Follow-up of fetal echocardiogram report
17HDC00950, 6 March 2018

Midwife ~ Midwifery ~ Heart defect ~ Fetal echocardiogram ~ Referral Guidelines ~ Right 4(1)

A woman in her twenties was pregnant after several miscarriages. During a second trimester ultrasound, a possible heart defect was detected and the radiologist suggested a dedicated fetal echocardiogram (fetal echo) be carried out.

The woman's lead maternity carer, a registered midwife, referred the woman for a fetal echo. A sonographer carried out a fetal echo and reported "fair views only", "no intra-cardiac abnormality detected", "suggest re-echo at 32/40". The midwife did not refer the woman to an obstetrician after receiving the second trimester ultrasound because there was no evidence of any confirmed abnormality.

The DHB told HDC that a copy of the fetal echo report was sent to the midwife care of the outpatient obstetrics department. However, the midwife was expecting to receive the report via her correspondence address and, therefore, she did not receive the report.

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

The midwife documented two occasions on which she enquired about the fetal echo. The first was during a telephone call to the woman, and the second was a telephone call to a hospital receptionist. The midwife never received a copy of the report and, as such, a repeat echocardiogram at 32 weeks' gestation was never arranged.

Findings

The midwife failed to provide services to the woman 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, the midwife did not recommend to the woman that a consultation with a specialist was warranted.
b) After the fetal echo, the midwife 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 the midwife.

Accordingly, the midwife breached Right 4(1).

Recommendations

It was recommended that the midwife provide a written apology to the woman and that the Midwifery Council of New Zealand undertake a review of the midwife's competence.