Antenatal care of woman with pre-eclampsia and HELLP syndrome (13HDC00952, 23 June 2015)

Midwife ~ Student midwife ~ Antenatal care ~ Pre-eclampsia ~ HELLP syndrome ~ Urinalysis ~ Weighing ~ Rights 4(1), 4(2), 1(1)

A woman became pregnant with her first child and engaged a midwife as her lead maternity carer (LMC). The midwife did not weigh the woman or test her urine at any of the antenatal appointments and kept minimal records. The woman felt that her appointments with the midwife were rushed, and she felt unable to ask questions.

When the woman was 38 weeks' pregnant, she had an appointment with the midwife, during which a student midwife was present. The student took the woman's blood pressure and informed the midwife that it was elevated. The midwife did not document rechecking the high blood pressure reading or any further action.

The woman recalls that the midwife informed her that the student would be present at the birth. The woman was concerned at this, so emailed the midwife explaining that she and her husband would prefer not to have the student there. The midwife responded to the email explaining that the student would be a great support, and stated: "Think it is not a wise decision."

A week later, the woman had a further antenatal appointment. The student midwife took the woman's blood pressure and recorded it as normal, but this was not checked by the midwife.

The woman called the midwife the next day as she had pain in her mid chest. The woman had eaten fried chicken an hour previously, and the midwife suggested the woman rest, as the pain could have been caused by the fatty food. The midwife said that if the pain did not subside, the woman might have food poisoning or a gall bladder problem and should seek medical help if her condition worsened. The woman self-presented to the local hospital emergency department that night with epigastric pain and high blood pressure. She was diagnosed with severe pre-eclampsia and HELLP syndrome.

The woman underwent an emergency Caesarean section, and her baby subsequently progressed well. However, the woman was transferred to the intensive care unit. Her recovery was complicated by a large subcapsular haematoma (bleeding in the liver), and she remained in hospital for a month.

It was held that the midwife's antenatal care of the woman was suboptimal. The midwife did not establish the woman's medical history, failed to monitor her appropriately by urinalysis and appeared not to elicit from the woman that she had oedema and that there had been a reduction in fetal movement. Further, the midwife failed to respond to the woman's high blood pressure appropriately at the 38 week appointment by rechecking the reading and by undertaking urinalysis at that point. At the 39 week appointment, the midwife did not assess the woman's blood pressure herself despite the high reading the previous week. Accordingly, the midwife failed to provide services with reasonable care and skill and breached Right 4(1).

The midwife's email response to the woman in relation to the student's presence at the birth was inappropriate and disrespectful, and therefore the midwife breached

Right 1(1). The midwife's inadequate documentation amounted to a failure to comply with professional standards and, accordingly, the midwife breached Right 4(2).

It was recommended that the midwife provide an apology to the woman, a reflection on the case, and undertake further training. The Midwifery Council of New Zealand was asked to consider whether a further competence review was warranted.