Registered Midwife, RM B

A Report by the

Health and Disability Commissioner

(Case 17HDC00950)

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

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Executive summary

1. Mrs A, aged 26 years at the time of these events in 2015, was pregnant, having had multiple miscarriages. At seven weeks and three days' gestation, Mrs A booked a self-employed registered midwife (RM), RM B, as her lead maternity carer (LMC).

2. RM B referred Mrs A for an obstetric consultation, owing to her history of multiple miscarriages. In Dr D's clinic letter addressed to RM B, he requested that she arrange for Mrs A to see him again after the 18- to 19-week anatomy scan. RM B told HDC that she "did not receive a letter from the obstetric clinic", and therefore she did not arrange another obstetric consultation with Dr D.

3. At approximately 20 weeks' gestation, Mrs A's second trimester ultrasound scan (USS) detected "a possible overriding aorta and possible pulmonary hypoplasia", and the USS report recommended a dedicated fetal echocardiogram (echo). RM B recommended this to Mrs A, and she was referred for a fetal echo. RM B told HDC that she did not "offer [Mrs A an] obstetric referral" after receiving the second trimester USS because there was no evidence of any confirmed abnormality.

4. A fetal echo was carried out. The echocardiographer, Mr C, concluded that there was "no intra-cardiac abnormality detected" but suggested a repeat echocardiogram at 32 weeks' gestation. The DHB told HDC that a copy of the fetal echo report was sent to RM B care of the outpatient Obstetrics Department. However, RM B was expecting to receive the report via her correspondence address, and, therefore, she did not receive the report.

5. Following the fetal echo, RM B stated that she expected Mr C to inform her of the outcome of the echo, but he did not. RM B said that her practice at the time was to refer to an obstetrician once she had confirmed an adverse diagnosis with the echocardiographer first. However, in Mrs A's case, there was no confirmed adverse diagnosis and, therefore, RM B did not consider an obstetric referral to be necessary. RM B added that Mrs A's other scans were "reassuring".

6. RM B has documented two occasions on which she enquired about the fetal echo. The first was during a telephone call to Mrs A, and the second was a telephone call to a receptionist at Hospital 1. RM B never received a copy of the report and, as such, a repeat echocardiogram at 32 weeks' gestation was never arranged.

Findings

7. RM B failed to provide services to Mrs A with reasonable care and skill in the following ways:

   a) After receipt of a second trimester USS report that identified a possible significant fetal abnormality, RM B did not recommend to Mrs A that a consultation with a specialist was warranted.

   b) After the fetal echo, RM B did not ensure that she received and sighted a written copy of the fetal echo report. In the absence of an obstetric referral, and as the practitioner who ordered the scan, this responsibility rested solely on RM B.

8. Accordingly, RM B breached Right 4(1) of the Code of Health and Disability Services Consumers' Rights (the Code).[1]

Recommendations

9. It is recommended that:

a) RM B provide a written apology to Mrs A.

b) The Midwifery Council of New Zealand undertake a review of RM B's competence.

Complaint and investigation

10. The Commissioner received a complaint from Mr A about the services provided to his wife, Mrs A, during her pregnancy. The following issue was identified for investigation:

- *Whether RM B provided an appropriate standard of care to Mrs A in 2015.*

11. The parties directly involved in the investigation were:

Mrs A	Consumer
Mr A	Complainant
RM B	Self-employed midwife/lead maternity carer

Also mentioned in this report:

Dr D	Obstetrician

12. Information was reviewed from:

Mr C	Echocardiographer
District health board	

13. Independent expert advice was obtained from a registered midwife, Ms Bridget Kerkin (**Appendix A)**.

Information gathered during investigation

Background

14. Mrs A, aged 26 years at the time of these events, was pregnant, having had multiple miscarriages. At seven weeks and three days' gestation, Mrs A booked a self-employed registered midwife, RM B, as her lead maternity carer (LMC).

[1] Right 4(1) states: "Every consumer has the right to have services provided with reasonable care and skill."

15. Due to Mrs A's multiple past miscarriages, RM B referred Mrs A for an obstetric consultation. Mrs A was seen by obstetrician Dr D. Dr D noted that Mrs A had a nuchal translucency scan[2] booked for the following week, and she was then to have a routine 18- to 19-week anatomy scan. In Dr D's clinic letter addressed to RM B, he requested that she arrange for Mrs A to see him again after the anatomy scan, to "touch base and see how [Mrs A was] getting on". RM B told HDC that she "did not receive a letter from the obstetric clinic". Therefore, RM B did not arrange another obstetric consultation with Dr D.

Second trimester ultrasound scan

16. At approximately 20 weeks' gestation, a second trimester ultrasound (USS) was performed, which reported the following findings:

> "Views of the fetal outflow tracts of the heart appeared to demonstrate a possible overriding aorta and possible pulmonary hypoplasia. A dedicated fetal echocardiogram is suggested at [Hospital 1]."

17. An overriding aorta is a congenital heart defect where the fetal aorta is positioned directly over a ventricular septal defect, instead of over the left ventricle. Pulmonary hypoplasia is a rare condition that is characterised by incomplete development of lung tissue. It results in a reduction in the number of lung cells, airways, and alveoli, which leads to impaired gas exchange.

18. RM B received the USS report in the post and discussed the situation with Mrs A on the same day. RM B told HDC that she recommended that Mrs A have an echocardiogram (echo), and then referred her to echocardiographer Mr C at Hospital 1, to have this performed.

19. Fetal echocardiography is a test similar to an ultrasound. The examination allows views of the structure and function of a fetus's heart. The examination uses sound waves that "echo" off the structures of the fetus.

20. RM B told HDC that at the time of the referral, she was not aware of any DHB guidelines specific to a community LMC about referrals for an echocardiogram. In the absence of such guidelines, RM B believed that it was her responsibility to "directly refer to a specialist, in this case [Dr C]". RM B stated: "[T]here were no guidelines informing me to refer to an obstetrician first."

Guidelines for Consultation with Obstetric and Related Medical Services (Referral Guidelines)

21. The Referral Guidelines provide guidelines for circumstances in which an LMC must recommend a consultation with a specialist or the transfer of clinical responsibility to a specialist. A specialist is defined in the Referral Guidelines as a medical practitioner who is registered with a vocational scope of practice in the register of medical practitioners maintained by the Medical Council of New Zealand, and who holds a current annual practising certificate. Mr C is not a specialist within this definition.

[2] The nuchal translucency scan uses ultrasound to assess a developing baby's risk of Down syndrome and some other chromosomal abnormalities, as well as major congenital heart problems.

22. The Referral Guidelines are to be used in conjunction with the Primary Maternity Services Notice 2007. The Referral Guidelines require that the woman is informed that a consultation is warranted in certain circumstances. Under "Consultation", the Guidelines state:

> "The LMC must recommend to the woman (or parent(s) in the case of the baby) that a consultation with a specialist is warranted given that her pregnancy, labour, birth or puerperium (or the baby) is or may be affected by the condition. Where a consultation occurs, the decision regarding ongoing care, advice to the LMC on management, and any recommendation to subsequently transfer care must involve three-way conversation between the specialist, the LMC and the woman. This should include discussion of any need for and timing of specialist review."

23. Under the conditions and referral category code 4007, fetal abnormality is a condition where the LMC must recommend to the woman that a consultation with a specialist is warranted.

24. RM B told HDC that she did not "offer [Mrs A an] obstetric referral" after receiving the second trimester USS because there was no evidence of any confirmed abnormality. RM B added that Mrs A was already experiencing anxiety, and she did not feel that it was necessary to add to this anxiety unless an adverse diagnosis was confirmed.

Fetal echocardiogram

25. At 22 weeks' gestation, Mrs A attended an appointment with Mr C, who performed the fetal echo. Following the fetal echo, Mr C reported the following:

> "22/40 Fetal Echocardiogram.
>
> Fair views only.
> Levocardia.[3]
> AV[4] and VA[5] concordance.
> No intra-cardiac abnormality detected.
>
> Suggest re-echo at 32/40."

26. The DHB told HDC that the fetal echo report was immediately and automatically uploaded to the hospital electronic records, and a paper copy of the report was sent by internal mail to RM B, care of the obstetric outpatient department. RM B's response to HDC indicated that she expected the fetal echo report to be sent to the address on all her correspondence with the DHB, but it was not.

27. After the fetal echo at 6.30pm, RM B telephoned Mrs A to discuss the results. From the conversation, RM B documented: "[A]ll well — surprised nothing found — said the [echocardiographer] … couldn't understand why it was requested." Mrs A told HDC that after the echo, Mr C expressed that "he didn't know what the others had seen" and that "he was looking at a perfectly healthy heart". RM B told HDC that following her conversation

[3] The heart is positioned on the normal side of the body (the left).
[4] Atrioventricular.
[5] Ventriculoarterial.

with Mrs A, she did not think any further about the possibility of the echocardiogram being incorrect, and she did not doubt Mrs A's verbal report.

28. Citing the Referral Guidelines, RM B stated that she expected "the specialist", "[Dr C]", to inform her of the outcome of the scan. RM B told HDC that her practice was to refer a woman to an obstetrician once she had confirmed an adverse diagnosis with the echocardiographer first. However, in Mrs A's case, there was no confirmed adverse diagnosis. Therefore, RM B did not consider an obstetric referral necessary.

29. RM B next saw Mrs A at 24 weeks' gestation. RM B documented in Mrs A's maternity notes that the fetal echo was normal and she was awaiting the report. RM B recalled telling Mrs A that if all was well, there might not be a report.

30. RM B told HDC that she had noted in her diary "call echo [Mrs A]" and was conscious that she needed to confirm the normal finding. In Mrs A's maternity notes, RM B documented a telephone call following up the fetal echo result with "[DHB secretarial support staff member]" at "echo reception". RM B documented that she received a "Verbal Report — "N[o] A[bnormality] D[etected] on dedicated fetal echocardiogram at [Hospital 1]. Have asked reception to send copy of report if possible." The DHB secretarial support staff member told HDC that she does not recall this conversation, and it would not be her usual practice to provide such information in a telephone call.

31. No further attempts were made to follow up the report. While noting that she had referred only one other client for a fetal echo, RM B said that she could not remember having personally received a written report from a fetal echo. She told HDC that she expected that "at some point I may or may not receive a written report". RM B understood that the procedure was "direct reporting between the echocardiographer and the responsible obstetrician", and that she would be copied into any such communication. RM B added that "an appointment for further review would then be made with the obstetrician and the midwife would pass this information on to the client".

32. RM B never received a copy of the fetal echo report and, as such, a second echocardiogram at 32 weeks' gestation was never arranged for Mrs A.

Subsequent ultrasound scans

33. At 28 weeks and six days' gestation, Mrs A received an ultrasound scan at a radiology clinic. The fetal stomach, kidneys and bladder were visualised and appeared normal for gestational age. The report concluded that there was satisfactory interval growth.

34. At 32 weeks and two days' gestation, a further scan was organised to assess the cause of the abdominal and flank pain that Mrs A had been experiencing. The radiologist found no abnormality of the maternal pancreas, spleen, kidneys, biliary tree, aorta or liver. It was also noted that the fetus had satisfactory interval growth.

35. RM B told HDC that there were no other clinical indications that a referral to an obstetrician was required. She said that Mrs A's other scans in the second and third trimester were "reassuring, including the scan at 32 weeks in which the aorta was viewed".

Birth and subsequent complications

36. Baby A was born at 37 weeks and two days' gestation at Hospital 2. Mr and Mrs A were visiting another family member at Hospital 2 when Mrs A went into labour. At 15 hours of age, Baby A had a dusky spell[6] and an audible heart murmur.[7] An echo showed Type 1 truncus arteriosus[8] with a large ventricular septal defect (VSD).[9] Baby A was transferred to Hospital 3.

37. At four weeks of age, Baby A underwent cardiac surgery for repair of the truncus arteriosus and VSD. She was transferred back to the Special Care Baby Unit at Hospital 1, and later discharged home.

Further information — RM B

38. RM B told HDC that she has changed her practice significantly when referring clients for a dedicated fetal echo. She now telephones immediately to ensure that the referral has been received, and ensures that she views the results personally and documents them. If the results are adverse, she will write a referral to an obstetrician.

39. RM B said that she has learned from this experience, and will more readily refer clients to obstetric services in the future, and will certainly require written reports for all scans and tests.

Response to provisional opinion

40. Mr and Mrs A were given an opportunity to comment on the "information gathered" section of the provisional opinion. They advised HDC that they had no comments to make.

41. RM B was given an opportunity to comment on the provisional opinion. RM B advised that she accepts the provisional opinion. She added that she has since attended training on ultrasounds to update herself on current best practice.

Other relevant standards

The New Zealand College of Midwives (NZCOM) consensus statement Laboratory Testing/Screening

42. The consensus statement provides:

> "If a midwife orders a laboratory test, she is responsible for following up on the results of the test in a timely manner, including;

[6] Unhealthy blue or purple quality.
[7] The sound of blood flowing (noise heard with a stethoscope).
[8] Truncus arteriosus is a defect of the heart. It occurs when the blood vessel coming out of the heart in the developing baby fails to separate completely during development, leaving a connection between the aorta and pulmonary artery.
[9] A hole between the bottom two chambers of the heart (ventricles).

- Discussing with the woman the interpretation of laboratory/screening results and, if warranted,
- Offering the woman a referral to the appropriate practitioner/specialist and initiating the referral,
- Ensuring copies of test results are included in the clinical records and document any discussions/decisions regarding care relating to the test results."

Opinion: RM B — breach

43. This opinion assesses the actions of RM B after Mrs A's second trimester USS detected a possible fetal abnormality. Other parties have been dealt with in a separate report.

Obstetric referral

44. RM B referred Mrs A for an obstetric consultation, owing to her history of multiple miscarriages. In Dr D's clinic letter addressed to RM B, he requested that she arrange for Mrs A to see him again after the 18- to 19-week anatomy scan. RM B told HDC that she "did not receive a letter from the obstetric clinic", and therefore she did not arrange another obstetric consultation with Dr D.

45. At approximately 20 weeks' gestation, Mrs A's second trimester USS detected "a possible overriding aorta and possible pulmonary hypoplasia", and the USS report recommended a dedicated fetal echo. RM B recommended this to Mrs A, and she was referred for a fetal echo. RM B told HDC that she did not "offer [Mrs A an] obstetric referral" after receiving the second trimester USS because there was no evidence of any confirmed abnormality.

46. Following the fetal echo, RM B stated that she expected "the specialist", "[Dr C]", to inform her of the outcome of the echo, but he did not. RM B said that her practice at the time was to refer to an obstetrician once she had confirmed an adverse diagnosis with the echocardiographer first. However, in Mrs A's case, there was no confirmed adverse diagnosis and, therefore, RM B did not consider an obstetric referral to be necessary. RM B added that Mrs A's other scans were "reassuring, including the scan at 32 weeks in which the aorta was viewed".

47. The Referral Guidelines state that fetal abnormality is a condition where the LMC must recommend to the woman that a consultation with a specialist is warranted given that her pregnancy, labour, birth or puerperium (or the baby) is or may be affected by the condition. My expert advisor, RM Kerkin, advised that the usual practice would be for an LMC to offer a woman a referral as soon as a potential fetal abnormality was identified. RM Kerkin acknowledged that the Referral Guidelines specifically address the recommended course of action if a fetal abnormality has been diagnosed, rather than the appropriate course of action in a situation of possible abnormality (as in this case). However, RM Kerkin considered that not offering Mrs A an obstetric consultation compromised RM B's ability to demonstrate an appropriate response to the clinical circumstances. RM Kerkin advised that the failure to offer Mrs A an obstetric consultation following the USS was, in her view, a "minor" departure from the accepted standard of care.

48. RM Kerkin advised that RM B's reference to the echocardiographer, Mr C, as "the specialist", indicates some misunderstanding about the appropriate interpretation of the Referral Guidelines and the role of an echocardiographer. RM Kerkin clarified that an ultrasound referral does not constitute a referral to a specialist, and the undertaking of an ultrasound is not a consultation in itself. RM Kerkin advised that RM B did not involve a specialist in Mrs A's care following the anatomy scan. To do so would have meant a referral to a cardiology or obstetric consultant.

49. RM Kerkin also considered RM B's statement that "the aorta was viewed" during Mrs A's 32-week gestation scan to be concerning. RM Kerkin advised that this aspect of the USS was summarising the maternal anatomy, not the fetal anatomy. RM Kerkin considers that this raises concerns about RM B's understanding of the reporting processes following tests and investigations undertaken by her client.

50. In relation to the request for a fetal echo, RM Kerkin noted that usually the ordering of fetal echos would be undertaken by an obstetric specialist, but acknowledged that there may be regional differences that made it appropriate for RM B to refer Mrs A directly for a scan. Nonetheless, RM Kerkin advised that the interpretation of the fetal echo falls outside RM B's scope of practice as a midwife and, therefore, an obstetric consultation was warranted.

51. I am concerned that RM B did not follow up on the outcome of her referral of Mrs A to the obstetric clinic. Had RM B done so, she would have known that the obstetrician had requested that Mrs A be referred to him again after the 20-week USS.

52. I am also concerned that RM B has misunderstood the role of an echocardiographer and, as a result, has applied the Referral Guidelines incorrectly. It concerns me that RM B requested a diagnostic test of which she had limited understanding, and the interpretation of which was outside her scope of practice. As a result, she would not have been in a position to inform Mrs A of the possible outcomes of the test in advance, or to review the report with Mrs A afterwards. In my view, these factors indicate that a restricted interpretation of the Referral Guidelines was not appropriate, and Mrs A should have been referred to an obstetrician when the USS detected the possible fetal abnormality.

Follow-up of fetal echo report

53. A fetal echo was carried out. The echocardiographer, Mr C, concluded that there was "no intra-cardiac abnormality detected" but suggested a repeat echocardiogram at 32 weeks' gestation. The DHB told HDC that a copy of the fetal echo report was sent to RM B care of the outpatient Obstetrics Department. However, RM B was expecting to receive the report via her correspondence address, and, therefore, she did not receive the report.

54. RM B has documented two occasions on which she enquired about the fetal echo. The first was during a telephone call to Mrs A, and the second was a telephone call to a receptionist at Hospital 1. RM B never received a copy of the report and, as such, a repeat echocardiogram at 32 weeks' gestation was never arranged.

55. The NZCOM consensus statement on Laboratory Testing/Screening provides that if a midwife orders a laboratory test, she is responsible for following up on the results of the test in a timely manner. RM Kerkin made reference to this statement and advised that although it does not refer directly to scans, the clinical information gathered in a fetal echo is used to

inform the care planning and decision-making of women in partnership with the LMC in the same was as laboratory tests. Therefore, the intent of the statement is relevant to, and directly applicable to, referrals for fetal echos.

56. RM Kerkin advised that the receipt of the written fetal echo report was extremely important following the potential abnormality identified by the USS. She stated that a verbal report from Mrs A and a receptionist was not adequate for reassurance in the circumstances. RM Kerkin acknowledged that often there are delays in reports being processed within a DHB, but said that it may have been possible for RM B to visit Hospital 1 to secure a copy of the report. In RM Kerkin's opinion, further follow-up was warranted, particularly given that Mrs A had not been referred back to an obstetrician.

57. RM Kerkin advised that if Mrs A had been referred to the obstetric service, the follow-up of the fetal echo might be considered a shared responsibility. Given that Mrs A had not been referred to an obstetrician and there was a potentially significant concern identified in the USS report, it was critical for RM B to verify the results by obtaining the written fetal echo report. RM Kerkin referenced the NZCOM Code of Ethics, which states that "[m]idwives have a responsibility to ensure that no action or omission on their part places the woman at risk". RM Kerkin added that this statement also relates to the fetus, as any action or lack thereof that affects the baby will also affect the well-being of the mother.

58. RM Kerkin advised that her peers would consider that RM B did not demonstrate a full appreciation of the potential seriousness of the USS findings and the implications for Mrs A's baby, given that RM B did not ensure that a health professional (RM B herself or an obstetrician) had sighted the report for the fetal echo she had ordered. RM Kerkin concluded that the failure to secure a written copy of the report constituted a moderate departure from the accepted standard of practice. I agree. As I have said previously, clinicians owe consumers a duty of care in handling test results, including advising patients of, and following up on, test results. The primary responsibility for following up test results rests with the clinician who ordered the tests.

Conclusion

59. RM B failed to provide services to Mrs A with reasonable care and skill in the following ways:

a) After receipt of a second trimester USS report that identified a possible significant fetal abnormality, RM B did not inform Mrs A that a consultation with a specialist was warranted. I am concerned at RM B's restricted interpretation of the Referral Guidelines, and critical that RM B requested a diagnostic test of which she had limited understanding, and the interpretation of which was outside her scope of practice.
b) After the fetal echo, RM B did not ensure that she received and sighted a written copy of the fetal echo report. In the absence of an obstetric referral, and as the practitioner who ordered the scan, this responsibility rested solely on RM B. Whilst RM B did enquire about the results through Mrs A and a receptionist at Hospital 1, this was inadequate.

60. Accordingly, I find that RM B breached Right 4(1) of the Code.

Recommendations

61. I recommend that:

a) RM B provide a written apology to Mrs A, within three weeks of the date of this report. The apology is to be sent to HDC, for forwarding to Mrs A.

b) The Midwifery Council of New Zealand undertake a review of RM B's competence.

Follow-up actions

62. 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 district health board, and they will be advised of RM B's name.

63. A copy of this report with details identifying the parties removed, except the expert who advised on this case, 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.

Appendix A: Independent midwifery advice to the Commissioner

The following expert advice was obtained from registered midwife Bridget Kerkin:

> "My name is Bridget Kerkin and I have been asked by the Health and Disability Commissioner [Investigator] to provide brief 'steering' advice regarding a current investigation. I have read, and agree to follow, the Commissioner's Guidelines for Independent Advisors.
>
> I registered as a midwife in 1998 and have worked primarily as a Lead Maternity Carer since then, with a focus on primary care in the community. I have provided care for women birthing at home and in primary and secondary care facilities. I have worked in rural, remote rural and urban environments. I am currently employed as a Senior Lecturer in the Midwifery School at Otago Polytechnic, while maintaining a small Lead Maternity Care practice. I am an active member of the New Zealand College of Midwives, having previously worked as a Midwifery Standards reviewer, represented the Wellington Region as the Midwifery Resolutions Committee Midwife Representative for three years and held a position on the core group of the Wellington regional branch of the New Zealand College of Midwives. I am currently the coordinator of the Education and Research Committee of the Wellington regional branch of the New Zealand College of Midwives. I have a BSc in psychology, a BHSc in midwifery and a postgraduate diploma in midwifery.
>
> *Summary of events:*
> [Mrs A], aged 26 years, at the time of these events, was [pregnant] having had [multiple] miscarriages.
>
> On [date], [Mrs A's] lead maternity caregiver, self-employed registered midwife ([RM B]) referred her to an obstetrician noting the [multiple] miscarriages. An obstetric appointment [occurred] and the clinic letter stated: *'She has a nuchal translucency scan booked for next week, and then she will have a routine 18–19 week anatomy scan. I would be grateful if you could arrange for her to see me again in the clinic after this so we can touch base and see how she is getting on.'*
>
> [At 20 weeks gestation], a second trimester ultrasound scan (USS) was carried out which reported *'Views of the fetal outflow tracts of the heart appeared to demonstrate a possible overriding aorta and possible pulmonary hypoplasia. A dedicated fetal echocardiogram is suggested …'*
>
> Following receipt of the USS report, [RM B] referred [Mrs A] for a fetal echo at the local DHB. Based on the notes we have to date, it appears that [RM B] did not refer back to the obstetrician at this stage. After the fetal echo on the same day, [RM B] telephoned [Mrs A] to enquire about the echo. [RM B] documented *'All well — surprised nothing found — said the [echocardiographer] was abrupt and couldn't understand why it was requested'*.
>
> [RM B had an appointment with Mrs A] where she documented: *'Has follow up dedicated echocardiogram following A/N indication that there was a heart defect. Echocardiogram saw nothing abnormal — LMC waiting for results …'*

Usual practice at the time was for a paper copy of the fetal echo report to be sent to the LMC, 'care of' [the DHB] Obstetrics Outpatients Department. [RM B] reported that she never received the report. Approximately two weeks after the echo, [RM B] documented *'Phone call to echo reception re [Mrs A's] echo results … unable to get hold of* [echocardiographer]. *Verbal report — NAD seen on dedicated fetal echocardiogram … Have asked reception to send copy of report if possible'.*

[RM B] advised that the verbal report was given over the phone by the receptionist. However, the receptionist does not recall providing a verbal report and advised HDC that was not her usual practice.

[RM B] told HDC she recalled making one further attempt at following up the fetal echo results approximately a month later but this is not documented. [RM B] never received the report.

Based on the notes we have to date, it appears [Mrs A] was not referred back to the obstetrician for the remainder of her pregnancy.

Advice request
Did [RM B] take appropriate steps following receipt of the second trimester ultrasound scan? If not, what do you consider the appropriate steps would have been? Please comment on the application, if any, of the Ministry of Health Guidelines for Consultation with Obstetric and Related Specialist Medical Services (Referral Guidelines) to this situation.

Following the fetal echo scan, do you consider [RM B] took appropriate action? In particular did [RM B] take adequate steps to follow up on the fetal echo report? If not, what do you consider the appropriate action and/or steps would have been?

Based on these facts, if you consider there to have been a departure from accepted standards, please indicate what these standards are, and whether this would be considered a **mild, moderate or significant** departure.

Commentary:
I declare that I have no known conflict of interest.

Before I commence my discussion, I would like to acknowledge the limited information I have at my disposal on which to base this commentary. I have only the information detailed above in the 'Summary of Events' section with which to provide my advice, and therefore my commentary is somewhat limited. As a result I am unable to comment on the degree of departure (if any) from accepted standards of care in this instance.

Did [RM B] take appropriate steps following receipt of the second trimester ultrasound scan? If not, what do you consider the appropriate steps would have been? Please comment on the application, if any, of the Ministry of Health Guidelines for Consultation with Obstetric and Related Specialist Medical Services (Referral Guidelines) to this situation.

There are regional differences in the action recommended when an antenatal scan requires follow up. It would have been appropriate for [RM B] to refer [Mrs A] for obstetric assessment following the anatomy scan, and an offer of obstetric consultation

is recommended by the Guidelines for Consultation with Obstetric and Related Specialist Medical Services (Referral Guidelines) (Ministry of Health, 2012). It was appropriate that the concerning anatomy scan was followed up in a timely manner by more in-depth ultrasound investigation of the baby's heart.

Ideally [RM B] would also have organised the repeat obstetric consultation as requested following the anatomy scan. However, it would have been equally appropriate for the obstetric clinic to have organised this follow up appointment after the initial consultation.

Following the fetal echo scan, do you consider [RM B] took appropriate action? In particular did [RM B] take adequate steps to follow up on the fetal echo report? If not, what do you consider the appropriate action and/or steps would have been?

The receipt of a written report from the fetal echocardiogram was extremely important following the abnormality potentially identified at the anatomy scan. [RM B] was obviously attentive to [Mrs A's] circumstances, ringing her to check on the outcome of the scan and attempting to follow up with the ultrasound department when she did not receive the report. However, a verbal report from the woman and the receptionist was not adequate for reassurance in this circumstance. It is my opinion that further follow up, in order that a health professional had sighted the ultrasound report, was warranted. If [RM B] had referred [Mrs A] to the obstetric clinic this follow up would have happened.

It may also have been possible for [RM B] to visit the ultrasound department to secure a copy of the report, or to access the report via the hospital computer system. I acknowledge that there are often delays in ultrasound reports being processed within a DHB which may have impacted on [RM B's] ability to access it.

Bridget Kerkin (RM: 15-11978)
6/5/2017

References:

Ministry of Health (2012). Guidelines for Consultation with Obstetric and Related Medical Services (Referral Guidelines). Wellington, New Zealand: Author."

The following further expert advice was obtained from RM Kerkin:

"My name is Bridget Kerkin and I have been asked by the Health and Disability Commissioner [Investigator] to provide full advice on the above investigation, following my initial brief 'steering' advice. I now have access to the full file and all details of the case. I have read, and agree to follow, the Commissioner's Guidelines for Independent Advisors.

I registered as a midwife in 1998 and have worked primarily as a Lead Maternity Carer since then, with a focus on primary care in the community. I have provided care for women birthing at home and in primary and secondary care facilities. I have worked in rural, remote rural and urban environments. I am currently employed as a Senior Lecturer in the Midwifery School at Otago Polytechnic, while maintaining a small Lead Maternity Care practice. I am an active member of the New Zealand College of Midwives, having previously worked as a Midwifery Standards reviewer, represented the Wellington Region as the Midwifery Resolutions Committee Midwife Representative for three years

and held a position on the core group of the Wellington regional branch of the New Zealand College of Midwives. I am currently the coordinator of the Education and Research Committee of the Wellington regional branch of the New Zealand College of Midwives. I have a BSc in psychology, a BHSc in midwifery and a postgraduate diploma in midwifery.

I have reviewed the documents provided to me:

- Email correspondence from [RM B] to [the DHB] (and then forwarded to HDC) on 11 March 2016.
- [RM B's] response to HDC dated 17 July 2017.
- Midwifery notes [RM B] provided to [the DHB] on 11 March 2016 but not to HDC on 17 July 2017 (see footnote 2 below).
- Midwifery notes [RM B] provided to HDC on 17 July 2017.
- Foetal echo report dated [date].

Summary of events:
[Mrs A], aged 26 years at the time of these events, was [pregnant having had multiple miscarriages].

She booked [RM B] to be her lead maternity care (LMC) midwife at [7 weeks and 3 days gestation].

[RM B] referred [Mrs A] to an obstetrician, noting the history of nine previous miscarriages.

An obstetric appointment [occurred] and the clinic letter following this appointment stated: *'She has a nuchal translucency scan booked for next week, and then she will have a routine 18–19 week anatomy scan. I would be grateful if you could arrange for her to see me again in the clinic after this so we can touch base and see how she is getting on.'*

[At 20 weeks gestation], a second trimester ultrasound scan (USS) was carried out which reported *'Views of the fetal outflow tracts of the heart appeared to demonstrate a possible overriding aorta and possible pulmonary hypoplasia. A dedicated fetal echocardiogram is suggested …'*

Following receipt of the USS report, [RM B] referred [Mrs A] for a foetal echocardiogram…

[Mrs A attended the foetal echo.]

[RM B] telephoned [Mrs A] to enquire about the result of the scan later the same day. [RM B] documented *'All well — surprised nothing found — said the [echocardiographer] was abrupt and couldn't understand why it was requested'*.

[RM B] had an appointment with [Mrs A] where she documented: *'Had follow up dedicated echocardiogram following A/N indication that there was a heart defect. Echocardiogram saw nothing abnormal — LMC waiting for results …'*

Approximately two weeks after the echocardiogram, [RM B] documented *'Phone call to echo reception re [Mrs A's] echo results ([DHB secretarial support staff member])*

unable to get hold of [Mr C]. Verbal report — NAD seen on dedicated fetal echocardiogram at NPH. Have asked reception to send copy of report if possible'.

A growth scan was ordered by [RM B] when [Mrs A] was approximately 29 weeks gestation due to a query about increased growth. The foetal growth and amniotic fluid volumes were found to be normal at the scan dated [date].

[Mrs A] had another ultrasound [at approximately 32 weeks gestation] due to maternal abdominal/flank pain. Foetal growth parameters were also assessed and were again found to be normal.

[Mrs A] moved to [the Hospital 2 district] at 36 weeks gestation and [Baby A], was born there at 37 weeks gestation. [Baby A's] significant cardiac abnormality was identified when she was less than 24 hours old and she was transferred to [Hospital 3] for care and surgery.

Advice request
You previously provided advice on the following issues:

1. Did [RM B] take appropriate steps following receipt of the second trimester ultrasound scan? If not, what do you consider the appropriate steps would have been? Please comment on the application, if any, of the Ministry of Health Guidelines for Consultation with Obstetric and Related Specialist Medical Services (Referral Guidelines) to this situation.

2. Following the fetal echo scan, do you consider [RM B] took appropriate action? In particular, did [RM B] take adequate steps to follow up on the fetal echo report? If not, what do you consider the appropriate action and/or steps would have been?

Please review the enclosed documentation and advise whether the additional information provided to you, causes you to change your advice on the above issues. If so, please advise how it changes your advice and why. In addition, please provide advice on the following issues:

1. Where an antenatal scan appears to have detected a fetal abnormality, is it accepted practice for a midwife to refer directly for a fetal echo, or should a referral first be made to an obstetrician?
2. In your opinion, whose responsibility was it to follow up the fetal echo results and carry out any follow up actions?
3. Was it appropriate for [RM B] to rely on [Mrs A] and a receptionist's verbal report of the results?
4. Please discuss the clinical soundness of [RM B's] response to HDC, including but not limited to:
    - [RM B's] application of the Referral Guidelines in respect to[echocardiographer], [Mr C]. In particular, her comment that 'the section 88 Guidelines state that "the specialist is responsible for informing the LMC of decisions, recommendations and advice following the consultation". [Dr C] did not inform me of the outcome of the scan'.

- [RM B's] statement in respect to her expectations of receiving the fetal echo results.
- [RM B's] reasons for not referring [Mrs A] back to an obstetrician.
- Any other statements made in [RM B's] response that may be cause for concern.

5. If the Commissioner made a finding that [RM B] received the clinic letter from [Dr D], how critical are you that [RM B] did not refer [Mrs A] back to [Dr D] after the routine 18–19 week anatomy scan, as requested?

6. Any other matters in this case, related to [RM B's] care, that you consider warrant comment.

For each question, please advise:

a. What is the standard of care/accepted practice?
b. If there has been a departure from the standard of care or accepted practice, how significant a departure do you consider this to be?
c. How would it be viewed by your peers?
d. Recommendations for improvement that may help to prevent a similar occurrence in future.

Commentary:
I declare that I have no conflict of interest.

Before I begin my commentary, I would like to clarify that I have chosen to address each aspect of the request for advice in respect of the information I now have available to me. When I provided my initial brief steering advice I had only partial information to base this opinion upon.

64. ***Did [RM B] take appropriate steps following receipt of the second trimester ultrasound scan? If not, what do you consider the appropriate steps would have been? Please comment on the application, if any, of the Ministry of Health Guidelines for Consultation with Obstetric and Related Specialist Medical Services (Referral Guidelines) to this situation.***

And

Where an antenatal scan appears to have detected a fetal abnormality, is it accepted practice for a midwife to refer directly for a fetal echo, or should a referral first be made to an obstetrician?

(I am going to address these aspects of the advice request together, as they are inter-related.)

As I stated in my initial brief steering advice, there are regional differences in the action recommended when an antenatal scan requires follow up. It would have been appropriate for [RM B] to offer [Mrs A] a referral for obstetric assessment following the anatomy scan, and an offer of obstetric consultation is recommended by the Guidelines for Consultation with Obstetric and Related Specialist Medical Services (Referral Guidelines) (Ministry of Health, 2012) when foetal abnormality is identified. It was important that the concerning anatomy scan was followed up in a timely manner

by more in-depth ultrasound investigation of the baby's heart. In my experience, it is usual that this follow up would be organised in consultation with an Obstetric Specialist within a secondary care obstetric service or maternal foetal medicine team.

In [RM B's] letter to the office of the Health and Disability Commissioner (HDC) dated 17/7/17, she states 'I did not offer obstetric referral prior to ordering the echocardiogram because there was no evidence of any confirmed abnormality. [Mrs A] was already experiencing anxiety and I did not feel that it was necessary to add to this anxiety unless an adverse diagnosis was confirmed.'

It may have been appropriate to order the echocardiogram and then offer [Mrs A] an obstetric referral, according to local policies, protocols and practices. However, regardless of the order in which events took place, an obstetric referral was indicated in this instance, in my opinion. Following his clinic appointment with [Mrs A], [Dr D] requested that [Mrs A] be referred back to the clinic following her anatomy scan. Therefore, the offer of an obstetric follow-up should not have been anxiety provoking for [Mrs A]. Additionally, [RM B] documented that [Mrs A] was 'no under care of [Dr D] — not fertility associates' following the appointment in the first trimester. I imagine this means that [Mrs A] had transferred her obstetric management from her previous arrangement with Fertility Associates to the obstetric service available through [the DHB]. Again, this would indicate that a follow-up obstetric appointment should not cause [Mrs A] unwarranted anxiety.

a. What is the standard of care/accepted practice?

The ordering of a foetal echocardiogram would usually be undertaken by an obstetric specialist. As previously stated, there may be regional differences which made it appropriate for [RM B] to refer [Mrs A] directly for this scan. However, the practitioner who orders a test or investigation is responsible for its follow-up and interpretation (NZCOM, 2002). The interpretation of a foetal echocardiogram falls outside the midwifery scope of practice and, therefore, an obstetric consultation was warranted.

b. If there has been a departure from the standard of care or accepted practice, how significant a departure do you consider this to be?

Although I believe usual practice would have a midwife offer a woman a referral as soon as a potential foetal abnormality was identified, I would like to acknowledge [RM B's] point that guidance for midwives is not entirely clear in this circumstance. The Referral Guidelines specifically address the recommended course of action if a foetal abnormality has been diagnosed, rather than the appropriate course of action in a situation of possible abnormality. Therefore, it is my opinion that not offering [Mrs A] an obstetric consultation on the basis of the anatomy scan result constitutes a minor departure from the accepted standard of care.

c. How would it be viewed by your peers?

The midwifery community would deem that not offering [Mrs A] an obstetric consultation compromised [RM B's] ability to demonstrate appropriate response to the clinical circumstances.

Following the fetal echo scan, do you consider [RM B] took appropriate action? In particular did [RM B] take adequate steps to follow up on the fetal echo report? If not, what do you consider the appropriate action and/or steps would have been?

And

In your opinion, whose responsibility was it to follow up the fetal echo results and carry out any follow up actions?

And

Was it appropriate for [RM B] to rely on [Mrs A] and a receptionist's verbal report of the results?

(I am going to address these aspects of the advice request together, as they are inter-related.)

The receipt of a written report from the foetal echocardiogram was extremely important following the potential abnormality identified at the anatomy scan. [RM B] was obviously attentive to [Mrs A's] circumstances, ringing her to check on the outcome of the scan and attempting to follow up with the ultrasound department when she did not receive the report. However, a verbal report from the woman and the receptionist was not adequate for reassurance in this circumstance.

I acknowledge that there are often delays in ultrasound reports being processed within a DHB, which may have impacted on [RM B's] ability to access it. [RM B] states (in her letter dated 17/7/17) that it was not possible to access the report via the hospital computer system in 2015. However, it may have been possible for her to visit the ultrasound department to secure a copy of the report. It is my opinion that further follow up, in order that a health professional had sighted the ultrasound report, was warranted.

The NZCOM consensus statement 'Laboratory screening/testing' (2002) specifically addresses the responsibilities of the midwife in relation to testing. Although this consensus statement does not refer directly to scanning, the clinical information gathered via ultrasound is used to inform the care planning and decision-making of women in partnership with midwives in the same way as laboratory tests and investigations. Therefore, the intent of the document is relevant for, and directly applicable to, referrals for ultrasound scans. The consensus statement explains that the midwife: 'is responsible for following up on the results of the test in a timely manner' and for: 'ensuring copies of test results are included in the clinical record'.

What is the standard of care/accepted practice?

Whilst a midwife should expect appropriate communication from an ultrasound service, it is her responsibility to follow up an investigation she has requested. [RM B's] response letter (17/7/17) states: 'I believed that the procedure was direct reporting between the [echocardiographer] and the responsible obstetrician (in this case [Dr D]) and I would be copied into such communication.' [Dr D] could not be expected to know about the potential abnormality on the anatomy scan if [RM B] did not inform him. A radiology department will generally report to the referring practitioner. Copies of the clinical report resulting from a scan may be directed to additional practitioners as appropriate. I am unclear whether [RM B] requested a copy of the results to be sent to [Dr D]. However, the referring practitioner remains responsible for coordinating the response to the results (NZCOM, 2002).

If [Mrs A] had been referred to the Secondary Care Obstetric service then the follow up of the ultrasound scan might be considered a shared responsibility. Given that she was not, and there was significant potential concern identified in the anatomy scan report, receipt of a written scan report verifying the normality of the foetal cardiac anatomy

was critical. Please see the 'Code of Ethics' provided by the New Zealand College of Midwives (NZCOM):

'Midwives have a responsibility to ensure that no action or omission on their part places the woman at risk' (NZCOM, 2015, p12).

This statement refers to the foetus also, of course. Any action, or lack thereof, which affects the baby will also affect the well-being of the mother.

If there has been a departure from the standard of care or accepted practice, how significant a departure do you consider this to be?

As a result of the considerations discussed above, it is my opinion that not securing a written copy of the report constitutes a moderate departure from the accepted standard of practice, on the part of [RM B]. My opinion arises particularly in light of the fact that [Mrs A] had not been referred back to the obstetric clinic.

How would it be viewed by your peers?

The midwifery community would consider that [RM B] did not demonstrate a full appreciation of the potential seriousness of the anatomy scan findings and the implications for [Mrs A's] baby, given that she did not ensure a health professional had sighted the report for a foetal echocardiogram she had ordered.

Please discuss the clinical soundness of [RM B's] response to HDC, including but not limited to:

- ***[RM B's] application of the Referral Guidelines in respect to [echocardiographer], [Mr C]. In particular, her comment that 'the section 88 Guidelines state that "the specialist is responsible for informing the LMC of decisions, recommendations and advice following the consultation". [Dr C] did not inform me of the outcome of the scan'.***
- ***[RM B's] statement in respect to her expectations of receiving the fetal echo results.***
- ***[RM B's] reasons for not referring [Mrs A] back to an obstetrician.***
- ***Any other statements made in [RM B's] response that may be cause for concern.***

[RM B's] response to aspects of the HDC investigation may indicate some misunderstanding on her part about the appropriate interpretation of the Referral Guidelines (MOH, 2012) and the role of [an echocardiographer]. An ultrasound referral does not constitute a referral to a specialist and the undertaking of an ultrasound is not a consultation in itself. Generally the results of an ultrasound will inform the care plan being developed between a midwife and her client, or the consultation process involving an obstetric specialist. [RM B] did not involve a specialist in [Mrs A's] care following the anatomy scan. To do so would have meant a referral to a cardiology or obstetric consultant.

I have already discussed [RM B's] assertion that she 'believed the procedure was direct reporting between the [echocardiographer] and the responsible obstetrician (in this case [Dr D]) and I would be copied into any such communication'. To reiterate, I do not believe that [Dr D] could be expected to know about the echocardiogram, and be

considered 'responsible' without a referral being made to him. It may be that [RM B] requested a copy of the echocardiogram be directed to [Dr D]. However, the responsibility for follow-up lies with the referring practitioner (NZCOM, 2002).

The only other statement in [RM B's] response that I would consider of potential concern, is her comment that 'the aorta was viewed' during [Mrs A's] 32 week gestation scan. [RM B's] commentary would lead me to believe that she thought this sonographic summary related to the foetal anatomy. However, the ultrasound report is summarising maternal anatomy, as the scan was organised in support of the assessment of the cause of [Mrs A's] abdominal and flank pain in her 3rd trimester of pregnancy. While this misinterpretation is unlikely to be of significance in terms of the outcome for [Mrs A's] baby, it does again draw attention to [RM B's] understanding of the reporting processes following tests and investigations undertaken by her client.

If the Commissioner made a finding that [RM B] received the clinic letter from [Dr D], how critical are you that [RM B] did not refer [Mrs A] back to [Dr D] after the routine 18–19 week anatomy scan, as requested?

[RM B] states, in her response letter dated 17/7/17, that: 'It is not unusual to receive no correspondence following a clinic visit'. I can advise that such deficiencies in communication with LMC midwives are common and may impact on the midwife's ability to effectively provide care to her clients. I also agree with [RM B] that the obstetric team should have arranged a follow up appointment for [Mrs A] at the time of [her initial clinic visit] if they felt one was warranted. However, regardless of whether [RM B] received the clinic letter resulting from this visit, there was indication to offer [Mrs A] an obstetric referral on the basis of the potentially abnormal anatomy scan results. I have addressed my opinion about this point previously.

Summary of opinion:
It is my opinion that the omission of a referral to the secondary clinic following the receipt of the results of [Mrs A's] anatomy scan constitutes a minor departure from accepted standards of care. Additionally, [RM B] should have secured a written copy of the report from the foetal echocardiogram, particularly in light of the fact that she chose not to refer [Mrs A] back to the obstetric clinic. This represents a moderate departure from expected practice.

Bridget Kerkin (RM: 15-11978)
21/8/2017

References:

Ministry of Health (2012). Guidelines for Consultation with Obstetric and Related Medical Services (Referral Guidelines). Wellington, New Zealand: Author.

New Zealand College of Midwives. (2002). Consensus statement — Laboratory screening/testing. Christchurch, New Zealand: Author.

New Zealand College of Midwives. (2015). Midwives handbook for practice. Christchurch, New Zealand: Author."