Registered Midwife, Mrs B

A Report by the

Health and Disability Commissioner

(Case 11HDC00771)

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

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Executive summary

Facts

1. Due to dissatisfaction with the care provided by her previous Lead Maternity Carer (LMC),[1] Ms A engaged registered midwife Mrs B as her LMC in late 2010, at 21 weeks' gestation. Following that appointment, Ms A had three more antenatal appointments with Mrs B. These occurred at 26 weeks' gestation, 28 weeks' gestation, and 33 weeks' gestation.

2. Following the third antenatal appointment a natural disaster occurred. Ms A left the region and returned two weeks later.

3. When Ms A was seen at the fourth appointment, at 33 weeks' gestation, Mrs B did not note any major concerns. The next appointment, at 35 weeks' gestation, did not occur as Mrs B was attending a birth. However, she did not contact Ms A to advise her until two days later. Ten days after that, at 37 weeks' gestation, Ms A did not attend an appointment because she was unwell with diarrhoea and abdominal cramps.

4. That evening, Ms A contacted Mrs B by text for advice on her symptoms. Mrs B said she would try to see Ms A the next day. After consulting with colleagues, Mrs B decided that a medical visit was more appropriate than a midwifery visit, and she advised Ms A of this by text the following day. As a result, no midwife visit occurred that day.

5. Ms A tried to book an appointment with her doctor the next day, a Friday, but no appointments were available. Ms A was advised by her doctor's receptionist that she could have blood tests done on the Monday, and was instructed to go to the after-hours doctor should the symptoms worsen over the weekend.

6. On Sunday, Ms A experienced sharp, stabbing chest pain, shortness of breath, headaches and upper abdominal pain. She was uncomfortable and had difficulty sleeping. On Monday at 9am she spoke with Mrs B on the telephone about her concerns. Mrs B thought that Ms A probably had a chest infection. She advised Ms A to rest, drink electrolyte fluids, and see her doctor if she was really worried.

7. Ms A was unable to book an appointment with her doctor that day as there were none available. She was advised that an emergency appointment could be made available if her LMC telephoned the doctor's practice. Mrs B told HDC that when Ms A contacted her regarding a doctor's appointment, she thought Ms A had an appointment already, and was asking her to call the doctor's practice only to confirm that Ms A would not be charged for the appointment. By 2pm Mrs B contacted Ms A by text to say that she had been unable to contact the doctor.

8. At 11pm on Monday, Ms A's chest symptoms worsened and her partner, Mr A, drove her to the after-hours medical clinic. It was suspected that Ms A had pre-eclampsia and she was transferred to the public hospital by ambulance for further assessment.

[1] An LMC is the designated health professional who co-ordinates a woman's maternity care.

9. On admission to the public hospital a diagnosis of pre-eclampsia was confirmed and the decision was made to deliver the baby by Caesarean section. Mrs B was notified of the admission by telephone and came in soon afterwards, around 4am. Mrs B stayed with Ms A during administration of the spinal anaesthetic, but was then called away to provide care for a labouring woman. Mrs B returned to see Ms A that afternoon.

10. Ms A stated that Mrs B saw her only briefly on two occasions (Tuesday and Wednesday) following the Caesarean section, and on neither occasion did she examine her or her baby. After discussion with one of the hospital midwives, Ms A decided to change to another LMC and notified Mrs B of this by text message.

Findings

11. When assessing whether Mrs B's standard of care was reasonable, the Commissioner took into account the unique context within which she was providing that care.

12. The information and care provided to Ms A by Mrs B between the first and fourth appointments was found to be of a reasonable standard.

13. However, Mrs B did not respond appropriately to the symptoms reported by Ms A in the days leading up to the birth. By failing to ensure that Ms A had a review during this period, and by failing to ensure she had an urgent review on the Monday evening in light of the symptoms reported by Ms A, Mrs B did not provide services with reasonable care and skill and breached Right 4(1)[2] of the Code of Health and Disability Services Consumers' Rights (the Code). In addition, by failing to document the text messages in the clinical notes, Mrs B did not provide services in accordance with professional standards and breached Right 4(2)[3] of the Code.

14. Clinical responsibility for Ms A was transferred from Mrs B to the Obstetrics and Gynaecology team at the public hospital following the decision to admit Ms A in order to perform an emergency Caesarean section. Accordingly, the Commissioner found that Mrs B's care was appropriate following Ms A's transfer to the public hospital.

Complaint and investigation

15. The Commissioner received a complaint from Ms A about the services provided to her by registered midwife Mrs B. The following issue was identified for investigation:

- *Whether midwife Mrs B provided an appropriate standard of care to Ms A.*

16. An investigation was commenced on 16 August 2012.

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

17. The parties directly involved in the investigation were:

Ms A	Consumer/complainant
Mrs B	Provider

18. Information was also reviewed from:

Mr A	Consumer's partner
The District Health Board	
Mobile phone provider	

19. Independent expert advice was obtained from registered midwife Mrs Joyce Cowan and is attached as **Appendix A**.

Information gathered during investigation

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.

21. 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 under section 88 of the New Zealand Public Health and Disability Act 2000. The Primary Maternity Services Notice states that the LMC is responsible for the care provided to the woman throughout her pregnancy and postpartum period.

Antenatal care — First to fourth antenatal appointments

22. Ms A, aged 22 years, was pregnant with her first child. Ms A had engaged the services of a registered midwife as her LMC but she was dissatisfied with the standard of care being provided. As a result, at 21 weeks' gestation,[4] she engaged the services of another registered midwife, Mrs B, as her LMC.

23. At their first meeting, Mrs B obtained Ms A's full obstetric history, took a blood sample and a urine sample[5] (both of which were normal) and referred Ms A for an ultrasound scan. Mrs B also showed Ms A around the primary birthing unit and spoke to her about her pregnancy history.

24. Ms A and her partner, Mr A, next met with Mrs B at the primary birthing unit at 26 weeks' gestation. Mrs B palpated Ms A's abdomen, took a urine sample (which was normal), and took Ms A's blood pressure (which was also normal).

[4] The age of the fetus. The normal period of gestation is 40 weeks.
[5] Urine samples are taken during pregnancy to help detect a variety of conditions such as gestational diabetes, urinary tract infections and pre-eclampsia.

25. Ms A and Mr A next saw Mrs B at Ms A's home at 28 weeks' gestation. Mrs B noted in the MMPO[6] notes that she had given Ms A a DVD on breastfeeding and advised Mr A where he could access a DVD called *Great Fathers*. Mrs B's notes indicate that discussions were had on various topics including iron tablets, magnesium salts, car seat hire, and IRD payments. Mrs B documented that the baby was growing and developing well and that Ms A was "reducing hours at work".

26. Mrs B told HDC that while it is her standard practice to offer women urine tests every time she sees them, she did not do so at this appointment as she did not have any dipsticks. Mrs B told HDC that she did carry out other tests "including blood pressure and visual".[7] Ms A's blood pressure was recorded (normal). The next appointment was booked for 12 days later.

27. As a result of the natural disaster, Ms A and Mr A went to stay with Ms A's mother. Accordingly, the appointment that was booked did not take place. While they were away, Ms A saw another midwife for a check-up.

28. Ms A and Mrs B arranged by text message for an appointment, however, Ms A cancelled this appointment and it was re-scheduled. Five days before the re-scheduled appointment, Ms A stated in a text message to Mrs B that she was "just starting to panic with count down and feeling really ill prepared".

29. At the fourth appointment, at 33 weeks' gestation, Ms A found Mrs B "to be more interested in [conversation about the natural disaster]", and said that the visit was "marginally baby related". Ms A told Mrs B again how ill prepared she felt about labour. Mrs B responded by reassuring her that she would be fine and that she had had women call her "when they were actually having the baby". Ms A said that Mrs B also gave her a DVD to watch about reducing pain during labour, and discussed a basic birth plan with her.

30. The birth plan arranged for Ms A was for her to give birth at the public hospital and that she would prefer not to use any drugs, forceps, or anything that would speed up the natural process of birth. Ms A told HDC that Mrs B never spoke to her "in depth of what to expect. [Her] water breaking, stages of labour (about giving birth to the placenta), worst case scenarios", and that Mrs B never told her about "specific symptoms to watch out for". Ms A does recall being told by Mrs B to call or text her if there was anything concerning her.

31. Mrs B's notes from this appointment state that Ms A was eating well and taking her iron tablets and magnesium salts. Mrs B recorded her palpation findings, Ms A's blood pressure (normal), and that she had given Ms A a DVD to watch. Mrs B did not

[6] MMPO stands for the Midwifery and Maternity Providers Organisation Limited. MMPO provides infrastructure and a business framework for LMCs. The notes taken by the midwife while providing care to a client are recorded in a booklet provided by MMPO and are referred to as the "MMPO notes".
[7] Mrs B explained to HDC that by "visual" she meant that she visually assesses the woman by looking for swelling around the woman's ankles, hands and face, and a "general look" at the woman to check that she is looking healthy.

test Ms A's urine at this appointment as she did not have any dipsticks. Mrs B told HDC that she also carried out a "visual" assessment.

Antenatal care following the fourth appointment

32. Mrs B failed to arrive at Ms A's house for the fourth appointment, at 33 weeks' gestation. Ms A sent Mrs B a text message later that day. The message said that Ms A had to go out and asked Mrs B to call her to re-schedule the appointment.

33. Mrs B contacted Ms A two days later. Mrs B sent Ms A a text message stating that she was "sorry about Friday [date]" and that she had attended two births that day so could not get to her phone. Mrs B advised that she had attended two more births since then and had just woken up. She asked Ms A if she was able to come to her clinic in three days' time. Ms A told HDC that she did not receive this text message. However, telephone records show that the text message was sent by Mrs B.

34. By the day of the appointment, at 35 weeks' gestation, Mrs B had not heard from Ms A, and sent her another text message asking if she would like to drop by her clinic that afternoon. Ms A told HDC that she did not receive this text message. Telephone records show that the text message was sent by Mrs B.

35. Ms A sent Mrs B the following text message two days later: "Hi [Mrs B]. I've just topped up my phone. Been really sick this past week. Can catch up anytime this week." Mrs B did not respond to this message. Ms A sent Mrs B another text message the next day: "Hi [Mrs B], [tried] calling you this afternoon. Could you get back to me so we can make [an appointment] to catch up on our visits. Hope everything is well with you."

36. Mrs B sent Ms A a text message the following day. She apologised for taking a while to respond, advising that it had been her weekend off. Mrs B and Ms A arranged for Ms A to attend Mrs B's clinic three days later.

Antenatal care until the birth

37. On the day of the appointment, at 37 weeks' gestation, Mr A informed Mrs B by text message that Ms A would not be attending the appointment that day. He said that Ms A had been "up all night" but now was asleep and he did not want to wake her. Mrs B responded by text message that this was fine and Ms A could call or text her later.

38. During that evening, Ms A sent Mrs B a text message stating that she had just woken up and had "been feeling pretty crap the last week". Mrs B and Ms A corresponded further by text message that night as follows:

> Mrs B: "Hi [Ms A]..you poor thing, when you say you feel like crap what do you mean?"
>
> Ms A: "Been really run down. headache, [diarrhoea], cramps in belly. Just not sleeping. [Resting] as much as I can, maybe change of weather ☹ not feeling like myself."
>
> Mrs B: "How long have you had cramps and [diarrhoea] for"

Ms A: "[Diarrhoea] for a week. And cramps slowly getting stronger up to now I sit down when I have them for maybe 8-9 days. Not unbearable just uncomfortable."

Mrs B: "Hmmm your body could be getting ready for labour or there could be a viral infection in your body. I will try to come [see] you tomorrow but I have a meeting for most of the day. I will call you tomorrow for a catch up. I might talk to [you] tomorrow about getting some bloods done tomorrow xx."

Ms A: "Yeah that's fine. Thanks."

39. Mrs B mentioned Ms A's symptoms to her colleagues during a meeting the following day and they agreed that Ms A should see her GP as the symptoms were not within a midwife's scope of practice. Mrs B then advised Ms A by text message that she should "probably go to [her] GP", in a text message conversation:

Mrs B: "Hey [Ms A] how are you feeling today. Have spoken to some midwives and doctors about your [diarrhoea] and they feel you should probably go to your GP or after hours as they said there are a lot of tummy bugs going around at the moment. Have you got any bleeding or abnormal discharge?"

Ms A: "No none of that. Just a constant headach[e]. OK I'll try book in shortly. Thanks."

Mrs B: "Hi [Ms A] how are you feeling."

Ms A: "About the same. Doctor's calling me tomorrow morning to get me in. just feel out of steam but ate a whole meal tonight."

40. The following morning, a Friday, Mrs B and Ms A sent the following text messages:

Mrs B: "Hi [Ms A] how are you this morning. When you go to the doctor today, if they take blood tests could you please ask them to copy them to me. Also wondering if you would like to catch up sometime xx"

Ms A: "Yeah just let me know when, I can come to your clinic if you like. When [you're] not too busy."

41. Ms A called her doctor to book an appointment. The receptionist told her that they were extremely busy with people who had the flu, and that because Ms A was pregnant she would need to ask her LMC to examine her and book a doctor's appointment if the LMC thought it was needed. Ms A said that she was also told by the receptionist that she would be charged for the visit if her LMC did not book the appointment, as they were already overfull and she would be classed as an emergency appointment.

42. Mrs B sent Ms A a text message later that day: "Hi [Ms A], what did the doctors say today? Hope [you're] feeling better…" Ms A and Mrs B sent more text messages that night:

> Ms A: "Hey [Mrs B], they said they [have] been flooded with people with flu like symptoms and to stay at home. They asked heaps of questions over the phone, will get me in Monday [date] for bloods but said to go to emergency [department] if I start [vomiting] or discharge changes etc. But I've been eating meals and feeling bit better."
>
> Mrs B: "Oh goodness! Have you got any swelling or visual disturbances?"
>
> Ms A: "Fluid retention. This all just sort of hit me at once. But nothing with my vision."
>
> Mrs B: "Oh good, you poor thing … there are so many terrible things going around at the moment, lots of viral infections which can make us feel pretty disgusting. Should we aim for a clinic visit this Wednesday?"
>
> Ms A: "Yep. Sounds good to me ☺ early if we can Just let me know what time suits you."
>
> Mrs B: "The earliest I have is ten thirty/11 o clock. Do those times suit you? But let me [know] how you are over the weekend."
>
> Ms A: "10am will be fine."

43. Ms A told HDC that by "fluid retention" she meant she had swelling. She said that she had very swollen ankles and feet, and one of her wrists was also swollen. With hindsight, Mrs B acknowledged to HDC that by using the term "fluid retention" Ms A may have meant swelling.

44. Following her text correspondence with Ms A, Mrs B was "satisfied at the time that [Ms A] had a vomiting bug, was seeing her GP on Monday and knew to go to emergency over the weekend if she felt worse". Mrs B "felt [Ms A's] headache was probably due to her feeling unwell with the diarrhoea and vomiting bug for such a long period — the previous 8–9 days, and assumed this question had been covered when she spoke with the GP practice".

45. Mrs B stated that Ms A had reported having headaches on and off throughout the antenatal period, which she had previously put down to tiredness. Ms A denies that she had headaches throughout the antenatal period. There is no reference to headaches in Mrs B's notes, only to Ms A feeling "exhausted". HDC did not receive any evidence that Ms A told Mrs B that she had been vomiting.

46. Ms A told HDC that on Sunday that she began to feel ill very quickly with upper abdominal pain, headaches, sharp, stabbing chest pain, and shortness of breath. She took some Panadol and tried to have a sleep in the afternoon as she was feeling very uncomfortable. As the night went on she began to feel more anxious and unsettled.

47. When she went to go to bed she found she was unable to lie down, as her abdominal pain had spread up towards her shoulder. She was starting to get "a sharp 'stabbing' pain in [her] right shoulder making it hard to breathe". Ms A said that she tried to sleep upright in the lounge, as lying down in bed was "unbearable". However, throughout the night the pain in her chest would not ease and she was unable to sleep.

Antenatal care — Monday

48. Ms A called Mrs B at around 9am on Monday. Ms A told Mrs B that she had not slept the night before and that she "had pains in [her] belly which spread up to sharp stabbing pains in [her] chest". Ms A recalls telling Mrs B that she had a headache and sharp stabbing pains in her shoulder above her heart, which felt like a heart attack.

49. Ms A told HDC that Mrs B replied that Ms A was "probably overtired and working [herself] up". Ms A stated that Mrs B told her that she had experience with "many women calling her saying they had very similar symptoms and they were told they had chest infections". Mrs B advised Ms A to get some electrolyte beverages, and said that if she was really worried she should visit her GP.

50. Mrs B said that when she asked Ms A whether she had other symptoms, Ms A told her that her swelling was no worse than before (Mrs B told HDC that she would describe Ms A's previous swelling as "minimal/barely anything"). Mrs B said that Ms A reported that she had no headaches or visual disturbances.

51. Mrs B's diary note states that Ms A had no headache or visual disturbances and was having "heart attack pains", but there is no mention of swelling. Ms A does not recall discussing swelling or fluid retention with Mrs B during the call, but believes that she mentioned her headache to Mrs B. There is no documentation in the clinical notes in relation to the text messages that Ms A sent about her symptoms in the two weeks prior to this telephone call.

52. Mrs B told HDC that she thought Ms A's complaint of chest pain sounded as if it "may have been more of an asthma pain", and "did not sound obstetric related". Mrs B said that she reached this conclusion on the basis that Ms A was not reporting any other obstetric-related symptoms. Mrs B did not ask Ms A if she had a history of asthma.

53. Ms A called her GP and asked to be seen as soon as possible. The receptionist told her that as they were overbooked, Ms A would need her LMC to call and make the appointment or she would not be able to be seen until the next day. Ms A recalls passing this information on to Mrs B by telephone and asking her to call the doctor to make an appointment for her. Ms A told HDC that Mrs B sent her a text message stating that she would call the medical centre and make an appointment for her when she was finished with her client at around 10am. However, there is no evidence of this text message in the telephone records obtained by HDC.

54. Mrs B told HDC that Ms A did not advise her that she (Mrs B) needed to call the doctor's practice to make the appointment. Mrs B understood that Ms A had an

appointment already, and that the reason Ms A wanted her to call the doctor's practice was to advocate for Ms A so that she did not need to pay for the appointment.

55. Mrs B told HDC that at the time Ms A asked her to call the medical centre, she was with another client. Mrs B says that she tried to call the medical centre from her client's house but could not get through. She later sent Ms A a text message stating that she was too busy to keep trying to get through to the medical centre but advised Ms A to go to the medical centre anyway. Mrs B said that the medical centre could call her when Ms A arrived if she was concerned about payment.

56. The following text messages were sent between Ms A and Mrs B:

> Ms A: "Hi [Mrs B], was waiting to hear back from you to [get me] in to the doctors? Did you manage to call them for me"
>
> Mrs B: "Hi [Ms A] have tried a couple of times but have been unable to get through and been too busy to keep trying sorry but when you get there tell them they can contact me… One of my other women got charged by her GP this morning for the same thing as they told her it was not maternity related. And another woman this morning did not get charged by her GP for the same thing."

57. Ms A called the medical centre again but was told she was unable to be seen unless her midwife called to make the appointment. Ms A said she was very emotional and called her mother to help calm her down. Ms A told HDC that at 11pm her "body took a sudden turn and [she] found it extremely hard to breathe". She felt overly anxious, and the pain in her abdomen and chest made her curl over.

58. In the early hours of the next morning, Mr A drove Ms A to an after-hours medical centre. Ms A stated that she never thought of going to hospital, as she thought the hospital was for "real emergencies" like broken bones or serious car crashes. She thought that if she went to the hospital she would be charged. Ms A told HDC that if she had known she would not have to pay to go to the hospital, and that she would have been welcome, she would have gone there when she had been unable to get an appointment to see her GP.

59. According to the documentation from the medical centre, Ms A arrived at 2.44am complaining of chest pain which was radiating to her right shoulder. It was also noted that she was "distressed". Ms A was noted to have high blood pressure (190mmHg/100mmHg),[8] and high levels of protein in her urine.[9] It was suspected that Ms A had pre-eclampsia, and she was transferred to the public hospital by ambulance for further assessment.

[8] Blood pressure between 90–130mmHg/60–80mmHg is considered normal.

[9] High levels of protein in urine in late pregnancy may indicate pre-eclampsia. Pre-eclampsia is when a pregnant woman develops high blood pressure and protein in her urine after the 20th week of pregnancy. It is considered to be a very serious condition and requires careful monitoring of the mother and fetus. In serious cases, it can endanger the life of the mother and fetus.

Transfer of care

60. Ms A arrived at the emergency department at 3.42am. She was assessed by an Obstetrics and Gynaecology (O&G) registrar, who formed the impression that Ms A was suffering from "severe PET",[10] and it was recommended that Ms A undergo an emergency Caesarean section.

61. The DHB advised HDC that once Ms A had been assessed by the O&G registrar as needing to undergo an emergency Caesarean section, clinical responsibility for Ms A's care was transferred from the LMC (Mrs B) to the O&G team. Clinical responsibility remained with the O&G team until care was formally handed back to the LMC.

62. The DHB said that in circumstances like this, where a woman is under the care of the O&G team, there is no obligation for the woman's LMC to visit or provide support to the woman. However, some LMCs choose to do so, in which case it is expected that the ongoing role of the LMC is clearly documented in the clinical notes.

63. At approximately 4am, Mrs B received a telephone call from the birthing suite at the public hospital about Ms A's condition. Mrs B was told that Ms A would be having a Caesarean section before 7.30am. Mrs B was the backup midwife for another client in the public hospital who was going to be induced at 7.30am. Mrs B planned to attend Ms A's surgery and then attend to the other client for the induction and birth.

64. There is nothing documented in the notes about what Mrs B's ongoing role would be once Ms A was under the care of the O&G team. Ms A understood that Mrs B continued to have responsibility for her care throughout her admission to the public hospital. No one explained to Ms A that once she was assessed as needing an emergency Caesarean section, her care transferred to the O&G team and Mrs B was no longer responsible for her care.

Caesarean section

65. By 5.13am, Mrs B was with Ms A at the public hospital. At 5.45am Ms A was prepared for surgery. According to Ms A's clinical notes, she was taken to theatre at 7.18am and was given spinal morphine[11] at 7.25am.

66. Ms A recalls that Mrs B sat with her while she was being given her spinal morphine, but that Mrs B "seemed rushed and distant". Once Ms A had been given the anaesthetic, Mrs B informed her that she had to leave to attend to another client but "would be back very shortly". Mrs B did not return to Ms A while she was in theatre.

67. When Ms A's surgery was about to start, Mrs B was asked by the birthing suite co-ordinator if Mrs B could attend the other client. The woman was now in established labour and there was no other midwife on duty to look after her. Mrs B said that she

[10] Severe PET (pre-eclamptic toxemia) is another name for severe pre-eclampsia and is characterised by blood pressure above 160mmHg/110mmHg, fluid retention and high levels of protein in the urine.
[11] Spinal morphine is a type of regional anaesthesia and involves the injection of a local anaesthetic into the spine.

"felt awful" for Ms A and Mr A and "tried to negotiate this with the birthing suite co-ordinator".

68. Unfortunately, there was no one else available to care for the woman in labour. Mrs B intended to go and see how far along the woman in labour was and then return to Ms A. However, the woman was at a point in her labour that meant Mrs B was unable to leave her.

69. Ms A's surgery commenced at 7.45am, and her baby was delivered at 7.50am. While recovering in hospital, Ms A's postnatal care remained with the O&G team. Midwifery care was provided by the staff midwives in accordance with the DHB practice outlined above in paragraph 61.

70. Ms A told HDC that Mrs B did not return to see her until 2.30pm that afternoon. Ms A recalled that when Mrs B visited her, Mrs B congratulated her, spoke briefly to Ms A's mother, and told Ms A she would return the next day. Ms A told HDC that Mrs B did not go near her newborn baby, or examine him, and did not ask Ms A how her surgery went. Ms A said that Mrs B's visit did not last any longer than five minutes.

71. Mrs B told HDC that she did return to see Ms A as soon as she could. However, Ms A's room "was busy with family" so she left Ms A to be with her family and newborn son. A staff midwife recorded in the clinical notes at midday that "LMC has been in". Mrs B did not document any notes in the clinical record. Mrs B said that she informed Ms A at this point that the hospital midwives would be taking care of her.

72. The following day Mrs B visited Ms A at around 4pm. During this visit, Ms A recalls that Mrs B "did not move from the door way". Ms A said that Mrs B asked her how she was feeling and "made small, general conversation", but did not examine the baby or come close enough to see him. Mrs B told HDC that during this visit Ms A's room was "filled with family" and she stood by Ms A's bed but did not feel that it was appropriate to stay for an "overly long time".

73. Mrs B believes that she assessed Ms A and her baby "appropriately". She recorded in Ms A's clinical notes at 5pm that she checked Ms A's wound and there was no bleeding or ooze. Ms A told HDC that Mrs B did not check her wound and did not come near her.

74. Mrs B stated that Ms A told her that her wound was sore but "the midwives [were] keeping up with [her] pain relief" and that Ms A described her bleeding as "hardly anything". Mrs B also recorded that Ms A told her that the baby was latching well to the breast and was feeding on demand every two to three hours. Mrs B noted that she was unable to observe the baby feeding as he was asleep.

Termination of relationship and discharge home

75. Two days following the birth, Ms A expressed to the staff midwives her dissatisfaction with the care she was receiving from Mrs B. The staff midwives told Ms A that she could request a new LMC at any time, and offered to refer Ms A to another midwife for postnatal LMC care. Ms A accepted the offer.

76. Later that afternoon, a registered midwife visited Ms A and offered to take over as her LMC. Ms A accepted the offer and sent Mrs B a text message advising her that she no longer required her services. Ms A was discharged home, at which time her care was handed over to the new midwife.

Meeting with Mrs B

77. Mrs B offered to visit Ms A in the hospital. Ms A said that she had been discharged and had returned home. The following day, Mrs B visited Ms A and Mr A at their home.

78. Ms A and Mr A met with Mrs B to explain why they had found Mrs B's services to be unsatisfactory. In particular, they expressed their concern that Mrs B had diagnosed Ms A's pre-eclampsia as a "chest infection", which had put both Ms A's and their baby's life at risk. They also expressed concerns in relation to the large gaps between antenatal visits, that Mrs B had not stayed with Ms A for the duration of the Caesarean section, and the lack of care from Mrs B after the birth.

79. Ms A recalls that Mrs B apologised and said she had been let down by her colleagues. Ms A was dissatisfied with Mrs B's response. Ms A told HDC that she felt Mrs B's apology was "cold" and that Mrs B "blamed [her midwifery practice group] for not supporting her".

80. Mrs B told HDC that "it is regretful that [Ms A] feels that there are parts of her care that did not meet her expectations and I feel sorry that that has occurred". Mrs B was "not sure when the symptoms of [Ms A's] pre-eclampsia would first have been detectable". Mrs B noted that "pre-eclampsia can arise quite suddenly" and said that "the missed appointment with [Mrs B] on [date], and the missed appointments with the GP were opportunities for detection of pre-eclampsia". Ms A has commented that it is incorrect to say she missed her appointment with her GP, as she never had an appointment.

81. Mrs B said that she listened to Ms A's and Mr A's concerns at the meeting and apologised for the issues they raised with her. She does not feel that she tried to blame her midwifery practice group for their lack of support. She feels that she works with a very supportive practice and is sorry if she did not adequately convey this to Ms A and Mr A.

Mrs B's actions since the complaint

82. Mrs B considers that, for the few visits she had with Ms A, there was "quite an extensive birth plan" and "it is regretful [Ms A] had felt unprepared". Mrs B notes that her antenatal visits with Ms A were an hour to an hour and a half long, and that during her visits they discussed "an in depth birth plan". Mrs B stated that it is her standard practice to have more discussion with her clients regarding labour and birth planning at around 36 weeks' gestation.

83. After reflecting on this experience and speaking with senior midwives, Mrs B does not consider that the type of chest pain Ms A was describing was the kind of chest pain that is usually related to pre-eclampsia. However, she has "learned from this and

now know[s] that epigastric pain is not just isolated to the upper abdomen". Mrs B told HDC that she is "now far more cautious when [women] call [her] with chest pain, which often has turned out to be asthma or heartburn".

84. Mrs B accepts that "it would have been prudent and appropriate for [her] to have been pro-active and more vigilant". She noted that even though Ms A was not reporting swelling or visual disturbances (which are both signs of pre-eclampsia), she should have offered to see Ms A during the weekend, as she had not been seen for some time. Mrs B added that she "very much regret[s] not paying more attention to the symptoms of headache and fluid retention" and apologises to Ms A for this.

85. Since this complaint, Mrs B reported to HDC that she has read the Society of Obstetric Medicine of Australia and New Zealand's "Guidelines for the Management of Hypertensive Disorders of Pregnancy" and integrated the guidelines into her practice. She is planning to attend the next local education session on pre-eclampsia.

86. In addition, as a result of this complaint Mrs B reported that she has made the following changes to her practice:

- She will impress upon women the importance of attending an appointment if certain observations have not been carried out earlier. In this case, "it would have been possible to have been clearer to [Ms A] that she should attend [the appointment] on [the day she was feeling ill] so that [Mrs B] could check [Ms A's blood pressure] and protein and assess her visually.
- She will maintain her own copy of the maternity notes after each visit as an aid to reviewing the care given previously.[12]
- She will telephone women rather than text them when they are unwell.
- She will follow up text messages with a telephone call if she does not receive a reply to her text message.
- She will ask women to call her rather than text her if they are unwell.

Advice by text message

87. The Midwifery Council of New Zealand's Code of Conduct contains the following guidance statement alongside the section relating to professional behaviour:

> "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."

[12] Mrs B told HDC that at the time of these events, it was her practice to pull out her copy of the MMPO notes at the end of her last postnatal visit. However, she never pulled out her copy of Ms A's MMPO notes as the relationship was terminated early. Ms A provided HDC with the MMPO notes in relation to the care provided by Mrs B.

88. The Midwifery Council told HDC that all midwives were consulted over the Code of Conduct and that every midwife with a practising certificate was sent a copy of the Code of Conduct in early 2011.

89. Mrs B does not believe that she was aware of the Midwifery Council's "stance on text messaging in [the month that Ms A's baby was born] when [she] was caring for [Ms A]". Mrs B provided HDC with a copy of the Council's newsletter from that time, which states that the Code of Conduct "has now been published and a hard copy will be sent out to midwives shortly. It can also be accessed on line at the Council Internet site." Mrs B told HDC that "given the circumstances in [the region] at the time" she does not recall reading all of the newsletters and information sent to her.

90. Mrs B told HDC that following this complaint her method of communication with clients "has changed completely". She no longer communicates through text messaging. Mrs B also told HDC that she now records all telephone discussions with clients in the MMPO database[13] or on an iPad application that is accessible to all her midwifery partners.

91. Mrs B said that she tried to contact Ms A by landline and mobile "on many occasions and left messages" and, at one point, Ms A's landline was not working. Mrs B told HDC that "[because] of the extreme difficulty I often found contacting [Ms A] through direct phone contact, I resorted to text messaging and found this to be a more effective way of being able to communicate at that particular time".

Relevant standards

92. The *Standards of Midwifery Practice* (2008) provides:

> "**Standard Four**
> The midwife maintains purposeful, ongoing, updated records and makes them available to the woman and other relevant persons.
>
> **Standard Six**
> Midwifery actions are prioritised and implemented appropriately with no midwifery action placing the woman at risk.
>
> **Criteria**
> The midwife:
> …
> - Plans midwifery actions on the basis of current and reliable knowledge.
> - Ensures assessment is on-going and modifies the midwifery plan accordingly.

[13] The MMPO database is a tool for midwives. It contains a list of all the midwife's clients and space to insert comments, diary entries, test results etc. The database is accessible only by the midwife, not the client.

- Identifies deviations from the normal, and after discussion with the woman, consults and refers as appropriate …"

Opinion: Mrs B

93. Some of Ms A's complaint relates to a period of time that was very challenging for everyone living in the region. During this time, midwives in the region were providing extra cover for colleagues and working around the closure of roads and key facilities, while at the same time trying to manage family and personal issues.

94. When assessing whether Mrs B's standard of care was reasonable, I have taken into account the unique context within which she was providing that care.

Antenatal care — From first to fourth antenatal appointment — No breach

95. Mrs B first met Ms A when Ms A was 21 weeks' pregnant. Following this, Ms A had three more antenatal appointments with Mrs B. These occurred at 26 weeks' gestation, 28 weeks' gestation and 33 weeks' gestation.

96. Ms A expressed concern at the lack of information Mrs B gave her during the antenatal period in relation to preparing for the labour and birth. Mrs B told HDC that while it is her standard practice to have more discussion regarding labour and birth planning at 36 weeks' gestation, a basic birth plan had been made with Ms A and Mr A.

97. My midwifery expert, Mrs Joyce Cowan, commented that the documentation of the antenatal visits was good but that there was very little documentation concerning discussion about the birth.

98. Mrs Cowan advised that "on the four occasions that [Mrs B] saw [Ms A] antenatally a reasonable amount of information was shared". Mrs Cowan added that "a final more detailed discussion [about birth planning and preparation for labour] usually occurs around 36 weeks approaching full term". As the last antenatal visit occurred at 33 weeks' gestation, "the opportunity for this detailed discussion did not occur".

99. In relation to information given to Ms A regarding pre-eclampsia, Ms A told HDC that she was never informed of the specific symptoms to look out for or the reasons for the urine tests. In contrast, Mrs B told HDC that she explains to each of her clients the reasons for taking blood tests and urine tests.

100. Mrs Cowan advised that information about pre-eclampsia is usually given incrementally, starting with an explanation about why blood pressure and urine are tested at the first visit, and the symptoms to be alert to (severe headache and sudden onset of swelling). This sort of information is usually provided very early in the pregnancy and, as Ms A did not engage Mrs B's services until she was 21 weeks

pregnant, "it would be harsh for peers to express disapproval concerning [Mrs B's] provision of information".

101. Mrs Cowan looked specifically at the failure by Mrs B to conduct routine urine dipstick testing at her visits at 28 weeks' and 33 weeks' gestation. Mrs B said that she would normally perform a routine urine dipstick but did not perform the test at these times because she had run out of dipsticks. Mrs Cowan stated in her report that while the lack of testing was not "ideal", it was unlikely to have revealed warning signs of pre-eclampsia at the time given the absence of other signs and symptoms.

102. Taking into account the advice of my expert and the events relating to the natural disaster, I consider that there are mitigating circumstances with regard to Mrs B's failure to carry sufficient dipsticks for testing.

103. It is my view that the information and care provided to Ms A by Mrs B during this period was of a reasonable standard. While I acknowledge that Ms A was feeling unprepared for labour and birth, I note that Mrs B had given Ms A a DVD to watch, directed her to websites on labour, and discussed a basic birth plan.

104. I accept Mrs Cowan's advice that a more in-depth discussion around labour and birth would have been likely to take place when Ms A was approximately 36 weeks' pregnant. Unfortunately, despite attempts by both Mrs B and Ms A, no antenatal visit occurred at this time (this is discussed in more detail below at paragraph 105).

Antenatal care — Following the fourth appointment — Adverse comment

105. No antenatal visits took place between the fourth visit at 33 weeks' gestation and Ms A's admission to hospital with pre-eclampsia at 38 weeks' gestation. In particular, Mrs B had arranged to meet Ms A at her home for an antenatal appointment. Mrs B did not attend this appointment and made no contact with Ms A until two days later. On that day, Mrs B sent Ms A a text message explaining that she had attended two births that day and could not get to her telephone.

106. Mrs Cowan advised that one month is a long time between visits for a first-time mother at this stage in her pregnancy. Antenatal visits usually take place fortnightly between 28 weeks' and 36 weeks' gestation, becoming weekly thereafter. Prior to Ms A first reporting feeling ill, she would have expected at least one antenatal visit to have taken place.

107. Mrs Cowan would have expected Mrs B to have repeated a full blood count and antibody screen at that time. However, as the gap between visits was unintentional and there were attempts by Mrs B to accommodate Ms A, Mrs Cowan advised that midwifery peers would not show disapproval in this particular situation.

108. I am concerned by the absence of antenatal visits for four weeks after the fourth appointment. While it is not possible to know whether an appointment during this time would have identified anything of concern, by failing to assess Ms A and carry out blood and urine tests an opportunity was missed to identify the impending complication.

109. I acknowledge that appointments were made but subsequently broken by both Mrs B and Ms A for work, social, and health-related reasons and that, at this time, midwives in the region were working in challenging circumstances.

110. In my view it was unprofessional for Mrs B not to contact Ms A before the appointment she missed to advise that she would not be able to attend. Although Mrs B had a satisfactory reason for being unable to attend the appointment, as a professional and out of common courtesy to Ms A, she should have called to advise that she would not be able to make the appointment.

Antenatal care — Five days leading to the birth — Breach

111. Ms A reported to Mrs B by text message that she was feeling run down, had a headache, and had experienced diarrhoea and cramps for eight to nine days. The next day, Ms A reported to Mrs B by text message that she had a constant headache. Mrs B told Ms A by text message that there were "a lot of tummy bugs going around" and that Ms A should probably see her doctor.

112. The following day, a Friday, Ms A attempted to make an appointment with her doctor but was told that the clinic was overbooked. She was told that if she wanted to be seen that day she would need to get her LMC to assess her in the first instance. If, after the assessment, her LMC still thought it was necessary for her to see the doctor, the LMC would need to make the appointment on Ms A's behalf. The receptionist then told Ms A that she could see a doctor on Monday for blood tests, and that Ms A should go to the emergency department if she started vomiting or if her discharge changed.

113. Ms A informed Mrs B by text message later that night that she had a doctor's appointment for Monday. Ms A also advised Mrs B that she had fluid retention and that "this all just sort of hit me at once". Ms A did not advise Mrs B that her doctor's office had said that she should meet with her LMC for an appointment first. However, Mrs B arranged at this time to see Ms A for an appointment on Wednesday.

114. During this time, Mrs B responded to Ms A by text message. Mrs B asked Ms A for more information about her symptoms and advised her to visit her doctor. At no point over these few days did Mrs B speak with Ms A on the telephone or see her in person.

115. Mrs B told HDC that she was satisfied that Ms A was seeing her doctor on Monday and knew to go to the emergency department over the weekend if she felt worse. Mrs B also told HDC that she was satisfied that Ms A had a vomiting bug, and that Ms A's headache was probably due to her feeling unwell with the diarrhoea and vomiting bug for such a long period. However, Ms A did not complain of vomiting in her text messages.

116. Mrs B did not hear from Ms A over the weekend, but received a telephone call from her at approximately 9am on Monday. Ms A reported that she had sharp stabbing pains in her shoulder that felt like a heart attack, and that she had been unable to sleep the night before. She also reported a headache but does not recall discussing other symptoms such as swelling or fluid retention.

117. Mrs B stated that Ms A denied having a headache, and said that her swelling was "no worse than usual" (which Mrs B had previously considered "minimal/barely anything"). Mrs B told Ms A to drink some electrolyte beverages and to see her doctor if she was really worried. Mrs B continued to communicate by text message after she had spoken to Ms A about her symptoms. Mrs B was under the impression that Ms A was seeing her doctor that day, and followed up by text message asking, "[H]ow did you get on today[?]". Had Mrs B telephoned Ms A, she would have been made aware that Ms A had not seen a doctor that day.

118. Mrs Cowan advised that while it was appropriate for Mrs B to recommend that Ms A see her doctor for a flu-like illness, "the responsibility for maternity care remained with the midwife". A "sudden onset [of swelling] is unusual and of concern" and chest pain "although more unusual with pre-eclampsia is a serious sign of severe disease".

119. Mrs Cowan advised that Mrs B "should have been aware that a severe headache and sudden onset of swelling were possible symptoms [of pre-eclampsia] and needed urgent review". Mrs Cowan noted that pre-eclampsia is unpredictable in its course and can endanger the life of mother and baby. She considered that Mrs B's "failure to personally review [Ms A] … would be viewed with moderate disapproval by her peers".

120. Mrs Cowan also commented that "when symptoms are reported, a midwife needs to speak to her client in order to clarify the level of concern and any need for follow up". I agree. As noted in the guidance statement issued by the Midwifery Council, "text messaging can be an unreliable method of communication, with message transmission delayed at times or messages open to misinterpretation". This is clearly shown by the fact that Mrs B misunderstood Ms A — forming the impression that Ms A had "a vomiting bug" when she did not.

121. As I emphasised in case 11HDC00596:

> "The provision of midwifery advice by text message must be done cautiously. Text message communication does not allow a midwife to properly assess a woman's level of concern, or allow the midwife to be sure that the woman has received the advice and interpreted it as intended. Phoning the woman allows the midwife to better assess any concern that has been expressed and determine whether a physical consultation is necessary."[14]

122. I accept that Mrs B may have had some difficulty in contacting Ms A by telephone to arrange visits. However, given the symptoms reported by Ms A (which could have indicated pre-eclampsia) and the fact that Mrs B had not assessed her for a month, I am concerned that Mrs B did not do more to assess Ms A. I agree with Mrs Cowan that "once [Ms A] did report that she was unwell, the situation changed" and, in those circumstances, Mrs B should not have responded to Ms A via text message without also calling her to clarify and follow up her concerns. Standard 6 of the *Standards of*

[14] At page 14.

Midwifery Practice requires that the midwife plan her actions on the basis of reliable knowledge. By dealing with Ms A's concerns by way of text message, Mrs B did not have reliable knowledge of Ms A's condition, and this placed Ms A at risk.

123. I consider that a personal review by Mrs B was required, as Mrs B was responsible for Ms A's maternity care, and she needed to satisfy herself that Ms A was receiving the care required. If Mrs B could not personally review Ms A, she should have ensured that an appropriate review was provided (if necessary, at the hospital).

124. On Monday, Ms A reported additional symptoms of chest pain. Those symptoms were more severe and required urgent action. Mrs B's response to the combination of symptoms (constant headache, fluid retention and chest pain) — advising Ms A to drink some electrolyte beverages and, if she was really worried, to see her doctor — was inadequate. Again, it was also inadequate for Mrs B to correspond by text message alone. In the circumstances, Mrs B should have carried out an urgent personal review of Ms A or advised Ms A to obtain a review at the hospital urgently.

125. In my view, Mrs B did not respond appropriately to the symptoms reported by Ms A. By failing to ensure that Ms A had a review in the days leading up to the birth, and by failing to ensure an urgent review on Monday in light of the symptoms that Ms A reported, Mrs B failed to provide services with reasonable care and skill and breached Right 4(1) of the Code.

Documentation — Breach

126. I am also concerned about Mrs B's failure to document the numerous text messages in the clinical notes. Accurate documentation of services provided is important to quality and continuity of care. Standard 4 of the *Standards of Midwifery Practice* requires that "the midwife maintains purposeful, ongoing, updated records…" The text messages contained important clinical information about Ms A's symptoms, which needed to be recorded in Ms A's clinical record for future care. Mrs B did not document those symptoms in the clinical notes and made only some brief diary entries.

127. In my view, Mrs B's record-keeping fell short of the requirements of Standard 4. Mrs B failed to provide Ms A with care in accordance with professional standards and, accordingly, breached Right 4(2) of the Code.

Transfer of care, Caesarean section and postnatal care — No breach

128. Ms A was transferred to hospital in the early morning of Tuesday following diagnosis of suspected pre-eclampsia at an after-hours medical centre. Following assessment by an O&G registrar, it was recommended that Ms A undergo an emergency Caesarean section. Mrs B stayed with Ms A during administration of the spinal anaesthetic but did not attend the procedure itself because she was called away to care for another woman in labour at the hospital.

129. While Mrs B made some visits to Ms A in hospital following the delivery, these were brief in nature and were not at the level expected by Ms A of her LMC.

130. My advice from the DHB and Mrs Cowan is that clinical responsibility for Ms A was transferred from Mrs B to the O&G team at the hospital following the decision to admit Ms A in order to perform an emergency Caesarean section. The responsibility for Ms A's care remained with the O&G team until care was formally transferred back to Ms A's LMC.

131. Given that clinical responsibility for Ms A's care lay with the O&G team, I consider that Mrs B's care was appropriate following Ms A's transfer to the public hospital. Where possible, midwives should check that their clients understand the role of the midwife when the client is admitted to hospital for treatment by an O&G team.

Recommendations

132. In my provisional opinion, I recommended that:

1. Mrs B provide a written apology to Ms A for her breaches of the Code.

2. Mrs B review her practice in light of my expert's comments and report back to me on her learning in relation to the local education section on pre-eclampsia that she is to attend;

3. Mrs B provide me with a progress report, including examples, on all changes made to her practice as outlined in her responses to this complaint, by **19 July 2013.**

133. Mrs B is to provide a written apology for forwarding to Ms A by **10 July 2013**.

134. Regarding my provisional recommendation 2, Mrs B has advised me that the first local education section on pre-eclampsia is in October 2013. Accordingly, I recommend that Mrs B review her practice in light of my expert's comments, and report back to me by **6 November 2013** on her learning in relation to the local education section on pre-eclampsia that she is to attend.

135. As per my provisional recommendation 3, I recommend that Mrs B provide me with a progress report, including examples, on all changes made to her practice as outlined in her responses to this complaint, by **19 July 2013.**

136. Further to HDC's notification to the Midwifery Council of New Zealand, the Council has advised that it has conducted a competency review of Mrs B.

Follow-up actions

137. A copy of this report with details identifying the parties removed, except the expert who advised on this case, will be sent to the Midwifery Council of New Zealand, and the Council will be advised of Mrs B's name.

138. A copy of this report with details identifying the parties removed, except the expert who advised on this case, will be sent to the DHB, the New Zealand College of Midwives, and the Maternity Services Consumer Council, and placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

Appendix A — Independent midwifery advice to the Commissioner

The following preliminary expert advice was obtained from Registered Midwife Mrs Joyce Cowan:

"I am a senior midwifery lecturer at Auckland University of Technology and have worked as a self-employed midwife from 1989 to 2011. I have been asked to provide preliminary advice to the Commissioner on [Ms A's] complaint about midwife [Mrs B].

Background Summary

[Ms A] transferred to the care of midwife [Mrs B] on [at 21 weeks]. She was seen again [at 26 and 28 weeks] but [a follow up] was not possible as [Ms A] left [the region]. While away [Ms A] was seen by another midwife. On [her return] there was some difficulty arranging an appointment due to pressure of work for [Mrs B], but [Ms A] was seen [at 33 weeks] and there were no concerns, apart from the fact that [Ms A] was anxious about the birth, as she had not been able to book in to antenatal classes. The next appointment was booked for [two weeks' time].

[Mrs B] was not able to attend [that] appointment as she was at a birth but did not contact [Ms A] until [two days later], when she asked [Ms A] to attend clinic [in three days' time]. [Ms A] did not attend this appointment but sent a text 2 days later asking for another appointment. [A time was made] but [Ms A] did not attend, as she was unwell with diarrhoea and abdominal cramps. That evening [Ms A] contacted [Mrs B] for advice re her illness and [Mrs B] advised [Ms A] to see her doctor, and said she would see her the next day. After consulting with colleagues [Mrs B] decided a medical visit was more appropriate than a midwifery visit and informed [Ms A]. [On Friday] [Mrs B] contacted [Ms A] to request results of any laboratory tests done following the doctor's visit. A consultation was not available due to the doctor being fully booked and an appointment was advised for the Monday with the instructions to go to the after hours doctor should the symptoms worsen over the weekend.

[On Sunday] [Ms A] experienced shortness of breath, headaches and upper abdominal pain. She was uncomfortable and had difficulty sleeping. On [Monday] at 9am she contacted [Mrs B], distraught and upset. [Mrs B] thought that [Ms A] probably had a chest infection and advised rest and electrolyte fluid replacement, and if really worried to see the GP. [Ms A] was unable to obtain an appointment until the following day unless her LMC could arrange something earlier by phoning the surgery, so she asked [Mrs B] to call for her. By 2pm [Mrs B] contacted [Ms A] by text to say she had been unable to contact the GP.

At 11pm that night [Ms A's] chest symptoms returned, and her partner drove her to the after hours medical clinic. [Ms A] was found to have 4 + proteinuria and a blood pressure of 180/99. There were fetal heart rate decelerations, and [Ms A] was transferred to [the] Hospital by ambulance.

On admission a diagnosis of preeclampsia was confirmed and a decision was made to deliver the baby by caesarean section. [Mrs B] was notified of the admission and came in soon afterwards. [Mrs B] stayed with [Ms A] during administration of the spinal anaesthetic but was then called away to provide care for a labouring woman. She returned to see [Ms A] at 2.30pm.

[Ms A] stated that [Mrs B] only saw her briefly on [two occasions postnatally] and on neither occasion did she examine mother or baby. After discussion with one of the hospital midwives, [Ms A] decided to change to another LMC and notified [Mrs B] by text that her services were no longer required. [A final visit was arranged] and [Ms A] told [Mrs B] she did not want her to claim a birth fee, as she did not attend.

Comment

Lead maternity care (LMC) midwives provide primary maternity care and when a woman is admitted under secondary care for a complication such as preeclampsia there is no contractual obligation for the LMC midwife to attend delivery. Many midwives choose to attend to provide support for their clients but this is not a compulsory requirement. This is the situation at [the] Hospital as has been confirmed by [the] Director of Midwifery, in an email communication to [an investigator at HDC].

During the immediate postnatal period following caesarean section, the woman stays under secondary care and receives her midwifery care from the hospital midwives.

The hospital midwives gave [Ms A] special care in the first two days following her operation, as she was still very unwell with pre-eclampsia. In this case the visits from her LMC were in a support capacity, and there would be no expectation that clinical care was provided. Until the care is clearly transferred back to the LMC midwife she has no responsibility to visit, but many do as in this case, just to provide continuity and support.

Supporting Information

I have read the following documentation prior to writing my report:-

1. Complaint letter from [Ms A]
2. [Mrs B's] response
3. [Ms A's] comments on [Mrs B's] response
4. [Ms A's] clinical notes from 24 hr clinic and [the] hospital
5. Letter from Ministry of Health regarding [Mrs B's] claims
6. Text message data between [Ms A] and [Mrs B]
7. Text message data between [Mrs B] and [Mr A]

Questions I have been asked to consider

1. Please advise what standards apply in this case
2. Was there a departure from those standards by [Mrs B]? If so please provide details
3. Please advise whether [Mrs B's] payment claims to the Ministry of Health were appropriate for the care she provided [Ms A].

4. [Ms A] felt unprepared for the birth and was not given any information about pre-eclampsia. Please comment on how peers would view this.

Response

[Mrs B] has a professional responsibility to work within the New Zealand College of Midwives Standards of Practice (NZCOM, 2008). These are as follows:-

One. The midwife works in partnership with the woman

Two. The midwife upholds each woman's right to free and informed choice

Three. The midwife collates and documents comprehensive assessments of the woman and/or baby's health and well-being

Four. The midwife maintains purposeful, ongoing, updated records and makes them available to the woman and other relevant persons

Five. Midwifery care is planned with the woman

Six. Midwifery actions are prioritized and implemented appropriately with no midwifery action or omission placing the woman at risk

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

Eight. The midwife evaluates her practice

Nine. The midwife negotiates the completion of the midwifery partnership with the woman

Ten. The midwife develops and shares midwifery knowledge and initiates and promotes research

2. I am aware that this complaint relates to a very challenging time for midwives working during and after the [natural disaster]. The stress of managing personal and family issues resulting from the disaster combined with extra professional cover for colleagues and the added challenge of travelling with damaged and closed roads with difficult access to key facilities must be considered. Due to the unique stressors of the situation the possibility that this complaint concerns midwifery care that was different from the usual standard provided by [Mrs B] must be considered.

For [Ms A], I acknowledge the experience of having fulminating preeclampsia and an emergency caesarean section has clearly been traumatic and I understand how shocked she would have been following this.

While the context in which the events of [Ms A's] last weeks of pregnancy occurred are unusual because of the [natural disaster], the expectation that a reasonable standard of midwifery care is provided remains. It is fortunate that [Ms A] and her baby were both well following emergency delivery for severe preeclampsia, but there was potential for a less positive outcome given the seriousness of [Ms A's] condition at diagnosis. There are discrepancies between the recall of events when comparing [Ms A's] complaint and [Mrs B's] response and it does seem that there may have been some network problems with receipt of SMS messages at times.

However from reading the documentation I have available it appears there may have been a departure from the standard of care expected for standards 4 and 6 as follows:-

Four. The midwife maintains purposeful, ongoing, updated records and makes them available to the woman and other relevant persons

From the clinical notes I have read, documentation of antenatal visits and the two postnatal hospital visits was good but there was no documentation in the clinical notes concerning the text messages relating to [Ms A's] symptoms in the two weeks prior to emergency delivery. [Ms A was unwell] and there were numerous text messages between this date and the date of admission to hospital but brief diary entries and the SMS transcripts are the only record.

Six. Midwifery actions are prioritized and implemented appropriately with no midwifery action or omission placing the woman at risk

There are several issues relevant to this standard. Whilst I acknowledge the considerable challenges faced by [Mrs B] in arranging antenatal appointments and managing her time faced with extra workload covering for colleagues after the [natural disaster], there was a long period of time between the last antenatal assessment [at 33 weeks of pregnancy and the delivery].

During this time much of the communication was by text message, which is not recommended for discussion of clinical matters. It is positive that [Mrs B] has reflected on this and stated in her letter to the Health and Disability Commissioner (HDC) that she has changed her practice regarding texting in favour of phone calls when women are unwell.

I would consider that peers would view text communication concerning clinical matters with moderate disapproval, but would affirm [Mrs B's] professional reflection on the issue and decision to change practice in the future. Texting is very common as a means of communication, even in a professional context but when symptoms are reported a midwife needs to speak to her client in order to clarify the level of concern and any need for follow up.

Due to the infrequent antenatal visits from 33 weeks it appears that the second antenatal blood tests were not done. It is impossible to know whether any changes could have been detected which may have indicated impending preeclampsia but it is usual to at least repeat a full blood count and antibody screen in the late second or early third trimester. [Mrs B] has stated in her letter to HDC dated September 22nd 2011 that she 'will impress upon women the importance of attending an appointment if certain observations have not been carried out earlier', so has clearly reflected on this matter and will address the issue of missed appointments differently now.

While there are discrepancies between the SMS transcripts and the recall stated in respective reports from [Ms A] and [Mrs B], it seems clear from text records that [Ms A reported a headache] which she described as 'constant' the following day. She reported a sudden onset of oedema [two days later] and then severe chest pain [three days later]. Even though it may have seemed that some of [Ms A's] symptoms could have related to a possible gastric upset or flu like illness, for which a GP assessment

was certainly appropriate as [Mrs B] stated, the responsibility for maternity care remained with the midwife.

As [Mrs B] had not assessed [Ms A] for some time prior to her becoming unwell, reports of a headache, sudden onset of fluid and chest pain needed urgent midwifery assessment, as these symptoms are associated with preeclampsia. At the least a blood pressure check and urine test were called for.

Headaches are common with other conditions and swelling is common in pregnancy but a sudden onset is unusual and of concern, and chest pain, although more unusual with preeclampsia is a serious sign of severe disease and any woman presenting with these symptoms should be seen by her midwife or referred to the hospital maternity assessment unit urgently.

The time between the last antenatal visit and [Ms A's] admission to hospital for preeclampsia was over a month. Usually a woman would be seen fortnightly between 28 and 36 weeks and thereafter weekly. It was very difficult for [Ms A] and [Mrs B] to organize times for visits and keep appointments due to pressure of work, social and health reasons but at least one extra visit during the interval between 33 weeks and delivery would reasonably have been expected.

Under the circumstances midwifery peers would have empathy with the challenges faced by [Mrs B] in arranging an antenatal appointment during this time. There were difficulties encountered by both [Mrs B] and [Ms A]. Aside from the issue of [Ms A's] illness leading up to delivery, peers would agree that a month is a long time between visits for a first time mother at this stage of pregnancy. However, it is clear this length of time between visits was unintentional and [Mrs B] tried to be accommodating with options. My opinion is that peers would not show disapproval knowing the difficult situation (**prior to onset of illness**).

Once [Ms A] did report that she was unwell, the situation changed. A GP visit seemed appropriate for the initial symptoms but importantly a visit in response to the above symptoms (headache, oedema and chest pain) would have been appropriate as preeclampsia can endanger the life of mother and baby and is unpredictable in its course. [Mrs B] has reflected on this and stated that she will respond more actively to reports of symptoms in the future.

The fact that [Mrs B] was expecting her client to be seen by a doctor for another possible (non pregnancy related) reason for the symptoms would have reassured the midwife that her client was going to have a professional review. She did try to contact the doctor herself to arrange an urgent appointment but was unable to get through to the surgery. However, the nature of the symptoms should have alerted her to consider the possibility of pre-eclampsia and arrange urgent midwifery review either by personal visit or referral to hospital.

Failure to personally review [Ms A] when she had reported a constant headache, sudden onset of fluid retention and chest pain would be viewed with moderate disapproval from peers.

3. [Mrs B's] claims to the Ministry of Health were for the last partial payment for the first and second trimester and the third trimester. [Mrs B] did not carry out the usual number of antenatal visits due to difficulties with communication and cancelled appointments for various reasons but in completing her claim forms for payment she would have had to state how many visits were completed in each trimester, and as there is no minimum number of visits required to qualify for payment, the claims appear appropriate for the duration of care provided.

[Mrs B] did not claim the birth attendance or for the three occasions when she visited [Ms A] postnatally. At this stage of providing preliminary midwifery advice I do not consider it appropriate for me to comment on *provision of care* in relation to claims rather the *duration of care* as above.

1. [Ms A] has stated she felt unprepared for the birth and did not have any information about pre-eclampsia.

(a) It is not possible to know how much discussion occurred concerning labour as there was very little documentation concerning discussion about birth apart from record of loan of a DVD. It is difficult to document all discussions as often aspects of birth are mentioned during trips to visit a birthing unit, or during an antenatal visit in general conversation. Usually the formal birth planning and preparation for labour happen in the last few weeks, generally around 36 weeks. As the last antenatal visit was at 33 weeks, the opportunity for this did not happen.

(b) Information about pre-eclampsia is usually given incrementally, starting with an explanation about why blood pressure and urine are tested at the first visit. Following that, if there are any concerns, more information is provided relating to the level of concern, possible further action and what may happen. No-one can ever be prepared for the severe pre-eclampsia experienced by [Ms A], but she should have been aware that a severe headache and sudden onset of swelling were possible symptoms and needed urgent review. The midwife usually discusses this sort of information very early in the pregnancy and often an information leaflet or list of things to report is provided for the woman.

In the circumstances, and due to the fact that [Ms A] had another midwife involved with her care prior to 20 weeks, it would be harsh for peers to express disapproval concerning [Mrs B's] provision of information. She did not get an opportunity to discuss a birth plan, as the appropriate antenatal visit did not occur. What was written in the notes does not necessarily reflect everything that was discussed but ideally sharing of information should be documented at each visit as a record of topics covered.

Conclusion

In writing this report I am mindful of the extremely difficult context due to ongoing pressures following the [natural disaster]. It would have been very challenging for any midwife to continue providing good care faced with such enormous stress, and increased workload due to covering for colleagues on top of all this. I am also aware

that the gaps in care were affected by problems with SMS communication and frequent need to change arranged times by both [Ms A] and [Mrs B].

While it is good to know that [Ms A] and her baby are well it is understandable that [Ms A] was concerned about her care. It is also positive that [Mrs B] has reflected on the complaint with her professional colleagues and made several positive changes to improve her care in the future.

Joyce Cowan
Midwife
MHSc. Hons

Reference

NZCOM (2008) Handbook for Practice. New Zealand College of Midwives"

Further expert advice in light of additional information provided to HDC:

The following further expert advice was obtained from Registered Midwife Mrs Joyce Cowan:

"1. I have been asked to provide additional advice to the Commissioner on [Ms A's] complaint about midwife [Mrs B].

2. As stated in my preliminary advice, dated 19th June 2012, I am a senior lecturer in midwifery at Auckland University of Technology and have worked as a self-employed midwife from 1989 to the present.

3. I did not mention previously, but feel it may be pertinent to this report to mention that I have a special interest in the pregnancy condition pre-eclampsia and have been Director of the charity New Zealand Action on Pre-eclampsia (NZAPEC) since 1995. The charity exists to raise awareness of the condition, support sufferers and provide information for professionals via newsletters and study days.

Background Summary

4. [Ms A] transferred from the care of her first midwife to the care of midwife [Mrs B] [at 21 weeks]. She was seen again [at 26 and 28 weeks] but [a follow up] was not possible as [Ms A left the region].

5. While she was away, [Ms A] was seen by another midwife. On [her return] there was some difficulty arranging an appointment due to pressure of work for [Mrs B], but [Ms A] was seen [for a fourth appointment] and there were no concerns on this date, apart from the fact that [Ms A] was anxious about the birth, as she had not been able to book in to antenatal classes. The next appointment was booked for [two weeks later].

6. [Mrs B] was not able to keep [that] appointment as she was at a birth but did not contact [Ms A] until [two days later], when she asked [Ms A] to attend clinic [in three

days' time]. [Ms A] did not attend this appointment but sent a text 2 days later asking for another appointment. A time was made [a few days later] but [Ms A] did not attend, as she was unwell with diarrhoea and abdominal cramps.

7. [That evening] [Ms A] contacted [Mrs B] for advice re her illness and [Mrs B] advised [Ms A] to see her doctor, and that she would contact her [the next day]. (After consulting with colleagues [Mrs B] had decided a medical visit was more appropriate than a midwifery visit and hence this is what she advised [Ms A]).

8. [Ms A] reported a constant headache [that day], during text communication following up the concerns of the previous day.

9. [On Friday] [Mrs B] contacted [Ms A] by text to request results of any laboratory tests done following the doctor's visit. [Ms A] informed her that a consultation had not been available due to the doctor being fully booked and an appointment was advised for the Monday with the instructions to go to the after hours doctor should the symptoms worsen over the weekend. On this date [Ms A] informed [Mrs B] that she was experiencing fluid retention which had developed suddenly.

10. [On Sunday evening] and continuing during the night, [Ms A] experienced shortness of breath, headaches and upper abdominal pain. She was uncomfortable and had difficulty sleeping. On [Monday] at 9am she contacted [Mrs B], distraught and upset. [Mrs B] thought that [Ms A] probably had a chest infection and advised rest and electrolyte fluid replacement, and if really worried to see the GP.

11. [Ms A] was unable to obtain an appointment until the following day [Tuesday] unless her LMC could arrange something earlier by phoning the surgery, so she asked [Mrs B] to call for her. By 2pm [Mrs B] contacted [Ms A] by text to say she had been unable to contact the GP.

12. At 11pm on [Monday night] [Ms A's] chest symptoms returned, and her partner drove her to the after hours medical clinic. [Ms A] was found to have 4+ proteinuria on the dipstick urinalysis and a blood pressure of 180/99. There were fetal heart rate decelerations, and [Ms A] was transferred to [the] Hospital by ambulance.

13. On admission a diagnosis of preeclampsia was confirmed and a decision was made to deliver the baby by caesarean section. [Mrs B] was notified by phone of the admission and came in soon afterwards, around 4am. [Mrs B] stayed with [Ms A] during administration of the spinal anaesthetic but was then called away to provide care for a labouring woman. She returned to see [Ms A] at 2.20pm.

14. [Ms A] stated that [Mrs B] only saw her briefly on [two occasions postnatally] and on neither occasion did she examine mother or baby. After discussion with one of the hospital midwives, [Ms A] decided to change to another LMC and notified [Mrs B] by text that her services were no longer required. A final visit was arranged for [two days following the birth] and [Ms A] told [Mrs B] she did not want her to claim a birth fee, as she did not attend.

Comment

15. Lead maternity care (LMC) midwives provide primary maternity care and when a woman is admitted under secondary care for a complication such as preeclampsia there is no contractual obligation for the LMC midwife to attend delivery. Many midwives choose to attend to provide support for their clients but this is not a compulsory requirement. This is the situation at [the] Hospital as has been confirmed by [the] Director of Midwifery, in an email communication to [an] investigator at HDC on June 1st.

16. During the immediate postnatal period following caesarean section, the woman stays under secondary care and receives her midwifery care from the hospital midwives.

17. The hospital midwives gave [Ms A] special care in the two days immediately following her operation, as she was still very unwell with preeclampsia. In this case the visits from her LMC were in a support capacity, and there would be no expectation that clinical care was provided. Until the care is clearly transferred back to the LMC midwife she has no responsibility to visit, but many midwives do as in this case, just to provide continuity and support.

Supporting Information

18. I have reviewed for the second time the following documentation:-

Complaint letter from [Ms A] (with supporting documentation)

[Mrs B's] response to the complaint

[Ms A's] comments on [Mrs B's] response and a copy of [Mrs B's] response for my reference

[Ms A's] clinical notes from 24 hr clinic

[Ms A's] clinical notes from [the] hospital

Letter from Ministry of Health regarding [Mrs B's] claims

Text message data between [Ms A] and [Mrs B]

Text message data between [Mrs B] and [Mr A] ([Ms A's] partner)

I have also read the additional information sent to me in March 2013 as follows:-

Notification letter

[Mrs B's] response to notification

Telephone interview with [Mrs B]

Further information from [Mrs B]

Further information from [Ms A]

Telephone interview with [Ms A]

Review of initial advice

19. I have been asked by [an] investigator for the Health and Disability Commissioner, to advise if my initial advice has changed in any way following my review of the additional information. There are two matters I would like to discuss following my access to the additional information.

a) Concerning texting

I note that in my original report on page five I commented 'I would consider that peers would view text communication concerning clinical matters with **moderate disapproval**, but would affirm [Mrs B's] professional reflection on the issue and decision to change practice in the future'.

I would like to modify my opinion to state that I would consider peers would view text communication concerning clinical matters in this case with **mild disapproval** *except* in the instance regarding the complaint of chest pain, sudden onset of fluid, and headache. I still consider that texting in regard to these symptoms would be viewed with **moderate disapproval**.

While the New Zealand College of Midwives has discouraged text messaging regarding clinical matters for some years through elective education workshops on communication and documentation, I have modified my opinion for the following reason:-

Firstly, I have considered [Mrs B's] response letter to [HDC] dated 26th September 2012. In point 4, [Mrs B] stated that she was not aware of the Midwifery Council's official stance on text messaging (as officially published in the Code of Conduct document) at the time that the complaint refers to. She had not received her printed copy of the document at the time in question and secondly, [Mrs B] has emphasised in this letter, (point 4) that she had extreme difficulty contacting [Ms A] directly by phone call.

b) **Concerning action following report of headache and later chest pain.**

My initial advice that 'failure to personally review [Ms A] when she had reported a constant headache, sudden onset of fluid retention and chest pain would be viewed with **moderate disapproval** from peers' is **unchanged.**

I must note however, that in the telephone interview between [Ms A] and [an] HDC investigator … dated 1st February 2013, and the response letter to [the investigator] from [Mrs B] dated 26th September 2012 there is conflicting evidence regarding the report of fluid retention.

[Ms A] stated in point 7 (record of telephone interview dated 1st February 2013) that she 'does not recall discussing fluid retention/swelling at all with [Mrs B]', but [Mrs B] has confirmed in her response letter (dated 26th September 2012, point 5) that [Ms A] [reported a constant headache and that on the following day] [Ms A] texted to report fluid retention: 'This just sort of hit me all at once. Nothing with my vision.'

Rapid development of swelling (oedema) is of significant concern, as it may be a symptom of preeclampsia (Lowe et al., 2008). A headache is a common symptom of severe preeclampsia, but there are many other less serious reasons a woman may experience headache in pregnancy.

[Mrs B] also agreed that [Ms A] had complained of chest pain, that the swelling was no worse than before and there were no other symptoms (point 6a). The date is not stated in regard to this point but it seems clear that point 6a refers to text communication on [Monday]. Even though the swelling had not become worse by [Monday] and there were no other symptoms on that date, the symptoms reported collectively [during the days leading up] were of concern. [Ms A] had not been seen for an antenatal check since [her fourth appointment] and therefore urgent midwifery review was indicated.

Additional questions I have been asked to consider:

20. Specific comment on the following matters:

1. The number of urine tests carried out during the antenatal period.
2. The level of information [Mrs B] gave [Ms A] regarding labour and birth
3. [Mrs B's] communication with [Ms A] regarding handover of her care to secondary services

Response

20.1. Urine testing

a) Urine testing is routine practice in maternity care in New Zealand, as it is in most parts of the developed world. The rationale for routine urine testing, apart from detection of infection, is to detect proteinuria (presence of protein in the urine), which can be a sign of pre-eclampsia, normally characterized by hypertension (high blood pressure). Hypertension is diagnosed when the blood pressure reaches a level of 140 mmHg systolic (top number) and/or 90 diastolic (bottom number). Proteinuria is the most commonly recognized additional feature after hypertension, but very occasionally might predate hypertension (Lowe et al, 2008).
b) The usual method of detection of proteinuria by midwives in the community is by dipstick urinalysis but there is a high degree of false negative and positive results with this method. Any positive result should be followed up by a more definitive test such as a urinary protein-creatinine ratio, performed in the laboratory.
c) Murray et al. (2002) looked at the usefulness of routine urinalysis in pregnancy by conducting a prospective study of 1000 Australian women. In the study, only 6 women developed proteinuria before the onset of hypertension, leading the researchers to question the value of routine testing for protein without other signs or symptoms of preeclampsia. An earlier study by Gribble, Fee and Berg (1995) had found that where there were no objective findings of possible pre-eclampsia, dipstick urinalysis did not provide any clinically important information regarding pregnancy outcome.
d) However, there is no current recommendation to drop this routine aspect of care and understandable concern that omitting it may lead to delay in diagnosis

of pre-eclampsia. I am aware that some practitioners do not routinely perform the test but this is definitely not the recommendation of my organization (NZAPEC) or our medical advisors.

e) In regard to the number of times [Ms A] had her urine tested while under the care of [Mrs B], there were four visits (at 21, 26, 28 and 33 weeks) and urine was tested and found negative on the first two visits. On the subsequent two visits the test was not performed because [Mrs B] had run out of dipsticks to perform the test. [Ms A's] blood pressure was normal on each of these visits at 110/60, 100/60, and 110/70 and 110/70 respectively. There were no symptoms of pre-eclampsia recorded, such as oedema, upper abdominal or upper back pain, headache, visual disturbances, nausea, or a general feeling of being unwell.

f) [Mrs B] has stated in her correspondence to [the HDC investigator] on 26th September 2012, point 2b that she normally would perform a routine urine dipstick at each visit. Had she seen [Ms A] on further occasions I am assuming she would have had dipsticks available and continued her usual practice of routine dipstick testing.

g) In summary, I do not consider it ideal that there was no routine dipstick testing at 28 and 33 weeks but in the absence of other signs and symptoms at those dates it was unlikely that proteinuria would have already been present.

h) In the circumstances of the [natural disaster] and aftermath, and in what appeared to be at the time a normal pregnancy, I feel that not having performed a urinalysis on two occasions was a departure from an appropriate standard of care but would be viewed with **only mild disapproval** by peers, and could be viewed as **satisfactory care** by others.

20.2. Level of information regarding labour and birth:

a) In response to this issue, it would have been helpful to see a copy of the care plan from the notes given to [Ms A], as I expect this would contain a record of the information shared. The investigator for the HDC requested a copy of this but at the time of writing this report the care plan had not been made available by [Ms A]. [Mrs B] did not retain a copy for herself, therefore was not able to provide it.

b) [Ms A] was anxious about labour and birth, as she had not been able to book into antenatal classes. [Mrs B] had tried to help with this but had also been unsuccessful. It is usual for midwives to discuss a detailed plan for labour care around 36 weeks. As the last antenatal visit for [Ms A] was at 33 weeks, it is understandable that details of labour were not yet fully discussed. However, in the four antenatal visits that [Ms A] had with [Mrs B], the following matters were discussed:-

I. Place of birth
II. Option of water birth
III. Partner's involvement
IV. Management of the third stage of labour (delivery of the placenta)
V. Partner to 'catch' baby and cut the umbilical cord
VI. Delayed cord clamping
VII. Skin to skin contact for mother and baby

VIII. Massage
IX. Moxibustion
X. A breast-feeding DVD was lent to [Ms A] by [Mrs B] and a DVD for fathers was recommended for [Ms A's] partner, [Mr A].

c) [A 'preparation for labour and birth' DVD] was loaned to [Ms A] by [Mrs B]. According to [Ms A] (telephone conference with HDC investigator) this did not include information about coping with labour and birth.
d) A visit to [the birthing unit] was also arranged and one of the antenatal visits occurred there.
e) It is understandable that [Ms A] did not feel fully prepared for labour and birth. It is difficult to prepare someone for the type of emergency that she experienced, and during the antenatal visits that [Mrs B] provided there had been no indication that [Ms A] would develop severe preeclampsia leading to emergency caesarean section.
f) I feel that on the four occasions that [Mrs B] saw [Ms A] antenatally a reasonable amount of information was shared. Information about labour and birth is often discussed incrementally and a final more detailed discussion usually occurs around 36 weeks approaching full term. The opportunity for this detailed discussion did not occur. According to the Midwives Handbook for Practice, which guides New Zealand Midwives, 36 weeks is the 'Fourth Decision Point in Pregnancy' and it is at this visit that details about the birth plan are discussed and recorded (NZCOM, 2008).
g) In the context of just four antenatal visits from 21 to 33 weeks, I do not feel that provision of information about labor and birth fell below a reasonable standard.

20.3. Communication regarding handover to secondary services:

a) In the correspondence to [the] HDC investigator … dated 15th February 2013, from [the] (legal advisor for the New Zealand College of Midwives), [Mrs B's] response to the following question was stated:-

Question:

'What conversations, if any, did she have with [Ms A] about the transfer of her care to the O& G team and hospital midwives?'

Response:

'Secondary services had already decided to perform a caesarean section by the time of my arrival at the hospital. A transfer of care had already occurred. It would be reasonable to expect the hospital team to have thus explained this to [Ms A]'.

b) In this circumstance, it would be reasonable for [Mrs B] to assume that transfer of care had been discussed with [Ms A] by the secondary team as the preparation for and procedure of emergency caesarean due to severe preeclampsia clearly fell out of the scope of primary care. It would have been optimal for [Mrs B] to check with her client that she understood this, but it

would be harsh to say that care fell below a reasonable standard because of this assumption. There was a degree of urgency with the transfer of care, and the fact that [Mrs B] had to rush away to care for another woman in labour compounded the situation. As stated in point 14, [Mrs B] had no obligation to accompany [Ms A] in theatre and was doing so voluntarily, even though the secondary team had called her.

c) As stated in points 15 and 16, there is no obligation for the LMC midwife to provide any immediate postnatal care until secondary services hand back the woman's care. Usually this is between 24 and 48 hours postpartum, and can be longer if there are any postpartum complications.

d) The circumstances around [Ms A's] development of severe preeclampsia and subsequent admission to hospital and emergency caesarean section would have been very traumatic for her. It is natural that she looked to her LMC midwife for clarification of her care. However, in the context of [Mrs B's] responsibilities to another woman in labour and the fact that handover of [Ms A's] care to secondary services had clearly happened before she arrived at the hospital, her assumption that handover had been explained by the secondary team was reasonable although clearly in hindsight clarification would have been helpful for [Ms A].

e) I do not consider that care fell below a reasonable standard on this point.

Summary

Overall, the circumstances faced by [Mrs B] during the time relating to this complaint were very challenging due to the [natural disaster], extra responsibilities providing cover for midwifery colleagues. [Mrs B] was in an unenviable position. While there was a departure from a reasonable standard of care, it is good to note that [Mrs B] has reflected and improved the standard of her documentation, has apologised to [Ms A] for not following up her symptoms, has changed her practice regarding texting and is seeking further education regarding preeclampsia.

Joyce Cowan
Midwife (MHSc. Hons)
21st April 2013

References

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