Registered Midwife, RM B

Te Whatu Ora|Health New Zealand

A Report by the

Deputy Health and Disability Commissioner

(Case 19HDC00068)

Contents

Executive summary 1
Complaint and investigation 2
Information gathered during investigation....3
Opinion: RM B — breach....12
Opinion: Te Whatu Ora|Health New Zealand — breach 16
Changes made/actions taken....18
Recommendations....19
Follow-up actions 20
Appendix A: In-house advice to Commissioner 22
Appendix B: Independent advice to Commissioner....29
Appendix C: Relevant standards....35

Executive summary

1. This report concerns the maternity care provided to a woman by her lead maternity carer and Te Whatu Ora Hauora a Toi Bay of Plenty in 2017.

Findings

2. The Deputy Commissioner was critical of the midwife's care in the following respects:

- The lack of proactive and timely action to arrange growth scans and an obstetrics appointment;
- The inadequate postnatal care and support provided; and
- The documentation of the woman's care was severely lacking.

3. The Deputy Commissioner found that the cumulative deficiencies in the care provided by the midwife amounted to a failure to provide services with reasonable care and skill, and therefore the midwife breached Right 4(1) of the Code.

4. The Deputy Commissioner considered that the midwife's standard of documentation failed to meet professional standards, and therefore breached Right 4(2) of the Code.

5. The Deputy Commissioner was very critical that the midwife did not fully inform the woman of her options for obtaining a growth scan during her pregnancy, to enable her to choose how she wanted to proceed. The Deputy Commissioner considered that a reasonable consumer in the woman's circumstances would have expected to receive an explanation of the options available, and, accordingly, that the midwife breached Right 6(1)(b) of the Code.

6. In relation to the woman's ED presentation, the Deputy Commissioner was concerned that Te Whatu Ora Hauora a Toi Bay of Plenty did not act appropriately on the Campylobacter result from a test taken at this presentation, by not notifying the disease to Manatū Hauora|Ministry of Health, arranging specialist review by an obstetrician, and ensuring that the result was communicated to the LMC (with the onus having been placed on the LMC to set up access to its system to receive the result). The Deputy Commissioner considered that Te Whatu Ora|Health New Zealand failed to provide services with reasonable care and skill, in breach of Right 4(1) of the Code.

7. The Deputy Commissioner also considered that it would have been prudent for the midwife to have followed up on the woman's ED presentation, and to have documented having done so, but considered that the discharge summary should have been provided to the midwife directly as the referrer, and as Whakatane Hospital had requested action be taken by her on test results.

Names have been removed (except Te Whatu Ora|Health New Zealand (Hauora a Toi Bay of Plenty), Whakatane Hospital and the independent advisors) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

Recommendations

8. The Deputy Commissioner recommended that the midwife provide a written letter of apology to the woman; provide an update on training she has undertaken and report on her learning from this; and undertake an audit of patient records with respect to documentation of visits and telephone calls.

9. The Deputy Commissioner recommended that Te Whatu Ora Hauora a Toi Bay of Plenty provide a written letter of apology to the woman, and review systems, policies and procedures in place for provision of discharge summaries, communication with and access to clinical records for providers in the community, and the management of test results, and advise of the outcome of its review, including whether any areas for improvement were identified and plans to remedy the issues.

Complaint and investigation

10. The Health and Disability Commissioner (HDC) received a complaint from Ms A about the services provided by Registered Midwife (RM) B. The scope of the investigation was extended to include the services provided to Ms A by Te Whatu Ora Hauora a Toi Bay of Plenty (formerly a DHB)).[1] The following issues were identified for investigation:

- *Whether RM B provided Ms A with an appropriate standard of care from Month4[2] to Month8 2017 (inclusive).*
- *Whether Te Whatu Ora|Health New Zealand provided Ms A with an appropriate standard of care from Month4 to Month8 2017 (inclusive).*

11. 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.

12. The parties directly involved in the investigation were:

Ms A	Consumer/complainant
RM B	Provider/registered midwife
Te Whatu Ora Hauora a Toi Bay of Plenty)	Provider

[1] On 1 July 2022, the Pae Ora (Healthy Futures) Act 2022 came into force, which disestablished all district health boards. Their functions and liabilities were merged into Te Whatu Ora|Health New Zealand. All references in this report to a DHB now refer to Te Whatu Ora Hauora a Toi Bay of Plenty, and all references to DHB2 now refer to Te Whatu Ora 2.

[2] Relevant months are referred to as Months 1–8 to protect privacy.

Names have been removed (except Te Whatu Ora|Health New Zealand (Hauora a Toi Bay of Plenty), Whakatane Hospital and the independent advisors) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

13. Further information was received from:

RM C	Provider/registered midwife
DHB2 (now Te Whatu Ora 2)	Provider/DHB

14. In-house midwifery advice was obtained from RM Nicholette Emerson (Appendix A), and external obstetrics advice was obtained from Dr Celia Devenish (Appendix B).

Information gathered during investigation

Introduction

15. In 2017 Ms A (in her thirties at the time of events) became pregnant for the first time. Ms A moved towns on 28 Month4 when she was 31+4 weeks pregnant to be near her family, and her care was transferred to RM B. This report examines the month of antenatal care provided to Ms A by RM B from 28 Month4, and the postnatal care she provided following the tragic birth of Ms A's stillborn son.

16. At the outset, I extend my sincere condolences to Ms A and her whānau.

Background — care provided by first LMC and DHB2

17. Ms A booked with Lead Maternity Carer (LMC) RM C at 7+1 weeks' gestation, when she was in the DHB2 region.

18. Ms A received antenatal care from RM C, including serial growth scans and management of her hyperemesis.[3] In Month1 and Month2,[4] Ms A was seen at DHB2 for hyperemesis, and was treated with IV fluids.

19. Ms A had a high BMI[5] of 48.9, and on 3 Month2 RM C referred her to the local hospital for an obstetrics management plan.

20. On 13 Month3, Ms A attended the antenatal clinic.[6] She was seen by an obstetrics consultant with RM C present. The plan included Ms A having an ultrasound scan at 28 weeks' gestation and every three weeks thereafter, being seen at the antenatal clinic again at 32 weeks (or to be referred earlier if needed), and for Ms A to deliver at DHB2.

[3] A pregnancy complication that is characterised by severe nausea, vomiting, weight loss, and possibly dehydration.

[4] 22 Month1 and 16 Month2.

[5] Body Mass Index (a measure that uses a person's height and weight to determine whether the person's weight is healthy).

[6] At 25+3 weeks' gestation.

Names have been removed (except Te Whatu Ora|Health New Zealand (Hauora a Toi Bay of Plenty), Whakatane Hospital and the independent advisors) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

21. The report of an ultrasound on 10 Month4 noted that estimated fetal weight was at the 31st percentile, fetal measurements were within normal limits, and there was normal liquor volume[7] and normal Dopplers.[8]

22. An antenatal clinic appointment was made for 11 Month4, but it was cancelled by Ms A, and the plan for an obstetrics consultant to see her after the 32-week scan did not eventuate, as by that time she had moved.

Transfer of care to RM B — 28 Month4

23. RM C told HDC that when Ms A decided to relocate to be near family, she gave Ms A a full copy of all her clinical records to date, and a further copy for her to give to her new midwife.

24. Ms A booked RM B to be her LMC on 28 Month4. Ms A told HDC that she provided her clinical records to RM B. RM B recalls having seen the clinical records, but by the time Ms A complained to HDC, RM B no longer had them in her possession.

25. The antenatal records that RM C gave to Ms A contained the following entry on 19 Month4: "Book next growth scan. Scan due 7 [Month5] …"

Antenatal care

26. Ms A told HDC that during the time she was under the care of RM B, she had irregular midwifery appointments, and did not receive a scan or specialist appointment. She said that she followed up about booking a scan on many occasions, and RM B told her that she (Ms A) would have to pay for a scan and travel to another town for it.

28 Month4 — booking appointment with RM B

27. On 28 Month4, RM B recorded: "[B]ooked today as just arrived and settled to live in [the region]." RM B noted that Ms A was at 31+4 weeks' gestation. RM B assessed Ms A's blood pressure (BP),[9] weight,[10] and the fetal heart rate,[11] and recorded that the baby's movements were "active". The fundal height was documented to be 31cm.

28. RM B told HDC that Ms A's high BMI made the recording of fundal height measurements "very, very difficult and probably highly unreliable".

7 Month5 — referral to Whakatane Hospital

29. RM B said that she understood that another growth scan was to be done. She stated that Ms A was eager for this, even though the most recent scan (in Month4) had been very reassuring.

[7] Amniotic fluid (the fluid that surrounds the unborn baby during pregnancy).
[8] A type of ultrasound used to measure the flow of blood through a blood vessel.
[9] 113/72mmHg.
[10] 135kg.
[11] 131bpm.

Names have been removed (except Te Whatu Ora|Health New Zealand (Hauora a Toi Bay of Plenty), Whakatane Hospital and the independent advisors) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

30. RM B said that at that time in Whakatane, midwives could not organise or authorise free growth and serial scans for women. Instead, midwives referred women who needed a scan to an obstetrician, who would then arrange the scan. The scans were outsourced to a radiology service, which reported back to the obstetrician.

31. RM B said that on 7 Month5 she prepared a handwritten referral requesting an obstetric review of Ms A in the antenatal clinic at Whakatane Hospital. RM B stated that she faxed the referral to the maternity front desk secretary at Whakatane Hospital.

32. RM B was not able to provide HDC with a copy of this referral or evidence that it was faxed to Whakatane Hospital. Te Whatu Ora Hauora a Toi Bay of Plenty told HDC that there are no handwritten faxed referrals in Ms A's paper records or in the electronic Clinical Health Information Portal (CHIP). It had only two typed faxed referrals from RM B[12] (outlined further below).

Process and options for arranging scans

33. Further to the reference to scan referrals set out in paragraph 30, RM B said that at the time, the radiology service had a waiting list of at least three weeks, and priority for scans was given to requests made by obstetricians rather than midwives, and therefore the fastest way to get a scan to check growth for Ms A was to refer her to the obstetrician.

34. RM B said that if she had referred Ms A for a growth scan herself, it would almost certainly have meant a three-week wait and a charge for Ms A. RM B also said that a free scan was otherwise available with a midwifery referral only by going to another town.

35. RM B stated that at that time she was not able to book a series of growth scans in advance, and even though things have changed recently so that a scan can be arranged prior to review by a specialist, the request must still be authorised and signed by a doctor at Whakatane Maternity.

36. Ms A commented that she was willing to pay for scans but was told that there were no appointments available. RM B acknowledged that in retrospect (although she did not consider it at the time), she could have requested a private scan for Ms A, which may have occurred sooner. However, private scans would have cost $160–180 and it did not cross her mind as something necessary at that time.

Information received from Te Whatu Ora Hauora a Toi Bay of Plenty regarding arranging growth and serial scans

37. Te Whatu Ora Hauora a Toi Bay of Plenty agreed with RM B's statement that a midwife could organise and authorise growth and serial scans (as per the Primary Maternity Notice) but, if they did so, the woman would incur a $45 co-payment.

38. Te Whatu Ora Hauora a Toi Bay of Plenty stated that in Month4, when community midwives requested and obtained publicly funded serial growth scans, a co-payment was

[12] A referral to the Emergency Department on 11 Month5, and a referral to the obstetrician on 21 Month5.

Names have been removed (except Te Whatu Ora|Health New Zealand (Hauora a Toi Bay of Plenty), Whakatane Hospital and the independent advisors) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

charged to the pregnant woman. Te Whatu Ora Hauora a Toi Bay of Plenty noted that this co-payment resulted in a barrier to access to publicly funded scans, which could lead to poor clinical outcomes.

39. Te Whatu Ora Hauora a Toi Bay of Plenty noted that in order to reduce this co-payment financial barrier, in Month4 a "work around" process was in place whereby the midwife could refer the woman to the obstetrician, who could request the scan, thereby avoiding the $45 co-payment (which was not charged in the case of DHB referrals, as per the DHB agreement with the radiology service). The provider could still claim the publicly funded component of $80.

40. In response to the provisional opinion, Te Whatu Ora advised that the equitable access to ultrasound scans in the Eastern Bay of Plenty and Western Bay of Plenty are currently held as an organisational risk and are logged on the Risk Register.

11 Month5 — review by RM B and presentation to ED at Whakatane Hospital

Review by RM B

41. RM B said that before an appointment date at the antenatal clinic was provided, Ms A presented to the Emergency Department (ED) at Whakatane Hospital on 11 Month5 (with a covering letter written by RM B), for vomiting/nausea, dehydration and tingling in her arm and leg.

42. No notes were made in RM B's antenatal record that day, but RM B's letter addressed to the Whakatane Hospital ED recorded that she had seen Ms A that day because Ms A had had diarrhoea and vomiting overnight. The letter also notes the observations taken that day, including the fetal heart rate (noted to be difficult to find due to Ms A's size), that Ms A had experienced nausea and vomiting throughout her pregnancy, and that Ms A did not yet have a GP.

Presentation to Whakatane Hospital ED

43. At around 1pm on 11 Month5, Ms A presented to the Whakatane Hospital ED.

44. Ms A was reviewed by an emergency medicine consultant, who documented that Ms A was 33 weeks pregnant and had nausea, diarrhoea and vomiting. The consultant noted that Ms A had lower abdominal cramping and that her left leg was numb and her left arm was tingling, and considered that these symptoms were caused by sciatica[13] and carpal tunnel syndrome.[14]

45. An intravenous (IV) line was placed at 2.09pm, and blood tests and an influenza swab were taken. IV fluids were started. At 3.01pm, Ms A's urine dipstick result was reported and

[13] Sciatica is a term used to describe nerve pain in the leg that is caused by irritation and/or compression of the sciatic nerve.

[14] A numbness and tingling in the hand and arm caused by a pinched nerve in the wrist.

Names have been removed (except Te Whatu Ora|Health New Zealand (Hauora a Toi Bay of Plenty), Whakatane Hospital and the independent advisors) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

noted "nil ketones[15]". A faecal specimen was taken at 3.48pm. At 4.20pm, the IV fluids were completed, and Ms A was discharged home.

46. Ms A was not seen by an obstetrician or taken to the maternity ward during this presentation.

47. RM B said that she believed that Ms A would be seen by a specialist at that time and placed "in the system". In a later response to HDC, she stated that she fully expected that Ms A would be seen by the on-call obstetrician and given IV fluids, and that a cardiotocography (CTG) trace (to monitor the fetal heart rate and uterine contractions) would be organised on the maternity ward, as this was not simple morning sickness.

48. Te Whatu Ora Hauora a Toi Bay of Plenty told HDC that a "specific request" would be required for an obstetrician to review a pregnant woman presenting to the ED, as the presentation might not relate to the pregnancy, and referral to an obstetrician would not happen as a matter of course.

49. In response to the provisional opinion, Te Whatu Ora noted that all LMCs can phone into Whakatane Maternity Unit to speak with a midwife or the duty obstetrician, and all LMCs can bring their women into the maternity unit for review of concerns by the duty obstetrician. The Whakatane Maternity Unit is always staffed by hospital midwives and a duty obstetrician, and the Neonatal High Dependency Unit is also located within the department.

<u>Discharge and coordination of care</u>

50. The discharge summary notes that the principal diagnosis was infectious diarrhoea, with additional diagnoses of carpal tunnel syndrome and sciatica. The plan included: "[M]idwife please help review stool c[ulture] results."

51. It is unclear who completed the discharge summary, or to whom a copy was provided. The discharge summary is unsigned, and the time of discharge is not recorded. Te Whatu Ora Hauora a Toi Bay of Plenty said that the consultant was the author of the discharge summary, and it was sent electronically to Ms A's identified GP practice.

52. Of note, the patient identification sticker on Ms A's clinical notes from her presentation on 11 Month5 states: "P[atien]t states no GP. Pts GP unknown." RM B's referral letter to the ED notes the same information.

53. Te Whatu Ora Hauora a Toi Bay of Plenty said that a copy of the discharge summary would not have been sent electronically to Ms A's LMC, as the DHB's electronic system at the time allowed only one recipient. However, Te Whatu Ora Hauora a Toi Bay of Plenty said that all LMCs were able to set up their own access to CHIP, where all letters, discharge summaries, and laboratory/radiology reports were available. It noted that normal practice is also to hand a copy of the discharge summary to the patient on discharge.

[15] Ketones in urine may indicate that the blood glucose is too high.

Names have been removed (except Te Whatu Ora|Health New Zealand (Hauora a Toi Bay of Plenty), Whakatane Hospital and the independent advisors) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

54. RM B said that when she referred Ms A to the ED, she did not expect to get any feedback from the staff there. She said that she has never been notified about any treatment and further care of any clients sent to the ED in such circumstances, and discharge summaries are not given to LMCs.

55. RM B said that instead, it was her practice to telephone the hospital some hours later or the next day, to find out what had happened. She said that sometimes it was not possible for anyone there to provide this information, especially if there had been a shift change, in which case all she could do was obtain confirmation that the woman had been seen and discharged.

56. There is no evidence in the antenatal record or hospital records that RM B contacted the hospital. RM B said that she is "pretty sure" that this happened, but it was not until she spoke to Ms A that she learned that she had been seen, rehydrated with IV fluids and, after seeing a doctor, given a prescription for more anti-emetics[16] and discharged. RM B cannot recall whether she asked Ms A whether she had had a CTG but stated that usually this would happen unless the maternity ward was very busy, in which case they would check the fetal heart with a Doppler.

57. RM B noted that at that time, she was still expecting Ms A to have a clinic appointment for an obstetric consultation very soon.

14 Month5 — faecal specimen result

58. The faecal specimen taken on 11 Month5 was reported on 14 Month5,[17] and showed Campylobacter gastroenteritis. The report contained the standard instruction that Campylobacter is usually self-limited, that antibiotic therapy is not indicated except in very severe or prolonged cases, and that this is a notifiable disease.[18]

59. Te Whatu Ora Hauora a Toi Bay of Plenty advised that the results of the stool specimen were available on CHIP. A doctor (name illegible) telephoned Ms A at 8.15am on 14 Month5 and told her the results and advised her to return to the hospital if she had a decrease in urine output, if she was unwell, and/or if the diarrhoea worsened.

17 Month5 — antenatal appointment

60. On 17 Month5, Ms A had an antenatal appointment with RM B. Ms A was then at 34+3 weeks' gestation. RM B documented:

> "Given lab test for ? [urinary tract infection].[19] Letter for specialist has been sent but no appointment yet. See in 2 weeks. 21 [Month5] — letter done to specialist re [Ms A]."

---

[16] Medication used to relieve and prevent nausea and vomiting.

[17] Produced at 10.05am on 14 Month5.

[18] A notifiable disease is one that health practitioners must notify to the medical officer of health in the local public health unit.

[19] On 23 Month5, the urine test result was noted as "no significant growth".

Names have been removed (except Te Whatu Ora|Health New Zealand (Hauora a Toi Bay of Plenty), Whakatane Hospital and the independent advisors) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

61. RM B also documented Ms A's blood pressure, the fetal heart rate, the fundal height, and that the baby's movements were "active".[20]

62. As noted above, there is no documentation that RM B discussed with Ms A the recent ED presentation, or that she accessed the discharge summary or the faecal specimen results.

63. RM B stated that Ms A told her that she still had not received a date for her obstetric appointment. RM B said she queried this with the hospital and was told that the referral was not in the system and there was no sign of Ms A being offered an appointment. There is no record of this call in Ms A's clinical records. Te Whatu Ora Hauora a Toi Bay of Plenty stated that it has no documentation of any telephone conversations with external providers relating to Ms A around this time.

21 Month5 — referral to Whakatane Maternity

64. RM B said that she typed another referral letter (dated 21 Month5) and hand-delivered it to the Specialist Maternity Services at Whakatane Hospital, to ensure that it was received and actioned. The referral outlined Ms A's high BMI, that she had been receiving serial scans, which would need to continue, that it was difficult to palpate/hear the fetal heart due to the maternal size, and that she had ongoing hyperemesis with two episodes of vomiting, one of which had required rehydration with IV fluids. The referral also requested review of Ms A's anti-emetic medication.

65. There is no specific information in the letter relating to Ms A's recent ED presentation, other than the reference to rehydration with IV fluids to manage hyperemesis, and there is no mention of the faecal specimen result.

66. An obstetrics and gynaecology consultant processed the referral on 22 Month5 and noted that Ms A was to be seen in the antenatal clinic within 10 days, because of her high BMI.

Care on 28 Month5

67. On 28 Month5, at 36 weeks' gestation, Ms A's membranes ruptured. Sadly, no fetal heartbeat could be found, and Ms A delivered a stillborn baby the next day. Further detail of the events of 28–29 Month5 are outlined below.

Review by RM B

68. Ms A recalled that on 28 Month5 she noticed a "show" (a discharge of mucus tinged pink or brown with blood) and, at around 6pm, her mother contacted RM B.

69. Ms A said that RM B took approximately 30 minutes to one hour to arrive. RM B told HDC that she was out visiting other clients at the time, and attended as soon as she could.

70. RM B told HDC that it appeared that Ms A's membranes had ruptured, so she went to the birthing unit/medical centre to get Amnicator sticks to confirm this. The test was positive.

[20] BP was 124/85mmHg, fetal heart rate was 140bpm, and fundal height was 34cm.

Names have been removed (except Te Whatu Ora|Health New Zealand (Hauora a Toi Bay of Plenty), Whakatane Hospital and the independent advisors) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

RM B recalled that Ms A informed her that there had been very little movement from the baby since that morning.

71. Ms A told HDC that she felt that she should have been told to go the hospital immediately after the rupture of her membranes. She recalled that RM B did not check the fetal heartbeat until "the last minute".

72. RM B said that neither the reduced movements that morning nor the small show of blood were very worrying on their own and are both fairly common occurrences at around 36 weeks' gestation, when the cervix is softening and thinning. There is less room for the fetus to move, and reduced movements for a few hours is not usually significant unless there is a lack of movements over a longer period. She said that she was more concerned to find that Ms A's membranes had ruptured, because if Ms A did not go into spontaneous labour, she would need to be induced in order to avoid ascending infection for the baby in utero.

73. RM B stated that when she searched for a fetal heartbeat, she could not find it where she expected to. She hoped that this was because of Ms A's size and/or the position of the baby. She said that at that point she wanted Ms A to be taken to Whakatane Hospital urgently.

74. RM B said that Ms A's mother and her koro drove Ms A to the hospital. RM B stated that she stayed behind to contact the obstetrician and ward staff to let them know they were on the way, and then followed right behind. She said that often an ambulance could take up to an hour to arrive, and therefore she believed that travelling in their own transport was the quickest option.

75. There is no documentation of the above events in RM B's notes.

Presentation to Whakatane Hospital

76. A doctor documented that RM B first telephoned about Ms A at around 6.45pm, and the doctor called back at 7.50pm. The doctor noted that RM B told her that she could not find a fetal heartbeat, and the doctor asked them to come to the hospital. When Ms A arrived at Whakatane Hospital, the doctor attempted to find a fetal heartbeat by ultrasound, and Ms A told her that she had felt no fetal movements since midday. Ms A was admitted to the maternity unit at 9pm, and the doctor planned to perform a formal scan the following day to confirm the stillbirth.

77. Sadly, an ultrasound scan at 11am on 29 Month5 confirmed intrauterine death. Ms A delivered a stillborn baby at 8.25pm that day.

Postnatal care

78. Ms A was discharged from Whakatane Hospital on 31 Month5. She told HDC that RM B attended her son's tangi, and came to see her the week after, but never returned to check on her after that.

Names have been removed (except Te Whatu Ora|Health New Zealand (Hauora a Toi Bay of Plenty), Whakatane Hospital and the independent advisors) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

79. RM B's postnatal record notes: "N[umber of] P[ost] N[atal] visits 6." No further details are recorded, including when the visits occurred or what was discussed.

80. RM B said that she recalled seeing Ms A at least a couple of times at home, and she visited another three or four times, but Ms A was not at home. RM B also recalled that Ms A told her that she would soon be going overseas to be with her husband.

81. Ms A said that she remained at home for two months after the death of her baby, as she did not want to leave her home. She travelled overseas in Month8.

82. In a later response to HDC, RM B said that she believes she saw Ms A at her home on one occasion after the tangi but failed to document the visit. RM B recalled that she definitely went to Ms A's home to see her at least three or four times but Ms A did not answer the door. RM B said that she considered asking another midwife colleague to visit for her, and in retrospect she should have done so, but at the time she did not think it was the right thing to do.

Referral/handover to secondary care

83. RM B told HDC that she was unable to consider a full handover to specialist care for Ms A, as this course of action was not an option at the time and has remained the same to date. RM B stated that this is because Whakatane Maternity is a very small secondary care unit, and there are barely enough staff midwives to cover the shifts on the ward, and therefore no staff available to form a specialist team. She noted that Ms A had a BMI of over 40 when she booked in the DHB2 region, and, although RM B understood that a transfer of care was warranted under the Ministry of Health Referral Guidelines, she could not do more than make a normal referral for an obstetric consultation through the channels available to her at Whakatane Maternity at the time, which she did.

RM B's documentation

84. RM B said that she does not have a lot of documentation for Ms A as she knew her for only about four weeks. RM B accepted that documentation is her "biggest problem" and said that while previously she believed that if there was no meeting between midwife and client there was nothing to document, she now understands that this is incorrect. She has since attended the New Zealand College of Midwives "Dotting the I's and Crossing the T's" documentation workshop.

85. RM B told HDC that she now documents every telephone call, text message and action in response to her clients, and has started to use parts of the computer programme EXPECT, which previously she did not know how to use.

Further information — RM B

86. RM B expressed her deep sympathy and hope that Ms A is recovering a little from the sorrow of her loss.

Names have been removed (except Te Whatu Ora|Health New Zealand (Hauora a Toi Bay of Plenty), Whakatane Hospital and the independent advisors) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

Responses to provisional opinion

Ms A

87. Ms A was given an opportunity to comment on the "information gathered" section of the provisional opinion but did not wish to comment.

RM B

88. RM B was given an opportunity to respond to the provisional opinion and advised that she accepts the findings.

Te Whatu Ora Hauora a Toi Bay of Plenty

89. Te Whatu Ora was given an opportunity to respond to the provisional opinion, and its response has been incorporated into this report where relevant.

Opinion: RM B — breach

Introduction

90. I again extend my sincere condolences to Ms A and her whānau for the loss of her precious baby boy.

91. RM B was involved in Ms A's maternity care from 28 Month4 onwards. As a healthcare provider, RM B was required to provide services to Ms A with reasonable care and skill, and in compliance with professional standards.

92. Having reviewed the information gathered during my investigation, in my view the care provided by RM B fell below accepted standards. I discuss this below.

Antenatal care

93. Ms A registered with RM B on 28 Month4, at 31+4 weeks' gestation, having relocated to be near family. Ms A's first LMC's records, which were provided to RM B, stated that a scan was due on 7 Month5. During the time Ms A was under RM B's care, she was not seen by an obstetrician, and did not receive a growth scan.

94. My midwifery advisor, RM Nicky Emerson, said that Ms A's BMI warranted obstetric referral/transfer of care under the Ministry of Health Referral Guidelines.[21] In addition, RM Emerson advised that as the estimated fetal weight at 29 weeks was just above the 10th centile (below the 10th centile required referral under the Referral Guidelines), in her opinion a repeat scan within three weeks would have been prudent to monitor growth, and this scan should have occurred at 32 weeks at the latest.

95. RM B said that she considered that the scan taken on 10 Month4 (prior to transfer) was reassuring, and she understood that another scan was to be done, and that Ms A wanted

[21] See Appendix C.

Names have been removed (except Te Whatu Ora|Health New Zealand (Hauora a Toi Bay of Plenty), Whakatane Hospital and the independent advisors) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

to have the scan. RM B explained the system for obtaining imaging at the time of events (see paragraph 30).

96. RM B told HDC that on 7 Month5 she handwrote and faxed a referral for obstetric review to Whakatane Hospital. RM B has been unable to provide evidence of this referral. There is no record of a referral having been made in Ms A's clinical records, the DHB did not receive a referral, and RM B did not keep a copy for her records. I note that reportedly this referral was handwritten, whilst the two subsequent referrals made by RM B that were in Ms A's records were typed and kept in the clinical records. I note also that the referral made on 21 Month5 did not refer to a previous lost referral.

97. On the evidence available to me, I consider it more likely than not that RM B did not refer Ms A for obstetric review on 7 Month5. This is a significant oversight in light of Ms A's risk factors and meant that Ms A did not receive an obstetric referral until 21 Month5, although sadly Ms A went into labour before her scheduled appointment. At the very least, RM B should have contacted an obstetrician to discuss Ms A's care. As RM Emerson advised:

> "If it is accepted that [RM B] was aware of the need to refer [Ms A] for specialist care and for on going serial growth scans and was unable to obtain a free scan for [Ms A], then in my opinion, considering [Ms A's] BMI, hyperemesis and the previous scan E[stimated] F[etal] W[eight] being on the 10th centile, [RM B] has moderately departed from accepted midwifery practice in not actively pursuing and discussing her concern regarding (either by phone or in person) [Ms A's] BMI, hyperemesis and need for ongoing growth scans with an Obstetrician at the DHB."

98. In addition to the failure to refer Ms A for obstetric review, I am also concerned about the information RM B provided to Ms A about her options for obtaining a scan, including via an obstetric referral, through midwifery referral with a $45 co-payment, going to another town for a free scan, or getting a private scan. There is no evidence that such a fulsome discussion occurred.

99. I prefer the evidence of Ms A, namely that she was told that she would need to pay for a scan and travel elsewhere for it. I note also that Ms A commented that she was willing to pay for scans but was told that there were no appointments available.

100. In my opinion, the evidence above indicates a lack of proactive and timely action to arrange an obstetric appointment and growth scans for Ms A. I acknowledge that the system under which RM B was operating created barriers for access to these services and had an impact on her ability to follow the Ministry of Health referral guidelines. However, RM B was aware of this system, and it was her responsibility in the circumstances to proactively follow up on matters, to ensure that appropriate checks were undertaken to monitor fetal wellbeing. In my opinion, this lack of proactive and timely action resulted in Ms A not being seen by an obstetrician or receiving a growth scan in the one month of antenatal care she received from RM B.

Names have been removed (except Te Whatu Ora|Health New Zealand (Hauora a Toi Bay of Plenty), Whakatane Hospital and the independent advisors) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

Postnatal care

101. Ms A was discharged from Whakatane Hospital on 31 Month5. RM B said that she recalled seeing Ms A at least a couple of times at home, and visited her another three or four times but Ms A was not at home. RM B also recalled that Ms A told her that she would be going overseas to be with her husband.

102. In a later response to HDC, RM B said that she believes she saw Ms A on one other occasion at her home after the tangi but failed to document the visit. RM B said that she definitely went to Ms A's home to see her at least three or four times but Ms A did not answer the door.

103. RM B has provided variable evidence about the number of times she visited Ms A or attempted to do so. There is no documentation of the visits, including the dates on which they occurred or what was discussed. The only documentation is a reference to six postnatal visits.

104. Ms A recalled that RM B attended the tangi, and that there was only one postnatal visit. Ms A said that she remained at home for two months after the events, as she did not want to leave her home, and she did not go overseas until Month8.

105. In light of RM B's differing recollections and lack of documentation to support her version of events, I prefer the evidence of Ms A. I consider it more likely than not that there was only one postnatal visit, not six.

106. RM Emerson advised:

> "[A]ccepted midwifery practice following a baby's death would involve comprehensive care regarding the wellbeing (both mental and physical) of the mother and whānau, particularly when the father is not in the country to provide support. This care would involve communicating intention to visit, either by text message or phone. A note left when the woman is not home would communicate caring and attempts to visit. Women are particularly vulnerable following the death of a baby."

107. I am very critical of the lack of postnatal support that RM B provided to Ms A. This was a particularly vulnerable period during which Ms A would have benefitted from support. I note that RM B said that she did consider asking another midwife colleague to visit for her, and in retrospect she should have done so, but that at the time she did not think this was the right thing to do.

108. In my view, RM B should have ensured that Ms A was supported appropriately during the postnatal period, and this should have included attempting further contact, and handing over Ms A's care to another midwife.

Documentation

109. RM B's documentation of Ms A's care was seriously lacking in several respects, as follows:

Names have been removed (except Te Whatu Ora|Health New Zealand (Hauora a Toi Bay of Plenty), Whakatane Hospital and the independent advisors) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

- Ms A's records do not contain essential antenatal information, including the blood and other test results provided by RM C. At the time of HDC receiving this complaint, RM B no longer had RM C's records in her possession;
- There is no evidence of an obstetric referral dated 7 Month5;
- The records of the antenatal appointments are scant, and on 11 Month5 the assessment is not recorded other than in the letter addressed to the ED;
- There are no notes of telephone calls or events prior to Ms A's admission to Whakatane Hospital on 28 Month5; and
- The detail of the one postnatal visit Ms A recalls is not recorded. I am also critical that nothing is documented as to the date or what was discussed on this visit.

110. RM B acknowledged that her notes are deficient, and she has undertaken further training.

111. RM Emerson advised that regardless of the period of time a woman is under the care of a midwife, the legal obligations related to record-keeping remain the same, and in her opinion RM B's documentation moderately departed from accepted practice.

112. I agree. Documentation is an important part of the provision of care. A clear record of the decisions made, care provided, and discussions had is essential for continuity of care. I am highly critical of RM B's documentation of Ms A's care.

Conclusion

113. In summary, I am critical of RM B's care in the following respects:

- The lack of proactive and timely action to arrange growth scans and an obstetric appointment for Ms A, including not making an obstetric referral for Ms A until 21 Month5;
- The inadequate postnatal care and support provided to Ms A; and
- The documentation of Ms A's care was severely lacking.

114. In my opinion, the cumulative deficiencies in the care provided to Ms A by RM B amount to a failure to provide services with reasonable care and skill. Accordingly, I find that RM B breached Right 4(1) of the Code of Health and Disability Services Consumers' Rights (the Code). In addition, I consider that RM B's standard of documentation failed to meet professional standards, and therefore breached Right 4(2) of the Code.

115. I am also very critical that RM B did not fully inform Ms A of her options for obtaining a scan, to enable her to choose how she wanted to proceed. It is evident that whilst some discussion of options occurred, this was not fulsome and, as outlined above, I prefer the evidence of Ms A. In my opinion, a reasonable consumer in Ms A's circumstances would have expected to receive an explanation of the options available. Accordingly, I find that RM B breached Right 6(1)(b) of the Code.

Names have been removed (except Te Whatu Ora|Health New Zealand (Hauora a Toi Bay of Plenty), Whakatane Hospital and the independent advisors) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

Follow-up after Ms A's ED presentation on 11 Month5 — adverse comment

116. As outlined above, Ms A presented to the ED on 11 Month5, and RM B assumed that Ms A would be seen by the obstetrics team. A discharge summary was not provided directly to RM B by Whakatane Hospital. RM B said that she did not expect to receive any information, and her usual practice was to telephone the hospital to find out what had happened. RM B stated that she discussed Ms A's ED presentation at her next antenatal appointment and is "pretty sure" she discussed the presentation with the hospital. However, neither of these discussions were documented.

117. Ideally, it would have been prudent for RM B to have followed up and documented having done so. However, in my opinion, a discharge summary should have been provided to RM B directly, to ensure that she was informed, particularly given that RM B had referred Ms A to the ED, and Whakatane Hospital had requested action by RM B on Ms A's test results. I discuss this further below.

Care on 28 Month5 — other comment

118. On 28 Month5, RM B assessed Ms A and arranged for transfer to Whakatane Hospital.

119. RM Emerson advised that she identified no departures from accepted midwifery practice in RM B's assessment of Ms A at home and during her labour in hospital.

Opinion: Te Whatu Ora|Health New Zealand — breach

120. As a healthcare provider, Te Whatu Ora Hauora a Toi Bay of Plenty was required to provide Ms A services with reasonable care and skill. I am concerned that Ms A's LMC did not have ready access to the DHB's clinical health information relevant to a pregnant woman under her care. There were deficiencies with the systems in place for the management and follow-up of test results and discharge summaries, which I discuss below.

Coordination of care following ED discharge on 11 Month5

121. On 11 Month5, Ms A was seen at Whakatane Hospital ED, with a referral letter from her midwife. The discharge summary is incomplete and noted the need for the midwife to review the stool results (which became available on 14 Month5).

122. Despite this, a copy was not provided to the referring midwife. Reportedly, a copy was sent to Ms A's GP, which contradicts the midwife's referral letter and the DHB clinical notes from this presentation, which state that she had no GP.

123. Te Whatu Ora Hauora a Toi Bay of Plenty stated that the stool result became available on CHIP on 14 Month5, and all LMCs are able to set up their own access to CHIP, where all letters, discharge summaries, and laboratory/radiology reports are available. I note that

Names have been removed (except Te Whatu Ora|Health New Zealand (Hauora a Toi Bay of Plenty), Whakatane Hospital and the independent advisors) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

the midwife confirmed that it was not usual to hear from the DHB after a woman's presentation, and that her usual practice was to telephone the hospital herself.

124. A doctor (name illegible) telephoned Ms A at 8.15am on 14 Month5 and told her the results and advised her to return to the hospital if she had a decrease in urine output, if she was unwell, and/or if the diarrhoea worsened.

125. My independent obstetric advisor, Dr Celia Devenish, noted that it would be usual practice to treat a Campylobacter infection with antibiotics and to follow up a pregnant woman with this diagnosis and refer her to a specialist. This is because maternal Campylobacter is known to cause infection of the placenta and fetus, with adverse outcomes.

126. Dr Devenish advised that the health practitioner responsible for Ms A's referral and ongoing care should have been advised of the result, in this case the LMC. Dr Devenish considered that the onus was on the ED to send the result to the LMC. She noted that the ED was staffed 24/7 and there was an obstetrics department with an on-call specialist, and cases could be referred to the main centre hospital for further discussion should advice be needed.

127. Dr Devenish noted that the results were accepted by a doctor, and Ms A was contacted on 14 Month5, but the hospital notes do not state whether she was advised of the Campylobacter result, or whether the medical officer of the public health unit, any GP, or her LMC were advised officially, and there is no record of a referral having been made to an obstetrics service or any practitioner after her discharge. Dr Devenish considers that if Ms A did not have a GP at the time, then the LMC or a local obstetrician should have been contacted.

128. Dr Devenish also noted that the hospital notes contain no comment regarding Campylobacter being a notifiable disease, nor any mention of the possible adverse effects to a pregnancy.

129. Dr Devenish considers that adequate care would have been to refer Ms A for a specialist opinion regarding the effect of Campylobacter on a pregnancy. Dr Devenish advised that the actions taken by the DHB were not adequate or appropriate, because a notifiable disease should be acted upon, especially when this is stated on the result, and should be recorded and shared with those providing care.

130. Dr Devenish stated that in this case it appears that the DHB systems did not enable clear communication of an important result.

131. I agree with this advice. I am concerned by the apparent lack of action taken on the Campylobacter result, in that it was not conveyed to the LMC, nor was a referral made to an obstetrician by DHB staff.

132. I acknowledge that there was a system to access the discharge summary and results electronically once available and it was intended for the midwife to follow up the results,

Names have been removed (except Te Whatu Ora|Health New Zealand (Hauora a Toi Bay of Plenty), Whakatane Hospital and the independent advisors) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

and that Ms A was informed of the results directly with some safety-netting advice. However, in the circumstances, I am concerned that the DHB did not act appropriately on the Campylobacter result, by not notifying the disease to Manatū Hauora|Ministry of Health, arranging specialist review, and ensuring that the result was communicated to the LMC. I am also concerned that the onus was on the LMC to set up access to CHIP to receive the result.

133. In response to the provisional opinion, Te Whatu Ora acknowledged that pre-term labour should have been considered, and a viable pregnancy at 33 weeks should have triggered the ED to request a maternity and/or obstetric review. It advised that a full work-up and review of Ms A would usually have been completed had the maternity unit or the duty obstetrician been advised, and would have likely resulted in an overnight admission to safeguard any concerns of pre-term labour in addition to any investigations and follow-up.

134. For the above reasons, in my view, Te Whatu Ora|Health New Zealand failed to provide services to Ms A with reasonable care and skill, in breach of Right 4(1) of the Code.

System in relation to arranging serial and growth scans

135. I am concerned by the description of the process for arranging serial and growth scans, both at the time of events and currently (see paragraph 83). The system in place at the time did not lend itself to timely intervention and appropriate monitoring of at-risk women (with reference to relevant referral guidelines). I will raise my concerns with Manatū Hauora|Ministry of Health.

Changes made/actions taken

Action by Midwifery Council of New Zealand

136. RM B advised that she was required to complete a competence programme, which took effect on 6 September 2019 for a minimum of 12 months, as follows:

- A period of supervision with monthly case reviews and the supervisor reporting to the Midwifery Council monthly.
- Satisfactory completion of Midwifery Council endorsed courses, and provision to the Deputy Registrar of a reflection that demonstrates the learning undertaken and changes made to practice, on the following:
  - Fetal heart rate monitoring;
  - Documentation; and
  - Complicated pregnancies and childbirth.

137. RM B has also participated in an online fetal surveillance course, which she will follow up with a study day when available. She also intends to attend a study day that helps

Names have been removed (except Te Whatu Ora|Health New Zealand (Hauora a Toi Bay of Plenty), Whakatane Hospital and the independent advisors) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

midwives to support a postnatal woman who has suffered a neonatal loss, and a course to become more proficient in measuring fundal heights and using growth charts.

Te Whatu Ora Hauora a Toi Bay of Plenty

138. In response to the provisional opinion, Te Whatu Ora advised that the following actions have been undertaken or achieved since 2017:

- Engagement with the Bay of Plenty ultrasound providers.
- LMCs in the Eastern Bay of Plenty can request ultrasound scans and have access to the result. These scans are free of charge to the woman.
- In the Western Bay of Plenty there is currently still a charge to the woman for an LMC referral. There is no charge to the woman for a (secondary care) obstetrician referral.
- The [Leaders of the maternity services] are working with the ultrasound providers on a solution to provide LMCs with a "secondary care" code to ensure the woman free access. This is for women who have been seen in the clinic and need subsequent follow-up scans but not necessarily antenatal clinic appointments if everything is progressing within normal ranges.
- Referrals are made via a central login email and are graded by an obstetrician, who will advise of timeframes for appointments and any additional information, and then the graded referral is sent back to the LMC. LMCs also make referrals to request advice, and again this is reviewed by an obstetrician. The advice is fed back to the LMC via their hospital email. Shift leaders and duty obstetricians can be telephoned at any time for urgent referral, eg, difficulty in finding a fetal heartbeat.
- There has also been a recent change in how support and follow-up is provided to women in Whakatane following a stillbirth:
    - For any woman needing a six-week debrief appointment, the SMO should communicate/email directly with Maternity Administration to book this appointment prior to the woman going home (or the next working business day if over the weekend).
    - The appointment can be in the antenatal clinic or the gynaecology clinic.
    - Maternity Administration makes this appointment for one hour, and a follow-up appointment can be made, eg, if autopsy results come in later and the woman and whānau would like another face-to-face review.

Recommendations

139. The Midwifery Council of New Zealand has already required RM B to undertake a competence programme.

Names have been removed (except Te Whatu Ora|Health New Zealand (Hauora a Toi Bay of Plenty), Whakatane Hospital and the independent advisors) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

140. I recommend that RM B:

a) Provide a written letter of apology to Ms A, which has been completed.

b) Provide an update on the training she has undertaken, and report back to HDC on the learning she has taken from this. In response to the provisional opinion, RM B provided a copy of her certificate of training completed in relation to "Safety and Sensitivity in Postnatal Care". She also advised that she would be retiring from midwifery practice in 2023. In light of this, I consider this recommendation completed.

c) Undertake an audit of patient records over the preceding three-month period to determine whether visits and telephone calls have been documented with sufficient detail. This information should be provided to HDC within three months of the date of this report.

141. I recommend that Te Whatu Ora Hauora a Toi Bay of Plenty:

a) Provide a written letter of apology to Ms A. The letter should be sent to HDC within three weeks of the date of this report, for forwarding to Ms A.

b) Review its systems, policies and procedures in place for provision of discharge summaries, communication with and access to clinical records for providers in the community (such as midwives), and the management of test results (including notifiable diseases), in light of the findings in this case. Te Whatu Ora Hauora a Toi Bay of Plenty is to advise HDC of the outcome of its review, including whether any areas for improvement were identified and plans to remedy the issues, within three months of the date of this report.

Follow-up actions

142. A copy of this report with details identifying the parties removed, except Te Whatu Ora|Health New Zealand (Hauora a Toi Bay of Plenty), Whakatane Hospital and the advisors on this case, will be sent to the Midwifery Council of New Zealand, and it will be advised of RM B's name.

143. A copy of this report with details identifying the parties removed, except Te Whatu Ora|Health New Zealand (Hauora a Toi Bay of Plenty), Whakatane Hospital, and the advisors on this case, will be sent to Te Tāhū Hauora|Health Quality & Safety Commission, the New Zealand College of Midwives, and Manatū Hauora|Ministry of Health, and placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

144. In addition, I will write to Manatū Hauora|Ministry of Health and Te Whatu Ora|Health New Zealand, pursuant to section 59(4) of the Health and Disability Commissioner Act 1994, outlining my concerns about equity of access and the systems in place for arranging

Names have been removed (except Te Whatu Ora|Health New Zealand (Hauora a Toi Bay of Plenty), Whakatane Hospital and the independent advisors) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

growth and serial scans at Te Whatu Ora Hauora a Toi Bay of Plenty, and the barriers of access to primary radiology services this creates. (Reference will be made to Te Whatu Ora Hauora a Toi Bay of Plenty's response to the provisional opinion where it advised that the equitable access to ultrasound scans in the Eastern Bay of Plenty and Western Bay of Plenty are currently held as an organisation risk and are logged on the Risk Register.)

Names have been removed (except Te Whatu Ora|Health New Zealand (Hauora a Toi Bay of Plenty), Whakatane Hospital and the independent advisors) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

Appendix A: In-house advice to Commissioner

The following in-house advice was obtained from RM Nicholette Emerson:

"10 July 2019

1. Thank you for the request that I provide clinical advice in relation to the complaint from [Ms A] about the care provided by LMC Midwife [RM B]. In preparing the advice on this case to the best of my knowledge I have no personal or professional conflict of interest. I agree to follow the Commissioner's Guidelines for Independent Advisors.
2. I have reviewed the documentation on file: Complaint from [Ms A] 30 October 2018, Complaint response [RM B] 24 February 2019 (including antenatal notes, scan and lab results), Clinical notes from [Te Whatu Ora Hauora a Toi Bay of Plenty] 28 [Month5]–1 [Month6], Antenatal notes and scan/lab results from [RM C] [2017].
3. **Background** [Ms A] lived in [the DHB2 region] and was booked with a LMC until 31 weeks gestation when she relocated to [another town] for family support. [In her thirties], this was her first pregnancy. Medical and surgical history included gallbladder surgery and allergies to tramadol and mushrooms. [Ms A] suffered from on-going hyperemesis gravidarum which necessitated hospital admission on numerous occasions. Booking BMI was very high at 48. On transfer [Ms A] booked with LMC Midwife [RM B]. Completed sets of notes were supplied from previous midwife for both [Ms A] and for LMC [RM B]. On-going follow up scans and specialist consultation was expected at the time of transfer based on [Ms A's] BMI and Hyperemesis which made her pregnancy high risk. At 36 weeks gestation labour began. On assessment at home by [RM B], no fetal heart was found. [Ms A] transferred to Whakatane Hospital where fetal death was confirmed. She established in labour and went on to birth her still born [baby boy] on 29 [Month5].
4. **Advice Request** I have been asked to advise whether the standard of care provided to [Ms A] was appropriate in the circumstances and why. In particular, whether adequate provision was made for a safe delivery.

[Ms A] was booked under the care of LMC [RM C] at 9 weeks gestation and the care continued until [Ms A] relocated at 31 weeks gestation. Care to date included serial growth scans and management of hyperemesis. Referral for an obstetric management plan was sent on 3 [Month2] at 20 weeks gestation. The reason for referral was raised BMI of 48.9 and on going Hyperemesis. [Ms A] elected to [relocate for] family support at 31 weeks gestation as her husband had to [go overseas]. Contemporaneous midwifery documentation and referral from [RM C] is of a high standard and is in keeping, with no departures from accepted midwifery practice.

Two comprehensive copies of contemporaneous notes were given to [Ms A], one for herself and one for her new midwife in [the town] (not yet chosen). The notes included laboratory results, scan reports and a customised growth chart.

Names have been removed (except Te Whatu Ora|Health New Zealand (Hauora a Toi Bay of Plenty), Whakatane Hospital and the independent advisors) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

[Ms A's] first antenatal appointment with [RM B] was on 28 [Month4] at 31 weeks and 4 days gestation. The next appointment was on 17 [Month5] at 34 weeks and 3 days gestation.

The documented entry in midwifery notes on 17 [Month5] states that the specialist referral had been sent but no appointment yet.

Referral for Obstetric care and growth scans

In [Ms A's] complaint (30 October 2018) she states that she tried to set up regular appointments as she had done with her previous LMC. She enquired regarding a follow up scan and was told by [RM B] that she would have to pay for a scan and drive to [another town]. '*At the end of 31 weeks I still had no scan and no specialist check up to see if baby was alright and so on till 35.' 'I heard nothing from [RM B] in regards to an appointment for a scan and no specialist check up, although I could feel my baby kicking inside me. It was mixed emotion I was happy and worried at the same time. At 36 weeks gestation still no scan and baby was kicking a lot.'*

In [RM B's] complaint response she states the following

- The last scan in [the DHB2 region] on 9 [Month4] was very reassuring
- There was difficulty getting free scans in Whakatane if not referred by a specialist for an existing problem diagnosed by them
- In Whakatane Hospital no radiographer employed was capable of doing a formal full anatomy scan and these scans were out sourced to [the radiology service] (either paid for by the hospital or when referred by the midwife — $45)
- A free scan was only available with a midwife referral by going to [the radiology service in another town].

[RM B] goes on to say that on 7 [Month5] she put through a hand written form asking for [Ms A] to be seen in antenatal clinic. [Ms A] was admitted to ED (referred by [RM B]) for Hyperemesis on 11 [Month5] and [RM B] believed [Ms A] would be seen by the Obstetricians at that time and now 'in the system'. On 17 [Month5] [RM B] enquired about the referral, finding that it appeared her referral had not been received. [RM B] says that she then followed up and hand delivered a typed referral four days later on 21 [Month5] to Whakatane Hospital.

In the DHB complaint response (21 February 2019) the referral letter is acknowledged as having been received on 21 [Month5] and seen by [an obstetrics and gynaecology consultant] on 22 [Month5]. The advice from [the consultant] was [Ms A] should be seen in the antenatal clinic within 10 days.

[Ms A] went into labour 6 days later before being seen by an obstetrician.

In [RM B's] complaint response it appears that the next contact from [Ms A] was on 28 [Month5] when [RM B] was out attending to community visits. She was phoned by [Ms A] whose labour had commenced at 36 weeks gestation.

Names have been removed (except Te Whatu Ora|Health New Zealand (Hauora a Toi Bay of Plenty), Whakatane Hospital and the independent advisors) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

In forming an opinion regarding referral for Obstetric care and for growth scans I have considered the following

- [Ms A] had a BMI of 48 and this warranted Obstetric referral/transfer of care under (*Guidelines for consultation with Obstetric and related medical services 2012* Morbid Obesity Body Mass Index (BMI) > 40; page 25, line 4017, may include an anaesthetic consultation — recommend Transfer of care).
- Serial scans for fetal growth had been arranged previous to transfer of care to [RM B]. The last growth scan was completed on 10 [Month4] at 29 weeks gestation and was considered by [RM B] to be reassuring. I acknowledge that accurate palpation and measurement is difficult on women with increased BMI therefore growth scans are often required for accuracy.

Plotting of the estimated fetal weight (EFW) on the customised growth chart at 29 weeks was just above the 10th centile. (Customised chart generated and provided in notes transferred by previous Midwife.) The relevance of this is that EFW (in 2017) below the 10th centile required referral under the referral guidelines *The Guidelines for consultation with Obstetric and Related Medical Services (referral guidelines — section 88) state (page 25/4011)*

> *Estimated fetal weight (EFW) <10th percentile on customised growth chart — consultation*

Whilst referral was not yet required (and may not have been) based on growth, a repeat scan within 3 weeks would, in my opinion, have been prudent to monitor growth. This scan would have occurred at 32 weeks at the latest.

- The referral letter to Whakatane antenatal clinic 21 [Month5] does state *'She has a high BMI at her original booking in [the DHB2 region] and was being seen and having serial scans up there. I am sure she will continue that with you' 'She is very difficult to palpate and to hear the fetal heart due to her size'.*

On receiving the referral, the Obstetric plan of Action was to see [Ms A] within 10 days (referral annotated and acknowledged in the DHB response — 21 February 2019).

If it is accepted when [RM B] took over care and booked [Ms A] at 31 weeks and 4 days on 28 [Month4], she considered a reassuring scan dated 10 [Month4] was provided. [RM B] has written an obstetric referral based on [Ms A's] BMI, hyperemesis and requirement for serial scans. In her complaint response, [RM B] states that the referral was sent 7 [Month5] and was misplaced/not received. [RM B] has assumed that [Ms A] has been seen by the obstetric team when she has been referred in to ED for vomiting and diarrhea on 11 [Month5]. At the routine midwife antenatal appointment 17 [Month5], it is acknowledged that referral is not in the system. [RM B] has hand delivered a referral on 21 [Month5] which has been seen and triaged on 22 [Month5]. Pre term labour commenced on 28 [Month5].

Names have been removed (except Te Whatu Ora|Health New Zealand (Hauora a Toi Bay of Plenty), Whakatane Hospital and the independent advisors) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

A. If the above is accepted then in my opinion [RM B] has met her midwifery obligations regarding referral (no departure from accepted practice) of [Ms A]. [RM B] states a scan could not be obtained free without specialist referral and travel to [another town] was required for the scan to be free with midwife referral. When the referral was finally received, the obstetric decision was made to defer an appointment for up to 10 days. A total of 4 midwife visits have taken place in the period from 28 [Month4] to 28 [Month5] prior to the commencement of [Ms A's] pre term labour.

B. If it is accepted that [RM B] was aware of the need to refer [Ms A] for specialist care and for on-going serial growth scans and was unable to obtain a free scan for [Ms A], then in my opinion, considering [Ms A's] BMI, hyperemesis and the previous scan EFW being on the 10th centile, [RM B] has moderately departed from accepted midwifery practice in not actively pursuing and discussing her concern regarding (either by phone or in person) [Ms A's] BMI, hyperemesis and need for on-going growth scans with an Obstetrician at the DHB.

I do note however that [RM B] states (complaint response) the process for obtaining a scan has now changed and midwives are able to refer prior to specialist consultation for a hospital funded scan. [RM B] states this was not the case at the time.

Whakatane hospital has seen [Ms A] on two occasions for rehydration and admission to the ward according to [RM B]. There is no documentation regarding whether the DHB has not arranged follow up for [Ms A].

Care in labour

On 28 [Month5] [RM B] received a phone call to advise her that [Ms A] had a 'show'. She was out visiting clients and attended as soon as possible. She left briefly to obtain some Amnicator sticks which, on return established that [Ms A] had ruptured her membranes. [Ms A] informed [RM B] that there had been very little fetal movement since the morning. [RM B] was unable to find a fetal heart and requested that [Ms A] go to Whakatane Hospital. [Ms A's] mother and Koro transported her there. [RM B] remained to inform the specialist obstetrician that they were coming and then followed behind. Contemporaneous notes from the DHB document receipt of the phone call. [The baby] was stillborn the following day after a spontaneous labour, [RM B] was present. In my opinion there are no departures from accepted Midwifery practice in [RM B's] assessment at home and in labour in hospital.

I note that [Ms A] expresses concern regarding her transfer to Hospital by car and not ambulance following the discovery of no fetal heart. Whilst I acknowledge this mode of transport must have felt distressing for [Ms A] and her whānau, it was likely to have been the quickest mode of transport in the circumstances.

Postnatal Period

In [Ms A's] complaint (30 October 2018) she expresses that [RM B] was unprofessional and her standard of care and support were appalling following the event. She states

Names have been removed (except Te Whatu Ora|Health New Zealand (Hauora a Toi Bay of Plenty), Whakatane Hospital and the independent advisors) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

that *'[RM B] had no empathy for me when I was pregnant and completely ignored my son's life'.*

[Ms A] states that [RM B] saw her once following her son's birth and the follow up hospital appointment a year later was not attended by [RM B] although she was invited.

In [RM B's] complaint response (24 February 2019) she states that *'I did see her a couple of times at home at least postnatally but I also came and she was out on another 3 or 4 occasions'.*

There is no contemporaneous midwifery documentation supplied to verify any postnatal visits or attempts to visit. I note [RM B's] postnatal summary states that 6 postnatal visits were undertaken.

[RM B] explains the non attendance at the follow up appointment *'I do remember being invited to attend but I was away from New Zealand at the time and could not do so'.*

In forming an opinion I have considered the following

- Midwifery documentation is not comprehensive. I will address the documentation separately.
- [Ms A] felt a lack of empathy shown for her and felt [RM B] completely ignored her son's life.
- [RM B] states that she did care; she has not documented any postnatal visits or any enquiry regarding [Ms A's] wellbeing. She states that [Ms A] told her that she was going [overseas] shortly to be with her husband. [Ms A] birthed 29 [Month5], however she returned [overseas] in [Month8].
- It would appear that [RM B] has not acknowledged the follow up appointment or informed either [Ms A] or the DHB that she would be away and could not attend.

In my opinion accepted Midwifery practice following a baby's death would involve comprehensive care regarding the wellbeing (both mental and physical) of the Mother and whānau, particularly when the father is not in the country to provide support. This care would involve communicating intention to visit either by text or phone. A note left when the woman is not home would communicate caring and attempts to visit. Women are particularly vulnerable following the death of a baby and [Ms A] states *'I got anxiety attacks and depression so that I couldn't handle anything. I left in [Month8] to be with my husband so that I could feel better'.*

[Ms A] expresses anger that '*I would not hear my son's first cry and also that his father could not see him and hold him in his arms'* (Complaint 30 October 2018).

In my opinion, it would appear that the concern and care that [RM B] felt has not been adequately expressed to [Ms A] in the postnatal period. There appears to be no documentation of the 6 postnatal visits documented in the postnatal summary.

Names have been removed (except Te Whatu Ora|Health New Zealand (Hauora a Toi Bay of Plenty), Whakatane Hospital and the independent advisors) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

A. If it is accepted that [RM B] did visit or attempt to visit [Ms A] on a couple of occasions and attempted a further 3–4 then in my opinion [RM B] has mildly to moderately departed from accepted Midwifery practice in not documenting her postnatal visits.

B. If it is accepted that [RM B] visited once in the postnatal period (not documented) and has not communicated that she is unable to attend a follow up appointment following the death of [Ms A's] baby then in my opinion this is a moderate departure from accepted Midwifery practice for the reasons outlined above.

Documentation

In my opinion [RM B's] documentation does not meet accepted Midwifery standards. [RM B] accounts for the lack of documentation *'I do not have a lot of documentation for [Ms A] as I only really knew her for about 4 weeks before the baby died in utero and she gave birth to her stillborn son' 'I was shown something from [RM C] — [Ms A's] first Midwife — But I think [Ms A] kept it or it went to the Coroner as I cannot find it in my possession now.'*

The onus is on [RM B] to maintain purposeful, on-going, updated records as specified by New Zealand College of Midwives (NZCOM).

- [RM B's] documentation does not contain essential antenatal information/ bloods/lab results. This was stated to have been supplied by [RM C] at handover (via [Ms A]) but it would appear that this information has not been transferred/transcribed to [Ms A's] current notes. The receipt of the records is acknowledged by [RM B] above.
- There is documentation of two antenatal visits and two referrals. There appears to be no documentation of postnatal visits.
- I note that the 'maternity record page' supplied by [RM B] to the HDC states that [Ms A] [age]; however her year of birth is [year]. The time of the care provided was 2017 when [Ms A] would have been [age].

In my opinion [RM B's] documentation moderately departs from accepted practice for the following reasons.

New Zealand College of Midwives (NZCOM) Practice Standards (Standard Four) requires that *the midwife maintains purposeful, on-going, updated records and makes them available to the woman and other relevant persons. In addition; ensures confidentiality of information and stores records in line with current legislation*. The current legislation in 2017 was that the records are stored by the midwife for 10 years following the last entry.

Competency for the Entry to the Register of Midwives (NZ Midwifery Council) Competency 2 — 2.16 *provides accurate and timely written progress notes and relevant documented evidence of all decisions made and midwifery care offered and provided.*

Names have been removed (except Te Whatu Ora|Health New Zealand (Hauora a Toi Bay of Plenty), Whakatane Hospital and the independent advisors) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

In my opinion, regardless of the period of time a woman is under the care of a midwife the legal obligations related to record keeping remain the same.

Education

The lack of postnatal documentation and the lack of retention of full history is highlighted by a lack of contemporaneous documentation.

- It may be useful for [RM B] to attend NZCOM's documentation workshop; *Dotting I's and crossing T's — Midwives record keeping*
- In addition NZ Midwifery Council has a pamphlet on their website https://www.midwiferycouncil.health.nz/about-s/publications/documentation-and-record-keeping which may be useful.

Summary

I have been asked to provide advice regarding the care provided to [Ms A] during her pregnancy and subsequent birth and postnatal period.

In my opinion the care provided by [RM C] meets accepted Midwifery Standards.

In my opinion the care provided by [RM B] does not meet accepted Midwifery standards in relation to documentation and care provided in the postnatal period.

I have highlighted concerns regarding timely referral for obstetric opinion and ultrasound scanning in the antenatal period.

Finally I extend my heartfelt condolences to [Ms A and her husband] and their whānau for the loss of their precious [baby boy].

I hope this report has addressed some of their remaining questions.

Nicky Emerson BHSc — Midwifery
Midwifery Advisor
Health and Disability Commissioner"

The following further advice was received 14 April 2020:

"As requested, I have reviewed my advice and [RM B's] response. I am heartened to see that [RM B] is engaging and benefitting from Midwifery Council conditions on practice. On review of my original advice, I have nothing to add following review of the documents you have supplied.

Regards, Nicky

Nicholette Emerson — In-house Clinical Advisor — Midwifery
Office of the Health and Disability Commissioner"

Names have been removed (except Te Whatu Ora|Health New Zealand (Hauora a Toi Bay of Plenty), Whakatane Hospital and the independent advisors) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

Appendix B: Independent advice to Commissioner

The following independent advice was obtained from Dr Celia Devenish, a specialist in obstetrics and gynaecology:

"**Re: Care provided to [Ms A] 19HDC00068**

I have been asked to provide an opinion to the Commissioner for the above. I have read the Commissioner's guidelines and I agree to follow these guidelines.

I am a Specialist Obstetrician and Gynaecologist, working within a generalist scope of practice, and have been accredited with Fellowship of both RANZCOG and RCOG.

I have practised as a Consultant in both Obstetrics & Gynaecology for 38 years in both tertiary and secondary provincial centres, in public, academic, rural and private practice sessions.

I have worked in a joint clinical and academic position, as a Specialist at Dunedin Hospital for 18 years. I have also been Clinical Leader in Obstetrics.

As an Otago University Lecturer, I am involved in research and teaching in the Dunedin School of Medicine at undergraduate and postgraduate levels. I have been an elected RANZCOG Board and Council member and have chaired and sat on various committees including the FRANZCOG and DRANZCOG Examination Committees. I am current Chair of the New Zealand Committee and attend SIMG interview panels for New Zealand and Australia. I am involved in specialist training and organise various workshops in NZ for trainees and fellows.

Please contact me if you require any further information.

Yours sincerely

Celia Devenish
Consultant Obstetrician & Gynaecologist
MBBS FRCOG FRANZCOG

Electronically reviewed & signed

Names have been removed (except Te Whatu Ora|Health New Zealand (Hauora a Toi Bay of Plenty), Whakatane Hospital and the independent advisors) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

Care provided to [Ms A]

Ref: 19HDC00068

[DHB2]

1. **Whether the antenatal care provided was appropriate.**
2. **Whether the actions taken to transfer [Ms A's] care to her domicile DHB when she moved away from [the DHB2 region] were reasonable.**
3. **Any other matters that you consider warrant comment about [DHB2].**

1. Whether the antenatal care provided was appropriate.

I believe the antenatal care provided by [DHB2] was appropriate. I believe this because [Ms A] remained under the care of the LMC, although a consultation had been requested by [RM C], but transfer of care occurred from primary to secondary care. This is because [Ms A] did not keep the appointment made in the maternity unit as she was in process of relocating. When the [DHB2] maternity clinic checked, she had left the area, as noted in the hospital documents. As [Ms A] remained under primary care, [RM C] correctly made the referral to a colleague midwife in [the town] where [Ms A] was relocating to. [Ms A] was transferred to [RM B's] primary care and a specific request to arrange a follow up ultrasound scan in the new area.

2. Whether the actions taken to transfer [Ms A's] care to her domicile DHB when she moved away from [the DHB2 region] were reasonable.

I believe the actions by [RM C] in arranging transfer of primary care and also the requesting a follow up Growth USS, given the GROW chart plotting was most appropriate. This certainly met the expected standards of primary care. I do not believe that there was a requirement for [DHB2] to arrange scans or follow up inter regional transfer at this time.

3. Any other matters that you consider warrant comment about [DHB2].

I do not believe [DHB2] were required to arrange transfer, as they would not have been advised of the change in area by [Ms A], and no follow up appointment had been made, following the original consultation, as this depended on the scan and a follow-up visit, which was not kept. For a woman under primary care, the expected standard of practice is for the new LMC to review the pregnant woman and continue the plan of care handed over.

I do not believe that there was a departure from the standard of care or accepted practice by [DHB2], as they had returned care to the LMC.

I believe my peers would agree with this.

Names have been removed (except Te Whatu Ora|Health New Zealand (Hauora a Toi Bay of Plenty), Whakatane Hospital and the independent advisors) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

*Te Whatu Ora Hauora a Toi Bay of Plenty***1. The timeliness of triaging the obstetric referral.**
2. Whether the timeframe for obstetric appointment provided was appropriate.
3. Any other matters that you consider warrant comment about the DHB.

1. The timeliness of triaging the obstetric referral.
I believe that the timeliness of the triaging of this referral was appropriate, in the light of the information provided by the LMC in the referral letter to the Maternity Unit.

I believe the referral was triaged with adequate timeliness given the content of the referral I believe my peers would agree with this.

A letter of referral to maternity unit was sent 10 days after an ED visit for acute diarrhoea. There was no mention of this or the positive stool culture subsequently obtained.

The ED visit had been appropriately managed, by oral fluids blood tests and stool culture which had subsequently shown campylobacter. It appears this result was not acted on since no treatment was instituted for this. Campylobacter in pregnancy is complicated by adverse fetal outcomes.

There was no referral to the maternity unit at this time. Campylobacter is a notifiable disease and there had been the comment by the LMC in the referral letter that there had been cases of enteritis in the area.

The description was not of a severe illness, and no mention of the need for follow up Ultrasound growth estimations was made, nor the recent ED visit or the positive Campylobacter stool culture. The ED discharge letter had requested this result to be followed up by the referring LMC in the absence of a current GP.

The sentence that 'the hyperemesis was well controlled by ondansetron', 'on ondansetron' implied the condition was not one requiring immediate intervention. Had the RM felt the appointment time was more urgent, it would be usual practice to contact the On Call Team and discuss this further.

The LMC had received [information from RM C] re the need for USS follow up, and as primary carer would be expected to arrange regular visits, ultrasound and specialist referrals as needed, particularly with the raised BMI. The referral letter makes no mention of a timeframe, in which secondary care consultation should be arranged. As a local LMC, the RM would know the expected timeframe of appointments in her locale and, if uncomfortable with the arrangement, might have expedited the consultation by phoning the O&G Consultants team.

On the basis of the information given in [RM B's] letter of referral, given there is no mention of other risk factors or reasons why referral should be earlier than the regular time frame.

Names have been removed (except Te Whatu Ora|Health New Zealand (Hauora a Toi Bay of Plenty), Whakatane Hospital and the independent advisors) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

In the absence of indications of severity, such as ketosis, on midwifery assessment, or dehydration, then it is understandable a shorter timeframe for the appointment. Therefore, a more urgent review would not be expected.

I do not believe there was a deviation from the expected standard of care.

I believe my peers would agree with this.

2. Whether the timeframe for obstetric appointment provided was appropriate. I believe that the timeframe for the appointment was appropriate in the light of the minimal information which was provided to the obstetrician at the time. This lacked any relevant reasons for more urgent concern.

3. Any other matters that you consider warrant comment about the DHB.
The positive stool cultures Campylobacter diagnosis was not followed up. It would be usual practice to treat with antibiotics and to follow up a pregnant woman with this diagnosis and refer to a specialist.

This is because maternal Campylobacter is known to cause infection of the placenta and fetus with adverse outcomes including stillbirth and preterm labour. An obstetrician should have been advised of this at the time. Unfortunately it seems that this was not recognised. The Emergency team had requested the LMC to assist in this. The post mortem also found that Group B Streptococcus was found with a small for dates baby and low placental weight. The chorioamnionitis noted at post Mortem could be related to both group B streptococcus and the effects of maternal and placental Campylobacter which causes placental necrosis. Both infections likely contributed to the chorioamnionitis and the significantly raised BMI also contributed to reduced fetal growth. The tragic outcome was probably a combination of several factors.

I do not believe that there was a departure from the standard of care or accepted practice by the Obstetrician who could not know of the ED visit and diagnosis of Campylobacter, as this result had not been acknowledged or flagged by the LMC nor was apparent within the hospital system.

I believe my peers would agree with this.

Antenatal resources are often limited, but it would be ideal if women relocating to an area could be seen sooner. However the availability of appointments and challenges of access regrettably create difficulties in achieving this.

Celia Devenish
Consultant Obstetrician & Gynaecologist
MBBS FRCOG FRANZCOG

Ref *Campylobacter jejuni in pregnancy. Goh & Flyn ANZJOG 1992 32 930 246–8*"

Names have been removed (except Te Whatu Ora|Health New Zealand (Hauora a Toi Bay of Plenty), Whakatane Hospital and the independent advisors) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

The following further advice was received on 1 March 2022:

"Re Complaint: [Ms A]

HDC

Ref: 19HDC00068

Thank you for your email request for further advice regarding 19HDC00068 and for providing further information regarding [Ms A's] stool culture result whilst she was pregnant in 2017.

I also reviewed the records of acceptance of this result which confirmed that [Ms A] had a diagnosis of the notifiable infectious disease, Campylobacter which was accepted and signed off by a DHB doctor.

In response to your request:

1. **Who should have received the discharge summary, including whether it was reasonable that a copy was not provided to the referring midwife.**

I believe the health practitioner responsible for her referral and ongoing care should have been advised of the result.

DHBs have different information systems, and in this DHB it appears that only one person may be advised of relevant results following an ED Visit.

In which case it is the responsibility of the doctor accepting the report to advise those most involved in her care. I believe the onus was on the ED department to send the result to the referring health practitioner. In this case that was the LMC.

In the event, it seems the LMC did not have access to the results without ringing, so she remained unaware of the culture result.

I note Whakatane has an Emergency Department staffed 24/7 and there is an Obstetric Department in the hospital with an on call specialist. Cases can also be referred for further discussion to [the main centre hospital] should further advice be needed.

2. **Whether the actions taken by the DHB on the campylobacter result were adequate/appropriate, and whether any further actions were indicated (such as referral to obstetric care).**

I do not believe the actions taken by the DHB were adequate or appropriate.

I believe this because a notifiable disease should be acted upon, especially when this is stated on the result and should be recorded and shared with those providing care.

I believe that adequate care would have been to refer for a specialist opinion regarding the effect of Campylobacter on a pregnancy.

Names have been removed (except Te Whatu Ora|Health New Zealand (Hauora a Toi Bay of Plenty), Whakatane Hospital and the independent advisors) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

The results were reported on 14 [Month5] after [Ms A's] 11 [Month5] visit to ED. The IT system records show that the result was subsequently viewed on 14 [Month5] and was accepted and signed off by [a doctor] on 15 [Month5]. It is unclear whether [the doctor] is an ED doctor.

There is a handwritten note on the result photocopied stating that patient was rung and her symptom status checked. The signature is unclear, so it is unclear who wrote this.

There was no hospital note stating whether [Ms A] was advised of the campylobacter result, nor if there was official notification to Public Health, any GP or her local LMC.

There is no record of a referral made to any Obstetric service. There are no letters to any practitioner subsequent to the discharge summary on 11 [Month5].

No comment regarding the campylobacter being a notifiable disease in the hospital notes. This advice was not recorded in the handwritten on the result record, nor was any mention of the possible adverse effects to a pregnancy.

There is no evidence that a consultation with an Obstetric doctor was held or planned.

I conclude, that in the absence of any evidence to the contrary, that the LMC, the local Obstetric Dept, and Public Health Dept were not contacted about the diagnosis.

I believe that if [Ms A] did not have a GP at that time, then the LMC or a local Obstetrician should have been contacted.

Even if the LMC was unaware of the risks to pregnancy, she might have called to mention the diagnosis of a notifiable infectious disease, additional her referral letter to the department, which would have added weight to this referral. This assuming the LMC did ring to find out the stool culture results following her referral to ED.

The LMC stated that she phones or checks the results after an ED visit as she is not usually advised of the outcome of the visit.

In this unfortunate case it appears that the DHB systems did not enable clear communication of an important result, which ultimately had consequences for the pregnancy."

Names have been removed (except Te Whatu Ora|Health New Zealand (Hauora a Toi Bay of Plenty), Whakatane Hospital and the independent advisors) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

Appendix C: Relevant standards

The Ministry of Health's *Guidelines for Consultation with Obstetric and Related Medical Services (Referral Guidelines)* 2012 provides a list of conditions for which an LMC should advise or recommend to the woman that a referral, consultation or transfer of clinical responsibility take place.

It states also that "LMCs must use their clinical judgement in deciding when and to whom to refer a woman. A condition that is normally a cause for a referral to a primary care practitioner may be severe enough on presentation to warrant a specialist consultation."

One of the conditions includes "Morbid obesity — Body mass index (BMI) > 40; may include an anaesthetic consultation", and the referral category[1] for this is "transfer". The Referral Guidelines state that in these circumstances the LMC must recommend to the woman that the responsibility for her care be transferred to a specialist given that her pregnancy, labour, birth or puerperium (or the baby) is or may be affected by the condition.

Under "Timing of referrals and transfer of clinical responsibility", the *Referral Guidelines* state:

> "The decision to refer and the timeliness of being seen will depend on factors such as the severity of the condition, the LMC's experience and scope of practice, the availability of services and the woman's access to them. All practitioners are responsible for their clinical decisions, including the timing of referral.
>
> For these reasons the revised Guidelines do not include timing recommendations for each condition.
>
> There may be situations when services required for a woman are not available in the area, or not available at the time she needs them (eg, the woman cannot be seen in outpatient clinic in a timely fashion). In this situation, the referring LMC should make the referral and document it in the woman's records. Where appropriate, the LMC should contact the service and advise it of the situation. The LMC should, where necessary, discuss other options for care with the woman."

[1] The Guidelines outline four referral categories: primary, consultation, transfer, and emergency.

Names have been removed (except Te Whatu Ora|Health New Zealand (Hauora a Toi Bay of Plenty), Whakatane Hospital and the independent advisors) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.