Antenatal care provided by midwife (11HDC00771, 26 June 2013)

Midwife ~ Response to symptoms ~ Pre-eclampsia ~ Communication ~ Documentation ~ Rights 4(1), 4(2)

This case is about the care provided to a 22-year-old woman in the third trimester of her first pregnancy. Due to dissatisfaction with the care provided by her previous Lead Maternity Carer (LMC), the woman engaged another registered midwife as her LMC at 21 weeks' gestation. Following that appointment, the woman had three more antenatal appointments with the midwife. After the third antenatal appointment a natural disaster occurred. The woman left the region and returned two weeks later.

When the woman was seen at the fourth appointment at 33 weeks' gestation, the midwife did not note any major concerns. The next appointment at 35 weeks' gestation did not occur as the midwife was attending a birth. However, the midwife did not contact the woman to advise her until two days later.

At 37 week's gestation, the woman did not attend an appointment because she was unwell with diarrhoea and abdominal cramps. That evening, the woman contacted the midwife by text for advice on her symptoms. The midwife advised the woman that she would try to see the woman the next day. After consulting with colleagues, the midwife decided that a medical visit was more appropriate than a midwifery visit, and she advised the woman of this by text the following day. As a result, no midwife visit occurred that day.

The woman tried to book an appointment with her doctor the next day, a Friday, but no appointments were available. On Sunday, the woman experienced sharp, stabbing chest pain, shortness of breath, headaches and upper abdominal pain. She was uncomfortable and had difficulty sleeping. On Monday morning the woman spoke with the midwife on the telephone about her concerns. The midwife thought that the woman probably had a chest infection and she advised the woman to rest, drink electrolyte fluids, and see her doctor if she was really worried.

The woman was unable to book an appointment with her doctor on Monday as there were none available. She was advised that an emergency appointment could be made available if her LMC telephoned the doctor's practice. When the woman contacted the midwife regarding a doctor's appointment, the midwife thought the woman had an appointment already, and was asking her to call the doctor's practice only to confirm that the woman would not be charged for the appointment. On Monday afternoon, the midwife contacted the woman by text to say that she had been unable to contact the doctor.

On Monday night, the woman's chest symptoms worsened and her partner drove her to the after-hours medical clinic. The woman was transferred to the public hospital by ambulance for further assessment. At the public hospital, a diagnosis of pre-eclampsia was confirmed and the decision was made to deliver the baby by Caesarean section. The midwife was notified of the admission by telephone and came in soon afterwards. The midwife stayed with the woman during administration of the spinal anaesthetic, but was then called away to provide care for a labouring woman.

When assessing whether the midwife's standard of care was reasonable, the unique context within which she was providing that care was taken into account.

The information and care provided to the woman by the midwife between the first and third appointments was found to be of a reasonable standard.

It was held that the midwife did not respond appropriately to the symptoms reported by the woman in the days leading up to the birth. The midwife failed to ensure that the woman had a review during that period, and failed to ensure she had an urgent review on the Monday evening in light of the symptoms reported by the woman. The midwife therefore did not provide services with reasonable care and skill and breached Right 4(1). In addition, the midwife failed to document the text messages in the clinical notes, and therefore did not provide services in accordance with professional standards and breached Right 4(2).

Clinical responsibility for the woman was transferred from the midwife to the Obstetrics and Gynaecology team at the public hospital following the decision to admit the woman in order to perform an emergency Caesarean section. Accordingly, the midwife's care was found to be appropriate following the woman's transfer to the public hospital.