no immediate attention required from hospital other than blood test prior to the medical team having read the scan result."

87. Ms B said that she tried to call Ms A, but Ms A did not answer. Ms B then sent the following text message to Ms A:

> "Hi [Ms A] can u call me … or my cellphone as you need to go to hospital to do blood test if u can today. [Ms B]"

88. Ms A said that she did not believe there was any urgency in this request. However, in a statement to HDC, Ms B stated:

> "I believe I did not delay referring [Ms A] to hospital and I had fulfilled my role as [Ms A's] LMC when [Ms A's] care became complicated. I am sorry that I did not explain clearly enough to [Ms A] over the phone when her pregnancy suddenly developed complications that care might be transferred however I was not privy to the clinical picture at that time."

89. I note the view of Ms Vague that "[Ms B's] management of the abnormal scan result suggests a lack of understanding of the urgency of the situation and her responsibility to effect prompt review." I agree.

90. There were a number of missed opportunities in which Ms B could have effectively communicated the urgency of the situation to Ms A. Ms B did not urgently contact Ms

A when the radiologist recommended urgent referral to hospital. When Ms A contacted Ms B directly, Ms B failed to advise her of the radiologist's recommendation. Then, when Ms B was contacted by the hospital midwife and told that Ms A needed to come in to the hospital urgently, Ms B failed to communicate this information to Ms A effectively. Ms B's decision to rely on a text message as the only method of communicating such important information further demonstrates her failure to appreciate and respond appropriately to the urgency of the situation. As I emphasised in two recent opinions, text message communication alone does not "allow the midwife to be sure that the woman has received the advice and interpreted it as intended".[10] In my view, by failing to act appropriately when she had been advised twice about the need for an urgent referral to hospital for blood testing, Ms B did not provide Ms A with an adequate standard of care. Effective service and care is best provided when the consumer is able to operate as a partner in the process. I note Ms Vague's comment that "partnership does not seem to have been well understood or practised …"

91. Informed and engaged consumers are better able to act as a partner in the process, to act in their own interest, and to contribute to effective care. In this case, the actions of other providers, and Ms A's fortuitous decision to attend hospital, notwithstanding the ambivalence in Ms B's communication, ensured effective care.

Postnatal care

Inpatient care

92. Ms B advised that she saw Ms A twice while Ms A was in hospital. Ms B did not document her first visit, and documented only brief notes for her second visit about the need for her back-up midwife to be contacted in the event that Ms A was discharged over the weekend. The Primary Maternity Services Notice requires an LMC to ensure that her client is provided with a daily visit while the woman is receiving inpatient postnatal care, unless otherwise agreed by the client and the maternity facility.

93. I note Ms Vague's comments:

> "On Days 1 and 4, while in hospital, [Ms A] was seen by [Ms B]. [Ms A] had had her first baby by Caesarean section and was naturally very concerned about the baby's welfare as she faced surgery and an unknown future. There is no documented record of any physical or emotional assessment in the hospital notes. Prior to her discharge, there is no evidence of any plan regarding issues like establishment of milk supply, adequate pain relief and rest being addressed."

94. I agree. Ms A had just given birth to her first child after unexpectedly learning that the baby was very unwell. In my opinion, this was not adequate care. Furthermore, I note that there is no evidence that Ms B made any arrangement with the hospital for her involvement during the postnatal period in accordance with the requirements of the Primary Maternity Services Notice.

[10] See Opinions 11HDC00596 and 11HDC00771.

Care following discharge

95. Because Ms B was not working during the weekend that Ms A was discharged from hospital, Ms A's initial postnatal visit at home was performed by Ms B's back-up midwife, Ms C.

96. Following Ms B's return from leave there is no documentation of any contacts or visits with Ms A. Ms A sent Ms B the following text message:

> "Hi [Ms B], this is [Ms A]. We are going to hospital soon. Be there about 10. May meet u there."

97. Ms B's response, received at 2.14pm, states, "[A] lady in labor last nite. I can not c u today but may see u at hospital tomorrow after 11. Thanks. [Ms B]."

98. Ms A told HDC that she made a number of attempts to contact Ms B to organise postnatal visits but Ms B kept deferring visits.

99. Ms B said that she tried to arrange to see Ms A at the hospital, but by the time she arrived at NICU Ms A had left. Ms B then sent a text message to Ms A requesting another time to meet, but Ms A responded that she had arranged another midwife to be her LMC.

100. The Primary Maternity Services Notice requires that an LMC provide five to ten home visits, and a minimum of seven postnatal visits. Following the birth of her baby, Ms A received two brief visits from Ms B while she was in hospital, and one home visit from Ms C the day after her discharge from hospital. There is then a period between day 7 to day 12 following the birth where Ms A received no postnatal care from Ms B. There is no evidence of any contact with Ms A following Ms C's visit until Ms B replied to Ms A's text message. Ms A terminated the relationship the following day. I accept that Ms A attempted to arrange for Ms B to visit, but Ms B deferred the appointments.

101. I note Ms Vague's view that "[Ms A] has some justification in feeling let down by her midwife in this stressful postnatal period. The support she received from a midwifery perspective could have been more frequent and effective."

102. In my view, Ms B failed to provide adequate postnatal care to Ms A. Ms A was particularly vulnerable, and more effort should have been made to support her during the initial postnatal period. In these circumstances, Ms B failed to provide services to Ms A with reasonable care and skill.

Documentation

103. Ms B did not document a number of her conversations with Ms A. Despite Ms A specifically requesting a referral for a growth scan when she was 33 weeks' gestation, Ms B made no record of this discussion. There is also no record of Ms B's discussions with Ms A about the delays in performing the Caesarean section.

104. Ms B failed to document adequate contemporaneous records. I note that Ms B's documentation of the antenatal care from 35 weeks onwards is written retrospectively,

the day the baby was born, with no explanation for the absence of documentation during that period.

105. Ms B did not document any of her postnatal visits or contacts in Ms A's midwifery notes. Ms B documented only one of her postnatal visits in the hospital records while Ms A was still in hospital, and the note is very brief and does not include any details about discussions she had with Ms A or a management plan. I note that Ms B accepts that her documentation did not meet the requirements as set out by the Midwifery Council of New Zealand.

Conclusion

106. In my view, the care Ms B provided to Ms A was unsatisfactory. Ms B failed to recognise the need to refer Ms A for a growth scan in a timely manner when the baby's growth stopped. Then, when the results of the scan had been received, Ms B failed to respond appropriately to the urgency of the situation and, as a consequence, failed to communicate adequately to Ms A the need for urgent follow-up.

107. Ms B failed to provide Ms A with adequate postnatal care. In particular, Ms B did not provide Ms A with an adequate number of postnatal visits, and the visits she did make were brief and failed to address Ms A's basic postnatal requirements or progress, such as her emotional state or establishment of her milk supply.

108. Although each of these failures viewed separately is not a serious departure from an accepted standard of care, when viewed cumulatively, the series of failures in the care Ms B provided to Ms A suggest a pattern of suboptimal care. As a result, I find that Ms B failed to provide services to Ms A with reasonable care and skill and, accordingly, breached Right 4(1) of the Code.

109. Ms B's records were superficial and, in some instances, nonexistent. The records for Ms A's antenatal care from 35 weeks onwards are written retrospectively, on the day the baby was born. Ms B did not document any of her postnatal visits or contacts in Ms A's midwifery notes. The only record made by Ms B is in the hospital records and is very brief. The record does not include any details about discussions Ms B had with Ms A or a management plan.

110. By failing to maintain adequate contemporaneous antenatal records, record her postnatal visits and any discussions and decisions in relation to Ms A's ongoing management, Ms B failed to meet the standards set by the Midwifery Council of New Zealand and, accordingly, breached Right 4(2) of the Code.

Recommendations

111. Ms B has agreed to comply with the following recommendations of my Provisional Opinion:

- Provide a written apology to Ms A. The apology has now been received by HDC and will be forwarded to Ms A.
- Enrol in a New Zealand College of Midwives Documentation Workshop.

112. Ms B should confirm her enrolment in further training on communication in conjunction with the New Zealand College of Midwives within three months of the date of release of this report.

113. In September 2013, as a result of being informed of the facts of this complaint by this Office, the Midwifery Council of New Zealand (MCNZ) undertook a competence review of Ms B's practice. Following the completion of this review, the MCNZ ordered Ms B to undertake a competence programme.

Follow-up actions

114.
- A copy of this report with details identifying the parties removed, except the expert who advised on this case, will be sent to the Midwifery Council of New Zealand, the New Zealand College of Midwives, and the district health board and they will be advised of Ms B's name.
- A copy of this report with details identifying the parties removed, except the expert who advised on this case, will be placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

Appendix A — Independent midwifery advice

The following expert advice was obtained from Stephanie Vague:

"My name is Stephanie Vague. My qualifications are Registered Midwife, 1979; Registered General and Obstetric Nurse, 1974 and Master of Health Science (Midwifery) (Hons) (Auckland University of Technology), 2004. I have worked as an employed midwife in secondary and tertiary hospitals, as a Senior Lecturer in the undergraduate midwifery programme at Auckland University of Technology (AUT) and as Lead Maternity Carer. I am currently employed as a midwife working casual shifts at Auckland Hospital.

I am a member of the New Zealand College of Midwives (NZCOM). I have been a Midwifery Standards Reviewer and am nominated as an expert midwifery advisor by NZCOM. I also work for the New Zealand Midwifery Council as a competence assessor and reviewer from time to time.

I have been asked to provide an opinion to you on case number C12HDC01474. I have read and agree to follow the Commissioner's Guidelines for Independent Advisors.

I have been asked to provide general comment on the adequacy of care received by [Ms A], as well as on the standard of antenatal and postnatal care provided by [Ms B]. In particular, I have been asked to provide an opinion on whether [Ms B] referred for scans and tests at appropriate times during the pregnancy and if she should have referred [Ms A] for a scan earlier in her pregnancy.

Sources of Information

- A copy of [Ms A's] original complaint, dated […]
- A copy of [Ms B's] response to the above complaint
- A copy of [Ms A's] midwifery notes
- A copy of [Ms A's] clinical notes from [the] DHB
- A copy of [Ms A's] pregnancy scan and report from [the radiology service]
- A copy of [Ms B's] response to my initial advice

Summary of Events

[Ms A] booked with [Ms B] for the birth of her first baby. She had the two scans which are offered in early pregnancy to screen for fetal abnormalities. These were both normal.

The pregnancy progressed to 35 weeks with the baby appearing to grow appropriately. [Ms A] stated in her complaint that she had asked to have a growth scan several times prior to this visit. [Ms B] did not document any such discussions in her midwifery notes but does mention [Ms A's] request for a scan at the 33 week visit in her later response to the complaint. [Ms B] recalled that she reassured [Ms A] and explained the reasons that she felt it was not clinically indicated.

At 35 weeks, when there [was] found to be no growth in the fundal height over the past two weeks, a growth scan was ordered by [Ms B].

[Ms A] had the scan one week later, at 36 weeks. It showed markedly reduced amniotic fluid around the baby and a serious abdominal fluid collection with probable kidney problems. The report recommended an urgent referral to [hospital]. The radiologist rang [Ms B] to advise her of the scan's findings in order to expedite an urgent assessment. [Ms B] was doing visits in the community and asked that the scan result be faxed to her clinic rooms and to the hospital. When [Ms A] phoned her shortly after this, [Ms B] tried to reassure [Ms A] and explained that a further scan or a blood test might be required.

Then [Ms B] had a phone call from a midwife at the hospital asking that [Ms A] come in for a blood test that day, so she rang and left a message on her cell phone to that effect. [Ms A] rang [Ms B] back and was asked to go for the blood test that day.

[Ms A's] recollection of the events following the scan differs. She was told by the radiologist that her midwife would contact her in light of the scan result. When she didn't hear from her, [Ms A] contacted [Ms B] and was told not to worry about the result of just one scan and that she would arrange another scan for the following week. She then got the text message asking her to call [Ms B] because she needed to have a blood test at the hospital. While at the hospital, [Ms A] queried the scan result with the midwife, who found the report and promptly referred [Ms A] to the consultant.

As a result, [Ms A] was admitted on a Friday for monitoring of her baby. A decision was made to deliver the baby by Caesarean section following a course of steroids to mature the baby's lungs. This was to be on Sunday if the baby remained stable enough.

[Ms B] was called to Birthing Suite later that evening as the baby's heart rate was causing concern and it seemed that she might need to be delivered urgently. [Ms B] was able to interpret for [Ms A's] husband and help reassure the distressed couple as the baby's condition settled and a decision was made to continue with the original plan.

[Ms B] visited on Saturday when she explained to [Ms A] the reasons for the delay in delivering the baby, ie that the heart rate was stable and the doctors were constantly assessing the situation. She described the need to prioritise within the public system according to needs and resources. This discussion has not been documented in the hospital notes but was recalled in the later response.

[Ms A's] recall of this visit again differs. She was very anxious about her baby and distressed by the ongoing delay in delivering due to other emergencies within the unit. When [Ms B] was asked by a friend to try to persuade the doctors to deliver [Ms A], she apparently replied rudely that this was a public system and

they would need to wait. She also made a comment about the fact that [Ms A] was now in secondary care and [Ms B] was not being paid for supporting her but was there out of kindness.

The baby's well being was closely watched and remained stable enough to encourage the doctors to try to delay birth until Monday when more staff would be around and the very full Neonatal Intensive Care Unit (NICU) might be better placed to receive a sick baby. In the event, the baby's condition deteriorated and she was born on Sunday evening. [Ms B] was present at the birth as support for [Ms A].

The baby spent several weeks in NICU. [Ms A] was discharged from hospital after 5 days and visited her baby daily. She received two postnatal visits from [Ms B] in hospital and a home visit from her back-up, [Ms C], when she had a weekend off. No documentation was supplied to me of these two days, beyond a diary entry from [Ms C] with [Ms A's] name listed, presumably as she was to be visited. [Ms C] stated in a retrospective account written [several months later] that she attempted to visit [Ms A] on [Day 6] at NICU but she had gone home for a break. [Ms C] was involved with a birth for the rest of the day and was unable to follow up. On the following day (Day 7), [Ms C] visited [Ms A] at home and conducted a postnatal visit.

[Ms B] stated in her response to the complaint that she texted [Ms A] regarding a visit with her in NICU on [Day 12]. She arrived about 5pm to find that [Ms A] had gone home for dinner but was returning later in the evening. [Ms B] was unable to wait. When [Ms B] texted on the following day, [Ms A] replied with a text that she wanted to change LMC. [Ms B] stated that she visited [Ms A] and the baby twice more in NICU following the completion of her care.

Response to Advice Requested

Antenatal care

The antenatal care provided by [Ms B] until [Ms A] reached 35 weeks gestation appears adequate from the information I have reviewed. The pregnancy had progressed fairly well, with some lower back pain and 'flu-like symptoms' being the only notable discomforts.

The baby was assessed at each antenatal visit for growth. This would include palpation of the uterus to clinically assess the size of baby in relation to landmarks on the mother's abdomen, a discussion about baby's movements and, from 24 weeks, a measurement of the fundal height. The midwifery notes suggest that the baby's growth, as determined by these practices, was broadly in agreement with the gestation until 35 weeks. Midwives are increasingly adopting the use of a customised growth chart to plot the baby's growth against an optimal weight chart. Personalised growth charts provide a more reliable tool to help identify babies whose growth is compromised. The use of GROW charts has been strongly recommended by the PMMRC (2009) and has been included in the current cycle of mandatory education, sanctioned by Midwifery Council, which all practising midwives must attend by April 2014.

At 35 weeks, the fundal height measurement showed no growth in two weeks and a growth scan was ordered. This was an appropriate action. On the antenatal record page of her midwifery notes [for this visit], [Ms B] has written 'well. For scan as (sic) [Ms A's] request". The scan was done one week later which could reflect the fact that [Ms B] had not suggested any haste was needed in arranging a scan which she was principally ordering for the reassurance of [Ms A].

It would generally be expected that a scan would be needed within a few days, given that the baby appeared to have stopped growing. If a scan was not available at private scanning places within that time frame, [Ms B] could have referred [Ms A] to the hospital clinic or assessment unit for a comprehensive assessment of the baby with scan and fetal monitoring.

When [Ms B] was contacted by the radiologist about the unexpectedly complicated scan result, there appears to have been no recognition of the urgency with which [Ms A's] baby needed assessment at the hospital. [Ms B] asked for a copy of the result to be faxed to the hospital, but didn't liaise with the consultant on call. When [Ms A] called her, [Ms B] suggested that a repeat scan might be required and tried to reassure her. Even after the phone call from the hospital requesting that [Ms A] present for a blood test, [Ms B] texted 'can you call me … as you need to go to the hospital to do blood test **if u can** today'.

Of Midwifery Council's four Competencies for Entry to the Register, Number Two states 'The midwife applies comprehensive theoretical and scientific knowledge with the affective and technical skills needed to provide effective and safe midwifery care' (NZCOM, 2005, p.6). In the Standards for Practice (NZCOM, 2005), Standard Six requires that 'midwifery actions are prioritized and implemented appropriately with no midwifery action or omission placing the woman [and her baby] at risk' (p.18).

I accept [Ms B's] response regarding the longer time frame within which a growth scan could be arranged following one instance of apparently no growth, especially when other factors like baby's movements were reassuring. I was unaware that this occurred on a Saturday which also makes a delay in booking a scan more understandable. However, she did not appear to recognize that the scan result required immediate action to liaise with the hospital in order to have [Ms A] reviewed urgently. I believe that her care would be viewed as a mild departure from that expected by the profession.

Scans

I have been asked to comment on the timing of the scans during [Ms A's] pregnancy. The first trimester combined screening and the anatomy scan in the second trimester, were both offered. The first scan was unable to be done because the pregnancy was not advanced enough for optimal screening. It was successfully repeated 13 days later. The anatomy scan was done at 20 weeks and was unremarkable. The timing of these scans was acceptable.

Given the regular growth of the baby's fundal height measurements and no stated concerns by [Ms A] about fetal movements, [Ms B's] assessments of the baby's growth being appropriate were reasonable. There appeared to be no clinical indication to order a growth scan earlier than 35 weeks. I note that [Ms A] had requested a scan on at least one occasion prior to 35 weeks. When midwives are working in partnership with women, they should place them at the centre of their care and have a responsibility to communicate effectively and sensitively to their needs. So, whilst there was no clinical reason for a growth scan, [Ms B] may have decided to order one at an earlier stage if [Ms A] was very anxious and difficult to reassure. The rationale behind such a decision would have been reasonable.

Documentation

Documentation is an area of concern. On the page named 'antenatal record' in the midwifery notes, the entry for the antenatal visit [at 35 weeks] occurred on the line below the entry dated [two days prior to birth] following the scan result. It had clearly been written at some time after the actual visit.

[Ms B's] signature tended to appear within the body of the narrative, not in the right hand margin. This made it difficult to see, particularly because she didn't print her name in capitals on each page beneath her signature as is recommended.

On subsequent pages in the midwifery notes, where the narrative was recorded about each antenatal visit, all the events from [35 weeks] onwards, were written retrospectively on [the day of the birth]. This is the day on which the baby was born. No explanation was given in the notes, or subsequently in [Ms B's] response to the complaint, for the complete absence of documentation over this period.

There is no postnatal documentation for [Ms A] in [Ms B's] midwifery notes. In the clinical notes from [the hospital], there is one entry on [Day 4 postpartum] by [Ms B] in which she gave no information about [Ms A's] postnatal state, but informed staff of her backup midwife's contact details in the event of [Ms A's] discharge, as she was to have a weekend off.

In her response to the complaint, [Ms B] stated that she visited [Ms A] on Day 1, and also saw the baby but there is no record in either the hospital's clinical notes or the midwifery notes of this. She goes on to detail aspects of a postnatal assessment on [Ms A] on Day 4 which are not noted in the contemporaneous clinical notes.

The postnatal visit by the backup midwife was not documented until [several months later]. There was no reason given in her later response for the lack of documentation at the time. This falls short of a reasonable standard of documentation.

Midwifery Council's Competency Two, performance criteria 2.16 states that the midwife 'provides accurate and timely written progress notes and relevant documented evidence of all decisions made and midwifery care offered and

provided' (NZCOM, 2005, p.7). In addition, Standard Four (NZCOM, 2005) requires that 'the midwife maintains purposeful, on-going, updated records' and 'reviews and updates records at each professional contact with the woman' (p.16).

The standard of documentation, and more particularly the absence of any record of substantial areas of care, would be regarded as a moderate departure from accepted midwifery practice.

Postnatal care

Three postnatal visits were made to [Ms A] prior to [day 12 postpartum], according to the documentation I have reviewed. On Days 1 and 4, while in hospital, she was seen by [Ms B]. [Ms A] had had her first baby delivered by Caesarean section and was naturally very concerned about the baby's welfare as she faced surgery and an unknown future. There is no documented record of any physical or emotional assessment in the hospital notes. Prior to her discharge, there is no evidence of any plan regarding issues like establishment of milk supply, adequate pain relief and rest being addressed.

[Ms A] was discharged from hospital on Day 5. [Ms C], the back-up midwife missed seeing her in NICU on Day 6 and then was involved with a birth for the rest of the day and unable to visit. She saw [Ms A] at home on Day 7. Her recollection of events from retrospective notes made six months later, record [Ms A] and her husband being very anxious and very tired with the frequent trips to and from the hospital. [Ms A] expressed her concern about being unable to rest at home for the first month as is usual [in her culture]. Traditionally, women [in this culture] were encouraged to rest, recover and concentrate on feeding their baby for the first month after childbirth. The woman's mother and other female relatives cooked nutritious meals and tended to all household chores in order to allow total rest for the new mother.

[Ms C's] response was that 'everyone does it, and are (sic) healthy and fine'. This statement suggests a lack of cultural safety which underpins the model which midwives should be working within. This notion is embedded in Standard One (NZCOM, 2005) which states that 'the midwife works in partnership with the woman' (p.13).

[Ms B] next attempted to see [Ms A] on Day 11 at NICU but she had gone home for dinner. When she contacted [Ms A] the next day, she received a message terminating their relationship. I believe [Ms A] has some justification in feeling let down by her midwife in this stressful postnatal period. The support she received from a midwifery perspective could have been more frequent and effective.

[Ms A] states that [Ms B] 'kept postponding (sic) her visits' and she eventually 'gave up' and found another midwife to complete her postnatal care. [Ms A's] account implies that she contacted [Ms B] on more than one occasion once she was back from her weekend off asking to see her. [Ms B] claims that she texted

[Ms A] 4 days later regarding a visit with her in NICU. Without any documentation of this period, I am unable to determine what transpired, but the result is apparent. [Ms A] received no postnatal care between Day 7 and Day 12 when she terminated the relationship.

Midwifery Council's Competency One (NZCOM, 2005) concerns partnership which is a cornerstone of midwifery care. Performance criteria 1.9 states 'the midwife communicates effectively with the woman and her family/whanau **as defined by the woman**' (p.6). NZCOM's Standard One concerning partnership describes the 'individual and shared responsibilities' which a midwife must recognise (p.13). Standard Five — 'Midwifery care is planned with the woman' encompasses woman-centred care and the expectation that the midwife 'sets out specific midwifery decisions and actions in an effort to meet the woman's goals and expectations and documents these' (p.17). Finally, Standard Nine states 'the midwife ensures the woman has had an opportunity to reflect on and discuss her childbirth experience' (p21).

[Ms A's] postnatal care was not of a reasonable standard by [Ms B] when it is measured by the above Competencies and Standards for Practice of the midwifery profession. This would be regarded as a mild departure from accepted midwifery practice.

Summary

My review of the enclosed documentation has found some concerns about the care provided to [Ms A]. Antenatally, [Ms B's] management of the abnormal scan result suggests a lack of understanding of the urgency of the situation and her responsibility to effect prompt review. The wider issues relating to inadequate communication and documentation have been discussed. And partnership does not seem to have been well understood or practised, particularly in the postnatal period, by either midwife.

My advice has been amended in parts after reading [Ms B's] response to my first report.

References

Ministry of Health. 2007. Primary Maternity Services (Section 88). Wellington: MOH.

New Zealand College of Midwives. 2005. Handbook for Practice. Christchurch:NZCOM.

PMMRC.2009. Perinatal & Maternal Mortality in New Zealand 2007: 3rd Report to MOH, July 2008 to June 2009. Wellington: MOH."