Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

A Decision by the Deputy Health and Disability Commissioner

(Case 22HDC01257)

Introduction

1. This report is the opinion of Rose Wall, Deputy Health and Disability Commissioner, and is made in accordance with the power delegated to her by the Commissioner. The report discusses the care provided to Ms A by registered midwife (RM) B.[1]

2. On 23 May 2022, the Nationwide Health and Disability Advocacy Service (the Advocacy Service) referred a complaint to HDC from Ms A regarding the care provided to her in 2021 by her lead maternity carer (LMC), RM B, an independent midwife. Ms A's complaint concerns RM B's lack of follow-up after arranging for Ms A to have a scan in her first trimester due to bleeding. RM B became uncontactable and did not respond to Ms A's requests for follow-up. As a result, Ms A had to engage a new LMC midwife.

3. RM B has not engaged with HDC about Ms A's complaint, despite HDC's repeated attempts to contact her.

4. The following issues were identified for investigation:

- *Whether the care provided to Ms A by RM B in December 2021 was appropriate.*
- *Whether following receipt of Ms A's complaint, RM B complied with Right 10(3) of the Code of Health and Disability Services Consumers' Rights.*

Information gathered during investigation

Background to complaint

5. In late 2021, Ms A was at an early stage in her pregnancy with her fourth child, which was due in July 2022. Ms A contacted RM B and engaged her to be her LMC.[2] RM B had been Ms A's LMC during her previous pregnancy.

6. Ms A told HDC that she did not have any documentation from RM B to confirm that RM B was her LMC.

[1] RM B is registered as a midwife with the Midwifery Council of New Zealand and holds an annual practising certificate.
[2] A Lead Maternity Carer is responsible for organising a woman's maternity care and for developing care/birth plans with the woman.

7. Ms A said that she experienced continual bleeding from the start of her pregnancy, and she told RM B this. RM B arranged an ultrasound scan for Ms A on 21 December 2021 and documented the clinical indication on the referral form as 'PV bleeding[3]'.

8. Ms A does not remember RM B giving her any indication of when she would be informed of the results of this scan. Ms A said that she telephoned RM B's work mobile telephone number in mid-January 2022 and was told by one of RM B's colleagues that RM B was on leave and would contact Ms A when she returned. Ms A does not recall any timeframe being provided for the call back.

9. Ms A told HDC that following the ultrasound scan, she did not receive any further communication from RM B about the scan results, nor did she receive any further communication from RM B. Ms A said that it was very distressing when she was waiting for RM B to contact her, as her bleeding continued, and she did not know the cause.

10. Ms A said that she made several unsuccessful attempts to contact RM B, by telephone call, text message, and email. Ms A provided HDC with a copy of one such email, dated 11 January 2022, but she was not able to retrieve records of her telephone and text attempts to contact RM B.

11. Ms A said that she had to engage another midwife in February 2022 to continue her antenatal care, as she had been unable to contact RM B. Ms A told HDC that there were no LMCs available in the district where she lived, so her doctor put her in contact with RM C, who was based in another district. Ms A relocated in early April 2022 to receive LMC care from RM C.

12. Ms A told HDC:

> 'This took a toll on my family and I as my partner was working in [our home town] so he stayed at our house and I had to move in with [a family member] just to be able to get any help with my pregnancy.'

13. Ms A received the results of the 21 December 2021 ultrasound scan from RM C at her first appointment on 24 February 2022. The scan showed a moderate right posterior subchorionic haemorrhage,[4] which is a common cause of bleeding in early pregnancy.

14. Ms A said that the rest of pregnancy went well, and she remained under the care of RM C.

15. Ms A delivered her baby 10 weeks early. As the baby was premature, Ms A and her baby were transferred to a main centre hospital. Ms A was discharged the following day; however, her baby was admitted to the Neonatal Intensive Care Unit (NICU). Her baby remained in hospital for nine weeks before being discharged home. Ms A feels that

[3] Per vaginum bleeding. It is common for pregnant women to have some bleeding during their pregnancy, but it can be a sign of miscarriage or other serious complications.
[4] Subchorionic bleeding is a collection of blood between the uterus and the gestational membranes during pregnancy. It can be associated with an increased risk of pregnancy complications.

inadequate care from RM B in the first part of her pregnancy contributed to the premature delivery of her baby.

16. Ms A told HDC:

> 'As you could imagine this caused a great stress as we had 3 other children at home and we had no idea that [baby] arriving early could even happen …
>
> I suffered emotionally during the whole experience of being in NICU. And I feel that if [RM B] had … given me the results of that scan then I could have tried to mentally prepare myself and my family to the possibility of a premature birth.'

Complaint to RM B

17. Ms A raised her concerns about the care she received from RM B with the Advocacy Service. A letter was written by an advocate on behalf of Ms A and sent to RM B on 21 March 2022. The key issues identified in the letter were the loss of contact with no explanation, the lack of reassurance or support despite bleeding continuously, and that the results of the scan were not available until Ms A engaged a new midwife.

18. As no response was received from RM B, another letter was sent by the Advocacy Service on 28 April 2022, asking RM B to respond to the original letter. RM B did not respond, and, to date, Ms A has not received any explanation from RM B for her loss of contact and lack of follow-up.

19. Ms A told HDC:

> 'At the end of the day, all I wanted from [RM B] was for her to acknowledge her negligence and for an apology. Not for her to ignore every attempt that was made to get in contact with her and drag this on for the past 2 years.'

20. Ms A said that RM B sometimes visits her workplace (for reasons unrelated to midwifery), and in the absence of an apology or explanation from RM B, these occasions cause Ms A distress. Ms A does not engage with RM B during these visits.

HDC's attempts to contact RM B

21. HDC asked RM B to provide information in relation to Ms A's complaint on several occasions — 12 July 2022, 7 November 2022, 9 January 2023, 31 January 2023, 29 August 2023, 26 September 2023, and 11 March 2024.

22. RM B communicated her intention to submit a response to Ms A's complaint on 9 January 2023, but to date, HDC has not received any such response, and RM B has not responded to HDC's subsequent attempts to contact her.

Responses to provisional opinion

23. Ms A and RM B were given the opportunity to respond to the provisional opinion.

24. Ms A confirmed to HDC that she had no comments on the provisional opinion.

25. RM B did not submit a response to the provisional opinion, despite several further attempts[5] by HDC to contact her by telephone and email.

Opinion: RM B — breach

26. As a healthcare provider, RM B was required to provide Ms A with services that met the accepted standards of midwifery care. In addition, RM B was required to respond to Ms A and take prompt steps to try to resolve her complaint. I am critical that RM B did neither of these things. I have set out my decision below.

Care and communication

27. The New Zealand College of Midwives (NZCOM) Handbook for Practice[6] outlines its Standards of Midwifery Practice (the standards). NZCOM states that its standards are 'the foundation of midwifery practice' and provide guidance for the midwife's practice and the appropriate use of the midwife's body of knowledge. I consider that two of the standards are particularly relevant to Ms A's experience.

28. Standard One — 'The midwife works in partnership with the woman' — requires that, amongst other things, the midwife facilitates open interactive communication and negotiates shared decision-making, shares relevant information within the partnership, and recognises that continuity of care enhances partnership.

29. Standard Five — 'Midwifery care is planned with the woman' — requires that, amongst other things, the midwife supports the woman in seeking out information; ensures that care is woman-centred; sets out specific midwifery decisions and actions in an effort to meet the woman's goals and expectations and documents these; and facilitates opportunity for the woman to experience continuity of care.

30. In the absence of any evidence from RM B, I accept Ms A's account of the care provided to her.

31. In not following up with Ms A after her scan and not responding to Ms A's attempts to contact her, RM B did not provide continuity of midwifery care or facilitate open, interactive communication. It is notable that RM B also failed to respond to the Advocacy Service or to HDC about Ms A's concerns. The New Zealand Midwifery Council (the registration body for New Zealand midwives) has advised me that it was also unable to contact RM B regarding this matter.

32. RM B did not support Ms A in seeking out information and did not share relevant information, including documented goals and actions. This is evident in RM B not sharing

[5] An email was sent to RM B on 9 July to follow up on her response to the provisional opinion (due on 8 July 2024), two telephone calls were made on 10 July 2024, two further calls were made on 12 July, and an email was sent to RM B on 24 July to advise that the report would be finalised without her response to the provisional opinion.

[6] New Zealand College of Midwives, *Midwives Handbook for Practice*. Wellington: New Zealand College of Midwives (2018).

Ms A's ultrasound scan results with her, and in the lack of documentation Ms A received, which is contrary to standards one and five of the NZCOM Standards of Practice.

33. RM B's overall treatment of Ms A was not woman-centred, as Ms A's need for information, continuity of care, and follow-up were not considered by RM B, and this left Ms A feeling isolated at a vulnerable time while she was experiencing bleeding in early pregnancy.

34. I therefore consider that in Ms A's case, RM B did not comply with midwifery professional standards. Accordingly, I find that RM B breached Right 4(2)[7] of the Code of Health and Disability Services Consumers' Rights (the Code).

Complaint handling

35. As outlined above, RM B has failed to provide a response to Ms A's concerns, and I am critical of her failure to engage with the complaints process and to facilitate the resolution of Ms A's concerns.

36. RM B has had numerous opportunities to resolve Ms A's complaint, by providing an explanation for the loss of contact and an apology to Ms A, including when the Advocacy Service wrote to RM B on behalf of Ms A.

37. I am disappointed that RM B did not take the opportunity to engage with my investigation, not only to provide answers and closure for Ms A, but also to present any mitigating circumstances that may have contributed to her actions. I am concerned that this could represent a repeated approach by RM B to handling complaints.

38. In my view, RM B has not facilitated the fair, simple, speedy, and efficient resolution of Ms A's complaint, and therefore I also find her in breach of Right 10(3) of the Code.

Recommendations

39. I recommend that RM B provide a written apology to Ms A. The apology is to be sent to HDC within three weeks of the date of this report, for forwarding to Ms A.

Follow-up actions

40. A copy of this report with details identifying the parties removed will be sent to the Midwifery Council of New Zealand, and it will be advised of RM B's name.

41. A copy of this report with details identifying the parties removed will be sent to the New Zealand College of Midwives and placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

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

Addendum

42. As of 20 September 2024, RM B has failed to provide a written apology to Ms A, despite follow-up by HDC.