Registered Midwife, RM B

A Report by the
Deputy Health and Disability Commissioner

Case 19HDC01820

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

Contents

Executive summary

1. This report concerns antenatal care provided by a registered midwife. The report highlights the importance of junior midwives recognising their limitations and ensuring that their caseload is appropriate for their experience, as well as the importance of communication between a woman and her lead maternity carer (LMC).

2. The midwife provided antenatal care for a woman and failed to read two ultrasound scan reports, which meant that issues with the pregnancy were not identified at an early stage of the pregnancy.

Findings

3. The Deputy Commissioner considered that by not reviewing ultrasound scans and following up on an ultrasound scan, the midwife breached Right 4(1) of the Code. The Deputy Commissioner also found that by not responding to repeated requests for information about the scan results, the midwife breached Right 6(1) of the Code.

Recommendations

4. The Deputy Commissioner recommended that should the midwife decide to recommence LMC work in the future, she should:

a) Receive all scans and laboratory reports electronically, and set up a shared system of electronic notes for midwives in the practice, to simplify access of results.

b) Introduce a system of "tasks to do", either electronically, through a diary, or in notebook form.

c) Introduce sharing of tasks or a system of delegating tasks to a colleague/practice partner.

Complaint and investigation

5. The Health and Disability Commissioner (HDC) received a complaint about the services provided to Mrs A by Registered Midwife (RM) B. The following issue was identified for investigation:

- *Whether RM B provided Mrs A with an appropriate standard of care in Month3[1] and Month4 2019.*

6. This report is the opinion of Deputy Health and Disability Commissioner Rose Wall, and is made in accordance with the power delegated to her by the Commissioner.

[1] Relevant months are referred to as Months 1–4 to protect privacy.

7. The parties directly involved in the investigation were:

Mrs A	Consumer
RM B	Provider/self-employed registered midwife/lead maternity carer (LMC)

8. Further information was received from:

RM C	Self-employed registered midwife, locum LMC
General practitioner (GP)	
Radiology service	

9. Independent expert advice was obtained from RM Fiona Hermann (Appendix A).

Information gathered during investigation

Background

10. Mrs A, aged in her thirties at the time of events, was pregnant with her first child. She engaged self-employed registered midwife RM B as her LMC. On 3 Month2, Mrs A had her first appointment with RM B at 10 weeks' gestation.

11. This report focuses on the antenatal care provided to Mrs A by RM B in Month3 and Month4.

RM B

12. RM B completed the Midwifery First Year Practice Programme (MFYP) and the New Graduate Programme in 2019. RM B holds a current practising certificate.

13. RM B commenced work as a self-employed LMC with one practice partner. Once a week, RM B rented clinic space at a midwifery clinic, although RM B did not belong to this practice. Her practice partner worked from a different clinic, and at the time of events she went on extended leave. All of the laboratory/screening results RM B ordered for her clients went to the midwifery clinic (via fax or post) and were filed in her personal drawer in a filing cabinet. RM B checked the filing cabinet on Tuesdays, Wednesdays, and Thursdays.

14. In Month3, RM B stopped having her clients' laboratory/screening results sent to the midwifery clinic fax machine and started to use a new system of receiving faxes — eFax, a fax-to-email service. She used both her personal email address and her work email address to carry out her work. RM B has acknowledged that by using both her email accounts, without clear separation of work and personal use, along with inadequate processes of receiving results, she created space for mistakes and miscommunication. RM B was using Post-it notes and a hand-written diary to keep track of her "to do list".

15. The Midwifery Council informed HDC that a caseload for an experienced LMC is between 40–50 women a year. The New Zealand College of Midwives (NZCOM) told HDC that all

midwives (whether community-based LMC or core-employed midwife) must participate in the Midwifery First Year of Practice programme (the Programme). NZCOM explained that the Programme eligibility criteria requires that an LMC graduate midwife is "expected to have a caseload of approximately 20 or more women (women at all stages of pregnancy) by programme completion". NZCOM does not specify a caseload for specific years of experience, but recommends 40–50 clients per year (three to four clients due to give birth per month) as realistic for a full caseload.

16. RM B told HDC that she had planned to build up her caseload slowly to gain LMC experience. When she began practising, RM B took over an established caseload of two to six women due to give birth each month. In Month2, RM B's practice partner went away for six weeks, and handed over the care of her patients to RM B. At the time, RM B had six women who were due to give birth In Month2. In Month3, RM B had a caseload of six women who were due to give birth in that month. This was above the caseload recommended by both the Midwifery Council and NZCOM, as it would equate to a caseload of 72 clients per year if the months of Month2 and Month3 were representative of the caseload for the other 10 months.

Treatment prior to 7 Month3

17. Mrs A's seven-week ultrasound scan (USS) took place on 10 Month1 (USS1). The USS1 report showed the expected delivery date.

18. Mrs A had a 12-week USS on 17 Month2 (USS2). The USS2 report stated:

> "The fetus is currently measuring 9 days smaller than dates (but still within normal limits for 12+2 weeks) so unfortunately the fetal size is below the range required for the nuchal assessment (CRL[2] is required to be between 45 and 84mm). Recommend nuchal scan[3] in 1 week. (We are required … to have a new referral form for that.) Report sent to the regional National Screening Unit Laboratory."

19. The radiology service confirmed to HDC that the USS2 report was faxed to RM B on 18 Month2 at 5.01pm.

20. The further USS for the nuchal scan took place on 24 Month2, at 13 weeks and two days' gestation (USS3). The USS3 report stated:

> "The fetal chest appears slightly small/bell shaped when compared to the abdomen. No other fetal abnormality seen. The developing placenta is anterior … The fetus still measuring 9 days smaller than dates. Suggest a scan at 16 weeks to check for early onset IUGR[4] or evolving skeletal abnormality."

[2] Crown rump length — the length of the embryo or fetus from the top of the head to the bottom of the torso.
[3] Measures the thickness of the fluid build-up at the back of the fetus's neck. If this area is thicker than normal, it can be an early sign of Down syndrome, trisomy 18, or heart problems.
[4] Intrauterine growth restriction.

21. The radiology service confirmed to HDC that the USS3 report was faxed to RM B on 24 Month2 at 4.29pm and the delivery status returned as "sent".

22. RM B did not review the USS3 report, and told HDC that she struggled to meet the new LMC lifestyle demands, and naïvely took on too much too quickly, with dire consequences.

Locum cover — handover

23. In the first week of Month3, because she was ill, RM B arranged for RM C[5] (a midwife who worked at the midwifery clinic) to provide locum midwifery cover for her on 7 Month3.

24. At 5.48pm on 6 Month3, RM B emailed RM C and attached a list of patient appointments that RM C would be covering on 7 Month3. The patient list noted the following information for Mrs A: "15+2, EDD27/01/[20 (sic)]. Normal primip, MSS1[6] results just back and low chance for all 3 conditions."

25. This was the only information RM C had regarding Mrs A, and RM C did not have access to Mrs A's records.

26. RM B told HDC:

> "I failed to mention the abnormal 13 week nuchal translucency scan (USS3) [Mrs A] had undertaken as I had not checked it myself. I received the MSS1 results which were all low risks and dismissed the other elements checked at this scan …
>
> I believe the acuity within the heavy caseloads [led] me to overlook [Mrs A's] screening by mentally categorising her as a 'normal primip[7]'. I feel ashamed by this statement … and again express my deepest regrets and apologies to [Mrs A] and the family."

7 Month3

27. RM C provided locum cover for RM B between 8.00am on 7 Month3 and 8.00am on 8 Month3.

28. On 7 Month3, Mrs A attended the appointment she had scheduled with RM B and saw RM C. RM C told HDC that Mrs A requested a USS form because she had been told that the fetus was a bit small at 12 weeks' gestation. RM C said that she provided Mrs A with the USS form and an anatomy scan form.

29. RM C documented: "USS for 16–17 week & anatomy scan 18–20 week." She noted that the fetal heart rate was 155bpm. RM C took a photograph of her notes and emailed it to RM B that day, and left the original notes in the clinic for RM B to collect.

[5] RM C registered as a midwife in 2008 and holds a current practising certificate.
[6] Maternal serum screening test taken from the mother in the first trimester.
[7] A woman who is pregnant for the first time.

30. RM B documented in her notes:

> "[Mrs A] seen in clinic by locum midwife [RM C] and [student midwife] as LMC unwell. [Mrs A] well, MSS1 results all low risk. Given forms to check baby's size 16–17 weeks and 20 week anatomy scan form. LMC to rebook apt."

10 Month3

31. RM C recalls a telephone call with RM B in which she discussed that Mrs A had requested a scan form for 16 weeks' gestation. RM C told HDC that she thinks that this call took place on the day she provided the locum cover (7 Month3). RM B's telephone records show that at 3.12pm on 10 Month3, RM C called RM B. RM B told HDC that she has no recollection of the call, and is unable to comment on the nature of the conversation. RM B stated that she feels certain that if she had discussed the abnormal results with a colleague, she would have actioned contact with the client immediately and referred to the appropriate places.

15 Month3

32. On 15 Month3, Mrs A had her 16-week USS (USS4). The USS4 report noted that the fetus measured 15 days smaller than the estimated delivery date, and stated: "? Early onset IUGR,[8] a fetal syndrome or chromosomal abnormality remains in the differential. Specialist opinion recommended."

33. On 15 Month3, RM C received the USS4 report by way of fax-to-email service.

34. At 3.43pm on 15 Month3, RM C sent an email forwarding the results of USS4 to RM B, stating: "Is this one of yours." At 5.39pm, RM B responded by email and confirmed that it was hers. RM C told HDC that she does not recall whether she read the USS4 report.

35. RM B took no action when she received the USS4 report. She has acknowledged that failing to follow up the results appropriately was a severe lapse in her professional judgement. RM B told HDC:

> "I suspect this was due to the 'busy-ness' of this time period but cannot comprehend the reason as to why the abnormal findings did not raise red flags in my mind … I failed to see this report due to having no clear process of receiving results."

36. RM B has explained that using both her email accounts when corresponding with RM C contributed to receiving but not interpreting the USS4 report. RM B told HDC: "For this I am very sorry." She said that she was under the impression that all abnormal results would have a telephone consultation follow-up from the radiology service, which did not occur.

16 Month3

37. At 4.43pm on 16 Month3, Mrs A sent a text message to RM B. Mrs A explained that she had had another USS at 16 weeks and three days' gestation, and that apparently the fetus

[8] Intrauterine growth restriction (IUGR) refers to poor growth of a fetus while in the mother's womb during pregnancy.

measured 14 weeks and three days' gestation. Mrs A said that the radiologist was to review the scan and write a report, and she wondered if the results had been sent to RM B. Mrs A asked that the ultrasound scan be shared with her, and asked RM B to let her know if there were any concerns.

38. At 5.09pm on the same day, RM B responded by text message stating:

> "Hey [Mrs A], well thank you. How are you? Oh okay I will keep an eye out for the report! Normal that gets faxed through in the evening or the following day so will let you know as soon as I have it. Have a lovely weekend, will be in touch soon."

39. Despite having already received the USS4 report on 15 Month3, RM B did not respond further to Mrs A about the report.

22 Month3

40. On 22 Month3, Mrs A sent a second text message to RM B and asked her whether she had received the report from the previous USS. RM B did not respond.

10 Month4

41. On 10 Month4, Mrs A had a further USS at 20 weeks and one day's gestation (USS5). The USS5 report stated:

> "Known discrepancy with dates since the 12 week scan, ?early onset IUGR. Dating by LMP, confirmed by our 7 week scan although the CRL was 5 days in arrears of LMP dating at that time. The EDD is … The anatomy scan is incomplete. There is a two vessel cord (i.e. single umbilical artery — SUA.) This finding alone does not significantly increase the risk of chromosomal abnormality, but it is associated with poor growth so a third trimester scan is recommended. (It is also associated with renal anomalies. There is no obvious renal abnormality today but they can be checked again at the growth scan when the baby is larger.) Unfortunately the fetal heart and the nasal bone are not well visualised.
>
> …
>
> Very small fetus, highly suspicious for IUGR. There has been progressive decline in the growth since 12 weeks. On the printed [public hospital] chart the AC[9] is well below 5%. (EFW[10] is close to 5% on the population chart. Refer to customised chart.) Liquor volume is normal. Refer to the national SGA[11] guidelines for management. Also a two vessel cord is noted. Recommend management of this be discussed with a maternal fetal medicine specialist. A follow up scan to complete the anatomical assessment is required and we can perform a serial growth scan in 2 weeks and uterine artery dopplers if required. Low lying posterior placenta (i.e. within 2cm of internal os). A follow up scan at 32 weeks is required."

[9] Abdominal circumference.
[10] Estimated fetal weight.
[11] Small for gestational age.

42. That day, Mrs A contacted her GP and told her that the fetus was measuring small and that she should have been referred to a specialist four weeks earlier.

43. At 5.04pm, Mrs A sent a third text message to RM B:

> "Hi [RM B]. [Mrs A] here. I went for my 20 week anatomy scan today and was quite upset to hear that I should have been referred to a specialist 4 weeks ago after my 16 week scan. I had specifically asked you twice about the radiology report and didn't get a reply."

11 Month4

44. At 9.32am on 11 Month4, RM B sent the following text message to Mrs A:

> "[A]m with mummy in labour. I am able to call you around 12pm? I'm really sorry there has been a miscommunication in the mix and I couldn't be more apologetic, talk soon, [RM B]."

45. RM B told HDC that when she received the distressed text message from Mrs A (on 10 Month4), she telephoned the radiology service. The radiology service faxed copies of Mrs A's earlier USS reports to her, and she made an urgent referral to the public hospital. The referral form shows that RM B referred Mrs A on 11 Month4.

46. RM B documented in her notes, and told HDC, that after receiving Mrs A's text message on 10 Month4, she tried to contact Mrs A several times on both her personal and work phones, and could not get through to her. RM B's telephone records do not show any attempts to call Mrs A on 10 or 11 Month4. RM B told HDC that she believes the telephone records do not reflect her attempts to call Mrs A because of faults with her phone. RM B said that the attempted call would dial and then go to a busy line tone, and would never reach a voicemail or person.

12 Month4

47. On 12 Month4, the GP referred Mrs A to the public hospital.

48. RM B told HDC that after several attempts of trying to contact Mrs A on both her personal and work numbers with no success, she had to resort to emailing her on 12 Month4. RM B's telephone records do not show any calls to Mrs A on 12 Month4.

49. RM B's email to Mrs A stated:

> "[RM B] midwife here, I have attempted calling you but unfortunately have not been able to get in touch. I'm so sorry that your scan has shown some further concerns about your baby. That is very stressful and scary for expectant mums/parents. I put through an urgent referral to [the public hospital] yesterday and am waiting to hear back from them regarding an appointment and plan going forward. They may be in touch with you directly to set up an appointment … I acknowledge that the way this has unfolded may have left you feeling unsafe. I want to reassure you that thorough care for you and your baby are of utmost importance to me. That said I completely understand if you feel the

> need to find another midwife. Although this can be difficult there are options and I am more than happy to ask my [colleagues] if they are available or refer you to the community team at [another] hospital. The most important thing is that you can continue to access care while you decide what suits you best. I am more than happy to talk about your concerns whenever you feel ready. If you are not ready yet that it is absolutely fine to text or email to let me know about the prescription."

50. Mrs A sent an email to RM B stating:

> "I received your text yesterday, but haven't had any calls on either my work or personal number. I have gone to see my doctor this morning and she has submitted a referral and I will prefer to be in her and the specialists care going forward. The radiology report from my 16w scan stated that I should be referred to a specialist (4 weeks ago) and I don't believe that it was a miscommunication as I had specifically asked you twice about the radiology report. Your lack of communication had led me to believe that perhaps there was nothing to be concerned about. Unfortunately, I do not feel like our care was of utmost importance to you and I definitely did not receive the necessary support, care and advice that a midwife should provide."

51. At 5.15pm, RM B sent a further email to Mrs A stating:

> "Thanks for your response [Mrs A], I really appreciate you taking the time to reply. I understand that you feel unsupported and that there was definitely a lack of communication. I am so sorry about the way you are feeling. It is good to know that you have seen your GP and I totally respect your decision to remain under her care with the specialist input. I will discharge you from my care but I am happy to assist you in finding another midwife if it is found to be necessary. I wish you all the best with your pregnancy going forward."

Events after 12 Month4

52. Further testing and assessment of Mrs A's fetus indicated that a syndromic diagnosis with uncertain prognosis was likely. At 25 weeks' gestation, Mr and Mrs A made the decision to terminate the pregnancy.

Responses to provisional opinion

53. Mrs A and RM B were given the opportunity to respond to relevant sections of the provisional opinion.

54. Mrs A had no further comments to make.

55. RM B stated: "I do not feel there is any further comment needed as the report is concise and comprehensive."

56. RM B advised that she has undertaken a competence programme as directed by the Midwifery Council and had a one-to-one education session with a midwife consultant, which gave her the opportunity to discuss and examine the decisions made and the learning and

changes to her practice with guided support. RM B further advised that she has reviewed NZCOM's *Midwifery Handbook for Practice* and the competencies that had been lacking.

Opinion: RM B — breach

Introduction

57. Mrs A was expecting her first child when she engaged RM B as her LMC. I have concerns about the care RM B provided to Mrs A — in particular her management of Mrs A's 13- and 16-week ultrasound reports (USS3 and USS4).

58. My consideration of any complaint is not to assess whether the actions of healthcare providers caused the outcome. Rather, my role is to assess whether, with the information available to the healthcare providers at the time the events occurred, those providers acted appropriately and in accordance with accepted standards of practice.

Caseload

59. The Midwifery Council has advised that a caseload for an experienced LMC is 40–50 women a year. The Council's advice is supported by NZCOM, which recommends that 40–50 clients per year (equivalent to three or four women due to give birth per month) is a realistic caseload.

60. RM B completed the MFYP programme four months prior to these events. MFYP graduates are expected to reach a caseload of approximately 20 women at the completion of the programme, which equates to one or two women due to give birth per month. I acknowledge NZCOM's advice that there is no specific caseload requirement for specific years of experience. However, in Month2 and Month3, RM B had a caseload of six women who were due to give birth, which is significantly higher than caseloads that would be considered to be realistic for an experienced midwife.

61. RM B was a junior LMC who had minimal support from her peers at the time of the events. It was inappropriate and unsafe for RM B to have such a high caseload. In my view, this reflects RM B's lack of awareness of her limitations. The errors RM B made highlight how important it is for LMCs to ensure that they do not take on unmanageable caseloads. Given that RM B was a junior LMC, this was even more pertinent.

Management of scan results

62. RM B told HDC that she did not read the 13-week USS3 carried out on 24 Month2. The USS3 reported that the fetal chest appeared slightly small or bell shaped and was still measuring nine days smaller than dates, and recommended a repeat scan at 16 weeks to check for early onset of IUGR or an evolving skeletal abnormality. RM B explained that the reason she did not read the USS3 report was that she struggled to meet the new LMC lifestyle demands, and naïvely took on too much too quickly, with dire consequences.

63. RM B told HDC that she does not know whether she read the 15 Month3 USS4 report. Although RM B was forwarded the results by locum midwife RM C on the day of the scan, when asked by Mrs A for a copy of it the next day, RM B said that she would "keep an eye out for it" and forward it on when she received it. In light of RM B's response to Mrs A, and as RM B did not forward a copy to Mrs A or take any other action in response to the USS4 report, I consider it more likely than not that RM B did not read the report.

64. My independent expert midwifery adviser, RM Fiona Hermann, advised that a midwife is expected to read and acknowledge every result. She commented that a midwife is expected to check results regularly, and is responsible for following up any scan/laboratory test she has requested. I share RM Hermann's view, as viewing and following up on results of tests they have ordered is a basic requirement of any health professional. If RM B had read either ultrasound scan report, she would have been alerted to possible abnormalities with the fetus. It was not until her 20-week scan that Mrs A became aware of the serious nature of the fetus's condition.

65. At the time Mrs A asked to see the USS4 report, she had noted in her text message to RM B that the fetus was small. RM Hermann advised that communication from a woman asking about the fetus being denoted as small would alert her and her peers of a need to follow up with the sonographer/scan provider. RM Hermann regarded RM B's failure to follow up the USS4 report with the sonographer/scan provider to be a severe departure from accepted standards. I accept that RM B was on notice of a potential concern with the fetus, and should have accessed the scan results to determine whether action was needed.

66. RM B's failure to read the USS4 results had significant consequences for Mrs A with regard to the subsequent advice she was able to give to Mrs A about the next steps for following up the results.

67. The *Referral Guidelines*[12] 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[13] (or the fetus) is or may be affected by the condition. RM Hermann advised that the appropriate management after receiving the USS4 result would have been a referral to a fetal medicine specialist.

68. It goes without saying that in order to discuss laboratory/screening results with a patient, or to follow up with appropriate action or advice, the midwife needs to read the results. RM B's failure to read the results of USS4 resulted in a missed opportunity to refer Mrs A to a fetal medicine specialist. There was also a missed opportunity for a discussion with Mrs A about the options available to her and her baby. The guiding principle of the *Referral Guidelines* is that the woman, her baby, and her whānau are at the centre of all processes and discussions. As part of this, the woman has the right to receive full, accurate, and unbiased information about her options and likely outcomes of her decisions. The woman

[12] The Ministry of Health's *Guidelines for Consultation with Obstetric and Related Medical Services (Referral Guidelines)* (February 2012).
[13] The period of about six weeks after childbirth during which the mother's reproductive organs return to their original non-pregnant condition.

has the right to make informed decisions on all aspects of her care. In order for this to occur, communication with the woman needs to be open, clear, and timely.

69. Mrs A was proactive in seeking information from RM B, and was met with either unfulfilled promises or silence. This did not create an environment where effective communication could occur, and ultimately resulted in the termination of Mrs A's therapeutic relationship with RM B. This would have been very distressing for Mrs A and her family six months into her pregnancy.

70. I am very concerned that RM B did not read the reports for USS3 or USS4. It is a basic requirement of a midwife to read laboratory and screening results that they order and receive. Clinicians owe consumers a duty of care in handling test results, including following up on and advising patients of test results and the options available for ongoing care. I am very critical that RM B failed to read and follow up on Mrs A's scan results, particularly when she was on notice of a potential concern with the fetus's size.

Conclusion

71. I consider that because RM B did not review the USS3 and USS4 results, and did not follow up the USS4 results, she failed to provide Mrs A midwifery services with reasonable care and skill. Accordingly, RM B breached Right 4(1) of the Code of Health and Disability Services Consumers' Rights (the Code).[14]

72. Furthermore, in the context of a possibly small fetus and Mrs A's repeated requests for information about the scan results, I consider the results of her scan and a discussion about their meaning and options going forward to be information that Mrs A could reasonably expect to receive. Accordingly, I also find RM B in breach of Right 6(1) of the Code.[15]

Changes made since events

73. RM B told HDC:

> "I have thought a great deal about [Mrs A], reflecting on the circumstances and the areas within my practice which may have contributed to gaps in her care. Due to this experience I have a written partnership agreement with my new backup midwife to ensure clear communication of needs, caseloads and management of time off. Any locum cover has clear outlines, handovers and up to date contact information. I have also followed up with [the radiology service] and discussed expectations of calls being made to inform of any abnormal findings and have been reassured that this will happen in the future. I also have my phone screened for telecommunications errors."

[14] Right 4(1) states: "Every consumer has the right to have services provided with reasonable care and skill."
[15] Right 6(1) states: "Every consumer has the right to the information that a reasonable consumer, in that consumer's circumstances, would expect to receive …"

74. RM B also told HDC that she has followed up with the radiology service and discussed expectations of calls being made to inform of abnormal findings, and she has been reassured this will happen in the future.

75. RM B said that following these events, she changed her organisational approach and now has a widget "to do list" on the front screen of her phone. Therefore, she is always able to have it with her and update things as they change. She also set up an application of the Maternity software on her phone to access or update each woman's notes at any time.

76. RM B told HDC that through the process of reflection and accountability, she wholeheartedly accepts the criticism of the care she provided to Mrs A during her pregnancy. To educate herself further, she has enrolled to attend an educational day on documentation later in the year.

77. RM B said that following the incident she sought advice and guidance from experienced LMC midwives, and changed many of her processes. Additionally, she is generally more reflective, and notes a momentous mind-shift surrounding her role and the importance of each screening process. She said that she has learnt so much from this adverse experience, and will continue to carry these invaluable lessons into the future to ensure that she is providing safe and accountable care.

78. Following her first response to HDC, and after thorough examination of the events, RM B has decided to discontinue booking women, and will finish LMC work.

Recommendations

79. I note that RM B has undertaken reflection and made significant changes to her practice and she has decided to cease LMC work. The Midwifery Council of New Zealand has also undertaken a review of RM B's competence.

80. In response to my provisional decision, RM B provided HDC with a written apology for forwarding to Mrs A.

81. Should RM B decide to recommence LMC work in the future, I recommend that she:

a) Receive all scan and laboratory reports electronically, and set up a shared system of electronic notes for midwives in the practice, to simplify access of results.

b) Introduce a system of "tasks to do", either electronically, through a diary, or in notebook form.

c) Introduce sharing of tasks or a system of delegating tasks to a colleague/practice partner.

Follow-up actions

82. 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 they will be advised of RM B's name.

83. A copy of this report with details identifying the parties removed, except the expert who advised on this case, will be sent to the district health board, the New Zealand College of Midwives, and the Ministry of Health, and placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

Appendix A: Independent clinical advice to the Commissioner

The following expert advice was obtained from a registered midwife, Fiona Hermann:

"**Summary of case:**

[Mrs A] was a [pregnant woman in her thirties] who was in the care of LMC midwife, [RM B]. [Mrs A's] USS scans on 17 [Month2] (12+2 weeks' gestation) and 24 [Month2] (13+2 weeks' gestation) showed the fetus measured nine days smaller than gestational age. [RM B] was unable to attend [Mrs A's] appointment on 7 [Month3] due to [RM B] being unwell, and she arranged a locum midwife to see [Mrs A]. The locum midwife made a referral for a further scan at 16 weeks' gestation to check the growth of the fetus. On 15 [Month3], at 16+1 weeks' gestation, the obstetric ultrasound showed the fetus measuring 15 days smaller than gestational age.

[Mrs A] contacted [RM B] that day to follow up on the scan results as the sonographer had remarked that the baby appeared small. As [RM B] had not yet received the report, she advised [Mrs A] that she would follow up by the end of the week, but this was not done. [Mrs A] states that she also contacted [RM B] on 22 [Month3] to follow up this request.

An obstetric anatomy ultrasound on 10 [Month4] (20+1 weeks' gestation) showed the fetus was small for gestational age and detected several anatomical abnormalities. On 11 [Month4], [RM B] obtained the radiology reports for the scans on 15 [Month3] and 10 [Month4] and made an urgent referral to [the public hospital]. Further testing and assessment indicated that a syndromic diagnosis with uncertain prognosis was likely. At 25 weeks' gestation, [Mrs A] and her husband made the decision to terminate the pregnancy.

Whether the care provided by [RM B] during the period from 3 [Month2] to 12 [Month4] was appropriate and consistent with accepted standards

The care provided by [RM B] during this time did meet the accepted standards **except** for the management of the results of the scan performed at 16+1 weeks. The standards for practice come from the NZ College of Midwives (https://www.midwife.org.nz/midwives/professional-standards/standards-of-practice/) — this online version does not contain the decision points which are linked with gestational age and occurrences in the woman's pregnancy. The full document is available in print from NZ College of Midwives. The other standard for practice or guidelines around LMC responsibilities and care is Section 88 of the Public Health and Disability Act 2000 (https://www.health.govt.nz/system/files/documents/publications/s88-primary-maternity-services-notice-gazetted-2007.pdf)

The midwife needs to have a way of ensuring that follow up tasks are recorded, and that ensuring handover to a locum or colleague is systematic.

In particular, do you consider that all appropriate actions were taken following the results of the scans at 12+2 and 13+2 weeks' gestation?

I do consider that the actions taken after these scans was appropriate.

As the woman had an established expected date of delivery (EDD) from an early (7 week) scan — a scan at this gestation is considered very accurate in terms of dating — the NT scans at 12 and 13 weeks should have concerned the midwife slightly. Nine days is a discrepancy that may be concerning. However, this is not a midwifery 'specialist topic' and as the sonographer has recommended a scan at 16 weeks to 'check for early onset IUGR or evolving skeletal abnormality' I would expect the midwife to do exactly that — refer the woman again for this scan. I would expect that the midwife would speak with the woman about this as it is not common and the comment about early IUGR or possible evolving skeletal abnormality would usually cause concern for both woman and midwife. The comment that the fetal chest is smaller than expected and bell-shaped is an uncommon one and something that would be memorable. At this time a midwife may consult an obstetrician or fetal medicine for advice — or simply continue with the recommended referral for a scan at 16 weeks. The decision to refer/request a specialist opinion may depend on the woman's level of anxiety and the midwife's experience with this occurrence and the ease of availability of specialist consult. In my experience a phone call to the local DHB obstetric registrar or consultant, or a call to the fetal medicine may be warranted. I would imagine that the recommendation would be wait and see, certainly refer for scan at 16 weeks.

However, not referring to fetal medicine then, and instead referring the woman for a 16 week scan without further consultation would also be considered acceptable.

Recommendations to prevent this happening again: while it is unrealistic to expect that the midwife will be expecting and looking out for every scan report, it is reasonable to expect that a midwife would remember that a woman has had a scan that has some unusual features, and be alert for her next assessment. Receiving all scan and laboratory reports electronically and having a shared system of electronic notes for midwives in the practice simplifies accessing results, removes having to chase or wait for a hard-copy report and means all locums and other colleagues needing to can view results at any time.

Whether further referral and/or assessment was appropriate following the results of the scan at 16+1 weeks' gestation?

I note that while [RM B] says she was away sick and a locum saw [Mrs A] and referred her for the 16 week scan, the scan report says a copy went to [RM B] via fax and indeed a fax cover letter backs this up. At this time, with a scan report faxed, and the woman making contact to ask about the scan report as it had told her the baby was abnormally small, I would certainly be concerned and alerted to the need for an urgent referral or consultation at this time.

A midwifery appointment at this time would not have added anything in terms of clinical assessment, but certainly may have helped [Mrs A] understand what was happening.

I accept that [RM B] says she was very busy and unwell and had not had communication from the locum midwife or the radiology practice. However, a call/text from a woman alerting the LMC that her baby was considered small at the 16-week scan should have been memorable.

I note that the locum sent the scan result to a past email address. As above, the clinical records seem to indicate a copy was faxed to [RM B]. … [RM B] told [Mrs A] that she would follow up by the end of the week. Even allowing for a busy time — midwifery certainly can mean appointments and follow-ups can be delayed — I regard the non-follow-up of the scan report by [RM B] as a serious departure from expected standards. A phone call to the radiology practice on the day [Mrs A] contacted [RM B] would have allowed a verbal report to be given, and a report faxed/emailed/sent electronically to [RM B] that day. The following week [RM B] must have had some time to follow this up, or request a colleague to do so. While pressure of work could well be a mitigating circumstance, this does not mean the woman doesn't deserve timely care and referrals.

Appropriate management at this time would have been a referral to [the public hospital] — while sadly the outcome for this baby is very unlikely to have changed no matter when the referral, the decision making for the parents and the resulting termination of pregnancy may have been more straightforward and certainly less delayed.

I would expect a midwife to make this a priority and keep in touch with the woman as to whether she had heard from the [public hospital] scheduler as to an appointment time.

I believe my peers would agree that this is a serious departure from expected standards of care. A delay of a few days for the referral *may* be acceptable.

Recommendations for future practice to ensure this doesn't happen again — the midwife needs to have some system in place of tasks to do. This can happen electronically, through a diary or in a simple notebook form. Sharing of tasks or a system of delegating tasks to a colleague/practice partner may be needed.

The adequacy of [RM B's] handover process to the locum midwife.

It is difficult to speak to this as [RM B] does not outline her processes. However, it would be fair to say that if the locum is sending scan reports to an old email address this seems inadequate. An adequate system of handing over would be giving electronic access if e-notes are used, having a printed list of all woman and discussing each woman with the locum, highlighting anything different about each woman or anything particular to note about her and having ways to contact the LMC or a colleague for assistance if need be. If the locum is from outside the LMC's DHB area then ensuring referral pathways

peculiar to that area are understood and any local 'ways' of practice are noted. It would appear that [RM B] has revised her ways of hand over and I acknowledge this change.

Recommendations for future practice to ensure this doesn't happen again — I recommend that [RM B] review her note keeping and ways of handing over to a locum.

The adequacy of [RM B's] follow-up with the radiology service following the scan at 16+1 weeks' gestation.

It is also difficult to comment on this as [RM B] does not outline how she followed up with [the radiology company] at the time of the scan being performed, or afterwards, in hindsight, other than to say 'I have also followed up with [the radiology service] and discussed expectations of calls being made to inform of abnormal findings and have been reassured this will happen in the future'. In my local centre, there is phone communication with the referrer about all unusual/abnormal scans. This includes early fetal demise, abnormal findings and anything that would necessitate an urgent response or referral. I cannot comment on [RM B's] practice setting. However, as stated above in question 3, communication from a woman asking about her baby being denoted as small at a 16 week scan would alert me, and my peers, to follow up with the sonographer/scan provider. If a phone call had not been received from the scan provider, usual practice on receiving a query from the woman would be to wait perhaps 24 hours for a scan report and then call the provider to ensure the report was sent to the requester or LMC. Regardless of whether the scan had been requested by [RM B] or her locum [RM B] should have been prompted to follow up after [Mrs A] messaged her. In addition, [Mrs A] contacted [RM B] a second time on 22 [Month3]. If for some reason [RM B] had been unable to access the scan report on 15 [Month3], the second request a week later must have prompted the LMC again to chase this report.

As commented above, an abnormal finding in the fetal size at 16 weeks is unusual enough that the midwife should be alerted to follow this up, even in view of a busy workload or ill health. This would be amplified by the woman asking the LMC to follow this up. I cannot agree that work pressures would mean the LMC does not have time to follow this up.

I believe this is a significant departure from expected standards of care, and would be viewed with moderate disapproval by my peers.

Recommendations for future practice to ensure this doesn't happen again — again, electronic note keeping and a system of tasks 'to-do' needs to be established. Phone calls or messages from women need to be reviewed on a daily basis to assess if a response is needed.

An auto-reply on a text message asking the woman to CALL the midwife if the matter is urgent can help prompt the woman to prioritise the matter, and let her know if there may be a delay to a response from the midwife."

RM Hermann provided the following further advice:

> "I have read the information provided in these emails and my original report.
>
> This added information does not change my findings in the report I have provided to HDC.
>
> Please don't hesitate to contact me if you need anything further."

The following further advice was obtained from RM Hermann:

> "Please advise whether consideration of the above guidance (in particular referral category code 4007) changes your advice?
>
> I did consider this referral guideline code, and that is why I have stated above that a conversation/verbal consultation with the local obstetric service or fetal medicine may be warranted. A consultation may not always be in writing. As there was no definitive fetal abnormality diagnosed and the recommendation was made to re-scan at 16 weeks by the radiologist I feel it would be reasonable to follow this recommendation.
>
> **In your report you outlined: 'while it is unrealistic to expect that the midwife will be expecting and looking out for every scan report'.**
>
> This comment was made meaning a midwife will not always know when a woman is attending for a routine scan or lab test and so may not be specifically checking/ expecting/looking out for a specific result. A midwife is expected to check lab results regularly — at least 3 times a week minimum. She is expected to read and acknowledge every result she does receive in a timely manner. If she is away on leave then her back up should be able to access reports.
>
> **If the midwife is not responsible for following up on scans who is?** I agree, midwife is responsible for following up any scan/lab test she has requested.
>
> Recommendations for future practice to ensure this doesn't happen again — the midwife needs to have some system in place of tasks to do. This can happen electronically, through a diary or in a simple notebook form. Sharing of tasks or a system of delegating tasks to a colleague/practice partner may be needed.
>
> *[RM B] has explained that she now has a widget 'to do list' on the front screen of her phone. Therefore, she is always able to have it with her and update things as they change. She also set up an application of the Maternity software on her phone to access or update each women's notes at any time.*
>
> **Please advise whether you feel these are appropriate actions?** If [RM B] uses electronic notes then all lab reports/scans can be sent electronically and remain 'unfiled' until formally reviewed. The actions she has chosen are only adequate if the reviews are done. The widget and software on the phone may not have any effect if she does not review reports frequently."

Appendix B: Relevant standards

NZCOM consensus statement on Laboratory Testing/Screening

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;
>
> - 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."

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

The Ministry of Health 2012 *Referral Guidelines* provide 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.

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."

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.

The *Referral Guidelines* that applied at the time defined "IUGR/small for gestational age (SGA)" as:

> "Estimated fetal weight (EFW) <10th percentile on customized growth chart, or abdominal circumference (AC) <5th percentile on ultrasound, or discordancy of AC with other growth parameters, normal liquor."