Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

A Decision by the Deputy Health and Disability Commissioner

(Case 21HDC00168)

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Introduction

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

2. The report discusses the care provided to Ms A by Pacific Radiology and Registered Midwife (RM) B.

3. The case concerns a post-dates ultrasound report that was not sent by Pacific Radiology (and therefore not received by RM B) or communicated to RM B, which contributed to a delay in care provided to Ms A and her unborn baby, Baby A.

4. The following issues were identified for investigation:

- *Whether RM B provided Ms A with an appropriate standard of care in 2021.*
- *Whether Pacific Radiology Group Limited provided Ms A with an appropriate standard of care in 2021.*

5. The parties directly involved in the investigation were:

Ms A	Consumer/complainant
Pacific Radiology Group Limited	Private radiology provider
RM B	Registered midwife

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6. Further information was received from:

Health New Zealand|Te Whatu Ora (Health NZ)	District healthcare provider
Ms C	Sonographer at Pacific Radiology
Dr D	Radiologist at Pacific Radiology

7. In-house clinical advice was obtained from RM Nicky Emerson (Appendix A).

Background and initial complaint

Facts gathered

Events prior to birth of Baby A

8. On 5 Month1,[1] Ms A was 6 weeks and 2 days pregnant and was referred to RM B. Ms A had a due date of 27 Month8.

9. RM B referred Ms A for routine ultrasound scans throughout her pregnancy. The scans were performed at Pacific Radiology, a private radiology provider.

10. An ultrasound performed on 9 Month8 noted a persisting low-lying placenta and a drop in the estimated fetal weight (EFW) to the 50th centile, down from the 75th centile noted in the previous scan (performed on 20 Month7). The scan indicated that there was a normal fluid volume.

5 Month9 appointment

11. On 5 Month9, RM B referred Ms A for a post-dates ultrasound scan as she was 41 weeks + 2 days pregnant and was booked to be induced on 8 Month9. The scan was undertaken at 11.45am by Ms C, a sonographer at Pacific Radiology. The scan noted oligohydramnios[2] with a DVP[3] of 0.8mm,[4] and a drop in EFW to the 16th centile. This was the first indication of oligohydramnios documented for this pregnancy.

12. Dr D (the radiologist who reviewed Ms A's scan) told HDC that oligohydramnios was the most pertinent finding from the 5 Month9 scan, and although Ms A being post-term provided a potential explanation for the drop in volume, there was still too little amniotic fluid present. This was categorised as an 'unexpected finding' that could result in significant morbidity if not treated appropriately. Dr D did not classify his findings as being immediately life-threatening as he was reassured that Ms A's Dopplers[5] were normal, the sonographer had noted good fetal movements, and there was also fluid highlighted in the stomach and bladder. Fetal growth was slowing, but this was not a new finding, and was a continuing trend from the previous scan, with the EFW remaining within normal range.

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[1] Relevant months are referred to as Month1–Month9 to protect privacy.

[2] Decreased amniotic fluid, defined as having a single deepest pocket of <2cm.

[3] Measures a pocket of a maximal depth of amniotic fluid, which is free of an umbilical cord and fetal parts. DVP (deepest vertical pocket) and SDP (single deepest pocket) are used interchangeably in this report.

[4] Pacific Radiology informed HDC that this was a typing error and is meant to read 8mm.

[5] A Doppler is a device with a probe used to detect blood flow through a blood vessel to pick up the sound of a pulse.

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13. Dr D told HDC that he expected that the report would be actioned within 24 hours and that the finding of oligohydramnios coupled with the slowing fetal growth meant that induction would 'most probably be expedited'.

14. Ms A told HDC that she was 'anxious' when Ms C advised her of the low amniotic fluid but was reassured as Ms C mentioned that it was 'quite normal for [her] stage' and that Ms C would send the report 'urgently' and call her midwife.[6] Ms A sent a text message to RM B that she had completed the scan, but did not mention the low volume of amniotic fluid, as she believed Pacific Radiology would get in touch with RM B.

15. Ms C told HDC that retrospectively she added a key image of the amniotic fluid pocket she had missed, marked the report as urgent,[7] and sent the report for reporting. Dr D reported and verified the report, which was noted as having been distributed at 1.02pm.

16. Although unknown at the time, a coding error meant that the scan report was not sent to RM B on 5 Month9. Pacific Radiology informed HDC that the electronic report distribution was sent via EDI (electronic report transfer) to the public hospital and the hospital ultrasound department addresses, as well as being faxed to the public hospital. A failed attempt was made to fax the report to the referrer (RM B), as the wrong code was used. Pacific Radiology did not call RM B at any stage regarding this report.

17. RM B told HDC that there was 'no indication' from Ms A's text regarding the scan on 5 Month9 that there was any abnormality in the scan's findings relating to fluid levels. RM B stated:

> '[Although it was not Ms A's job to report fluid levels, Ms A] knew the main purpose of the scan was to assess fluid volume and blood flow … to give me a heads up to expect some contact was going to be made with me would have been useful and alerted me to possible abnormal findings.
>
> …
>
> I didn't enquire as [Ms A] didn't lead me to consider there was an issue … and I hadn't had a phone call from the Radiologist to advise anything was abnormal.'

18. RM B said that she 'sync'd' her phone multiple times that afternoon and evening for the results of the scan. She believed that the absence of a report was 'unusual but not impossible given that the workload for the scanners is large especially given the holiday season and a four day weekend …'.

[6] Pacific Radiology also informed HDC that the sonographer noted: '[P]atient booked for induction on Friday, will be talking to midwife today.' It is unclear whether this indicates that the sonographer or the patient would be talking to the midwife.

[7] Ms C informed HDC that 'scans flagged as urgent go to the top of the priority worklist for radiologist reporting and are reported within an hour'.

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19. Dr D told HDC that he 'considered' calling RM B but was 'reassured this was not necessary' due to the following reasons:

a) The sonographer noted that Ms A would be speaking to her midwife after the scan;

b) As the scan was marked urgent, Dr D expected the report would be typed and sent immediately to Ms A's midwife as per usual practice;

c) As the scan was for a post-term pregnancy, Dr D assumed that Ms A's midwife would be looking for Ms A's results that day; and

d) The sonographer did not alert Dr D to anything of immediate/critical concern regarding Ms A's case.

6 Month9

20. RM B told HDC that she noticed that the report had still not come through on 6 Month9. She stated:

> 'I thought it would come through soon and was reassured by the fact that I had not had a phone call from Pacific Radiology and [Ms A] did not indicate that there was anything wrong with the findings at the scan and I had told her that I particularly wanted to know about the fluid levels.'

21. RM B said that she continued to 'sync' her phone over the course of the day to check for the report and 'thought that they were running rather late with their writing …'.

22. RM B stated:

> '[In the evening of 6 Month9 I was] bothered and niggled that I [had not] received the report yet and thought I could ring the O&G long day registrar to request they check the system for this report [but then I] reassured myself as I hadn't had a phone call from Pacific Radiology, and I hadn't been alerted anything untoward by the woman, that I would not bother the after-hours staff when they are often very busy and challenged to provide the cares they need to, for something so routine, but I will follow this up first thing in the morning.'

23. In response to the provisional opinion, RM B told HDC that she found herself 'falsely reassured', anticipating direct communication if the situation was severe, and that in the event she was unreachable, that the local maternity assessment unit would be contacted.

7 Month9 appointment

24. Ms A told HDC that on 7 Month9 she noticed some bleeding and contractions and texted RM B about the bleeding at around 8.40am. RM B and Ms A discussed the bleeding over the phone,[8] and Ms A mentioned that the baby's movements 'had been a little reduced' that morning. RM B advised Ms A to let her know if there was any further bleeding, to stop doing

[8] Ms A claims that she called RM B to discuss her symptoms, while RM B claims that she called Ms A to discuss the bleeding.

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the housework, and do whatever usually elicits baby movements and ring her back within the hour if they were at all reduced. RM B did not receive a call back from Ms A.

25. RM B told HDC that it was, and still is, her practice that 'if a woman states clearly her baby has reduced movements to see them as soon as possible for an acute assessment or arrange for this to be done by someone else to make it as timely as possible', but that this was not the case with Ms A as initially Ms A was unclear/unsure of the fetal movements. RM B stated that Ms A's 'lack of clarity' led to uncertainty in triaging the situation, and that Ms A's choice to text as opposed to call regarding the bleeding was a deviation from the advice RM B gives to her patients. However, RM B acknowledged that ideally her recommendation should have included expressing her preference to meet Ms A for a comprehensive assessment.

26. RM B told HDC that she then contacted Pacific Radiology to ask about the 5 Month9 scan, at which point Pacific Radiology realised the coding error that had occurred, and that the scan had never been sent to RM B. Pacific Radiology proceeded to send the scan report to RM B. On receiving the scan report, RM B noted the oligohydramnios and immediately contacted the on-call obstetrician and gynaecologist at the time, who suggested that Ms A attend the hospital for a CTG scan[9] as soon as possible.

27. Ms A presented to the public hospital at 11.06am on 7 Month9 and a CTG scan was performed. The on-call obstetrician and gynaecologist was unable to find a fetal heartbeat for Ms A's baby, and no fetal movements were detected. On 8 Month9 Ms A was induced for labour, and on 9 Month9, Ms A's baby, Baby A, was stillborn.

28. Ms A believes that she was falsely reassured by the sonographer at Pacific Radiology and was let down by Pacific Radiology when they did not send the scan report or call RM B. Ms A also believes that RM B did not fulfil her duty when she did not follow up on the results of the scan until prompted by Ms A. Ms A wishes those involved to be held accountable for the 'negligence of their actions'.

Further information

Pacific Radiology

29. Pacific Radiology provided the following explanation of its standard processes regarding ultrasound scans and notifying midwives of scan results:

> '[I]f Pacific Radiology receives a reporting referral for an ultrasound scan done at [Health NZ] that study has a Z-code attached to it so that the referrer who requested the scan through [Health NZ] gets the report when it is sent back to the [Health NZ] system.
>
> …
>
> If an urgent result needs to be notified to a midwife this would typically be actioned by the reporting radiologist via a telephone call to the midwife at the time of

[9] Abbreviation for cardiotocography, a technique used to measure a baby's heart rate.

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reporting/verification. Assessment of urgency includes using clinical judgment and taking into account [the] expected course of events on the day of the examination.'

30. Referrer codes that are 'interface doctor entries' (also known as 'Z-codes') have no distribution details loaded to them, so 'any visit attributed to such a referrer [code] will go nowhere'. In this instance, RM B had two active entries in Pacific Radiology's system (the midwives code and the Health NZ code). At the time of booking the ultrasound visit, the incorrect code was selected for RM B, which meant that the report was not sent to RM B.

31. Pacific Radiology also provided HDC with a copy of its Communication of Critical/Actionable Results Policy (version 1.0 issued December 2018), which states: 'Radiologists have a duty of care to ensure that a radiology report of a significant new or unexpected abnormality is successfully communicated to the referring doctor …'

32. The policy also states that critical findings are one of two groups of findings where direct notification to the referring doctor should occur and is defined as a new/unexpected radiological finding that could result in mortality or significant morbidity if appropriate diagnostic and/or therapeutic follow-up steps are not undertaken. There are three levels of critical results findings, which require three different communication pathways: communicate as soon as possible/immediately, communicate as soon as practicable within 60 minutes, and communicate within three days.

Dr D

33. Dr D identified two further errors made by the sonographer: a typing error in relation to the volume of fluid documented (0.8mm instead of 0.8cm), and not saving a key image and therefore retrospectively adding measurements. Dr D noted, however, that these did not have a bearing on his considerations and judgement made.

34. Dr D also stated:

> '[I]f I had any reason to suspect there was an IT issue with our system, or if I had any doubts as to whether [Ms A] would be followed up in a timely manner, I would have taken steps to check the report had been received and was being acted on appropriately.
>
> …
>
> With the benefit of hindsight and full knowledge of the sad outcome of this case, I deeply regret not calling [Ms A's] midwife to check the report had been received. I believe that not calling the midwife to check she had the report was reasonable under the circumstances where I believed [Ms A] was going to be in contact with her midwife that same day and the results were not immediately life-threatening. I also had no reason to doubt the scan report had been sent both to the midwife and to the Antenatal clinically urgently.'

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Health NZ

35. Health NZ commented on the timeliness of the escalation of Ms A's care following her 41-week scan and subsequent admission to the public hospital. Health NZ stated:

> 'The indication for a 41-week ultrasound scan is to assess placental function and fetal wellbeing by measuring liquor volume using Single Deepest Pocket (SDP) and assess fetal movements. If the scan is not normal, the woman needs an obstetric assessment the same day. Any practitioner who requests a scan must have a plan to follow up the result of the scan. With a 41 week scan one would assume the plan would be to follow up the result the same day. One would also assume that a sonographer who scans and a radiologist who reports the scan would call the requesting practitioner to make them aware of the result straight away.'

Provider responses to in-house clinical advice

Pacific Radiology

36. Pacific Radiology acknowledged that the report was not sent electronically due to a coding error, and that the reporting radiologist did not call through regarding these findings.

37. However, Pacific Radiology noted that if results are not available electronically, the referrer is able to ring the practice or on-call radiologists 24/7, and that there was 'some onus' on the referrer (RM B) to have followed up on the results herself, as any scan performed post-dates may 'change management acutely'. In response to the provisional opinion, RM B told HDC that she was unaware of the on-call radiologist service mentioned by Pacific Radiology, and that such a resource would have been 'invaluable' in obtaining necessary results after hours.

RM B

38. RM B emphasised that in the absence of the radiology report she had 'no insight into this being an abnormal situation and therefore anticipated labour' and she 'absolutely expected and still do[es] expect' to be notified personally by phone about such findings. RM B stated: '[T]he onus is on the ultrasonographer and radiologist as they had the information and [Ms A] and I did not …' RM B told HDC that she would have 'actively sought out' the report sooner if she had known of abnormal findings, but she accepted that her delay in following up on the report was 'suboptimal'.

39. RM B believes that 'true 24/7' care could have made a difference to the outcome, which includes Ms A being able to access ultrasound assessment exactly at 41 weeks (which would have been on 3 Month9), and RM B having 24/7 access to the relevant database that holds the results without having to rely on results being sent to her.

Relevant standards and HDC precedent

40. The Competencies for Entry to the Register of Midwives as set out by the Midwifery Council states that the midwife should apply 'comprehensive theoretical and scientific knowledge with the affective and technical skills needed to provide effective and safe midwifery care'. The midwife should:

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> '2.1 … [be] responsible for, midwifery care of the woman … during pregnancy …
>
> 2.2 … order and interpret relevant investigative and diagnostic tests … and systematically collect comprehensive information concerning the woman's health and well-being.'

41. The New Zealand College of Midwives also issued a Consensus Statement regarding laboratory testing/screening,[10] which states that it is the responsibility of the midwife who ordered the test to follow up on the results of the tests in a 'timely manner'.

42. The New Zealand Obstetric Ultrasound Guidelines[11] as set out by the Ministry of Health states that anhydramnios[12] (no amniotic fluid) is classified as a reporting alert level 'requir[ing] phone discussion with the referrer before the woman leaves the department to determine management (same-day assessment is usually required)'.

43. HDC has found in previous decisions that it is the midwife's role and responsibility to follow up on test results:

> '[A] midwife is expected to check results regularly, and is responsible for following up any scan/laboratory test she has requested … viewing and following up on results of tests they have ordered is a basic requirement of any health professional.[13]'
>
> …
>
> '[A]s the person who ordered the scan, [the midwife] had a responsibility to follow up the test results in a timely manner, particularly in the context of known concerns … telephone calls from radiologists to midwives are increasingly becoming standard practice where a significant change in the ultrasound findings is reported … the responsibility for following up on, and understanding, an ultrasound report remains the responsibility of the midwife who requested the scan.'[14]

Responses to provisional opinion

Ms A

44. Ms A was provided with an opportunity to respond to the 'information gathered' section of the provisional report.

45. Ms A told HDC that it was 'extremely difficult' to read the provisional report as it brought back 'traumatic memories' of her daughter's passing. However, Ms A reiterated that she brought the complaint to help the system make necessary changes for the betterment of its

[10] Ratified November 1996, updated 2002.
[11] Published December 2019.
[12] Although Ms A's report stated oligohydramnios, considering the amniotic fluid was initially reported at a very low level of 0.8mm, the oligohydramnios should have prompted reporting of a similar degree of urgency.
[13] 19HDC01820.
[14] 17HDC01980.

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practices, so that incidents like this do not happen again, and she thanked HDC for 'upholding [her] rights as a patient and mother'.

RM B

46. RM B was provided with an opportunity to respond to the provisional report. RM B acknowledged that as the requestor of the test, she retained the ultimate responsibility for following up the results, but she believes she lacked the 'requisite authority' to fulfil this role. Further information received from RM B has been incorporated into this report where relevant.

Pacific Radiology

47. Pacific Radiology was provided with an opportunity to respond to the provisional report. Pacific Radiology confirmed that it had no further comments to make.

48. Pacific Radiology also confirmed that the relevant sections of the provisional opinion and proposed recommendations had been brought to the attention of Ms C and Dr D. Ms C had no further comments to make. Dr D provided a separate response.

Dr D

49. Dr D largely accepted the proposed findings but added a few comments. Information received from Dr D has been incorporated into this report where relevant.

Opinion: Pacific Radiology — breach

50. Ms A underwent a post-dates ultrasound scan at Pacific Radiology on 5 Month9, in which oligohydramnios was first noted. Although not immediately life-threatening, Ms A was assured by the sonographer that the report would be sent urgently, and the results communicated to the midwife (RM B) who had ordered the test. Unknown to the sonographer and reporting radiologist at the time, the scan report was not sent by Pacific Radiology to Ms A's midwife because the wrong code was used on its IT system. In addition, Pacific Radiology did not call RM B about the scan results.

Empty referrer codes — breach

51. As a healthcare provider, it is Pacific Radiology's responsibility to provide services in accordance with the Code of Health and Disability Services Consumers' Rights (the Code), and to an appropriate standard. Ensuring that RM B was alerted to the 5 Month9 scan report was a key, if not critical, aspect of Ms A's care. Regarding the 5 Month9 scan report not being sent to RM B, Pacific Radiology has taken full responsibility for the omission and accepted that it occurred because of a coding error in its internal system. I am highly critical that Pacific Radiology was aware that it was using an IT system that held 'empty' codes, which, if selected, would result in the report in question going 'nowhere'.

52. I am also critical that it appears that no checking systems or policies were in place for such cases (when there was a failed attempt to fax the results to the referrer), whether that be within the system itself, and/or follow-up by frontline staff. Considering the known urgency

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of the matter, I believe it is reasonable to expect the report to have been followed up to ensure that it had been delivered successfully.

53. The responsibility for communicating clinical findings rests with the health service provider, not the patient, and it is crucial that a health service provider has systems in place that support, and are conducive to, such a responsibility. In the circumstances of this case, I consider that Pacific Radiology failed to provide Ms A with an adequate standard of care, on account of its inadequate IT system, which compromised the effective communication/ delivery of the scan report. Furthermore, it had no checking systems or policies in place to verify successful delivery of the scan report. Therefore, I find that Pacific Radiology breached Right 4(1)[15] of the Code.

Opinion: Dr D — adverse comment

54. Dr D was the reporting radiologist of Ms A's 5 Month9 ultrasound. Dr D reviewed Ms A's 5 Month9 scan against previous scans, noted oligohydramnios, and categorised the scan as an 'unexpected finding' that was not immediately life-threatening but could result in significant morbidity if not treated appropriately. Dr D said that he considered whether to call RM B but was 'reassured' that this would not be necessary.

Phone call discussion of results — adverse comment

55. As set out in its Communication of Critical/Actionable Results Policy, '[r]adiologists have a duty of care to ensure that a radiology report of a significant new or unexpected abnormality is **successfully** communicated to the referring doctor [emphasis added]'. Although I acknowledge that a series of assumptions led to the resulting clinical judgement not to call RM B, I consider that these assumptions were not sufficient to absolve Dr D, as the reporting radiologist, of his responsibilities, which included contacting RM B. Pacific Radiology also told HDC that the decision to call a referrer is determined by the reporting radiologist on a 'case-by-case basis using clinical judgment'.

56. Furthermore, considering that anhydramnios is classified as requiring a phone discussion with the referrer prior to the woman leaving the department to determine their ongoing management, I consider that amniotic fluid volume of (what was at the time incorrectly noted as) 0.8mm should have prompted urgent action to such or at least a similar degree. The fact that no phone call was made on 5 Month9, nor the following day, has not been explained adequately. Although the sonographer's and radiologist's assumption that Ms A would be in touch with RM B on the day of the scan was not wrong, their expectation that Ms A would convey the relevant clinical findings was unfounded and should not have been expected of the patient. I am critical that Dr D did not take further steps to fulfil his duty as a radiologist subject to the Communication of Critical/Actionable Results Policy for ensuring that the results of the report were communicated to RM B successfully. This should have at least included a phone discussion with RM B.

[15] Every consumer has the right to have services provided with reasonable care and skill.

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57. In response to the provisional opinion, Dr D stated that he believes that he was entitled to trust Pacific Radiology's processes, and that the alternative (to check that every abnormal finding recorded has been sent to the referrer) is 'clearly not possible'. I consider that the aforementioned deficiency in Pacific Radiology's systems limited Dr D's ability to fulfil this duty, and therefore this mitigates against finding Dr D in breach of the Code.

Opinion: RM B — breach

58. RM B was the lead maternity carer for Ms A during her pregnancy. RM B requested a post-dates ultrasound scan, which was performed on 5 Month9 at 11.45am. RM B received a text confirmation from Ms A that the scan had been completed. However, RM B failed to follow up with Pacific Radiology, despite not having received any report or communication until the morning of 7 Month9.

Failure to follow up as the requestor — breach

59. As mentioned by RM Emerson and Health NZ, and further supported by previous HDC decisions[16] and relevant standards, any practitioner who requests a scan is responsible for checking on the results. Accordingly, it was RM B's responsibility, as Ms A's midwife and the person who had requested the scan, to follow up on the scan report with Pacific Radiology, particularly as it was a post-dates scan and days away from Ms A being induced for labour.

60. I accept RM Emerson's advice that the nature of the scan (a 41+2 post-dates scan) should have warranted extra attention by RM B, with Health NZ also stating that 'with a 41 week scan one would assume the plan would be to follow up the result the same day'. An unusual result from a 41-week ultrasound scan often requires obstetric assessment that same day, especially in the case of anhydramnios or oligohydramnios. Considering the time-critical nature of acting on the results of such a scan, I consider it is reasonable to expect that RM B should have followed up sooner with Pacific Radiology.

61. In response to the provisional opinion, RM B stated that she felt falsely reassured considering the 'agreed standard of communication' in such cases, and that there was an expectation for the practitioner to engage the local maternity assessment unit if RM B was unavailable, but that no such efforts were made.

62. Although I acknowledge this expectation, I accept RM Emerson's advice that although RM B's failure to follow up on the scan results with more urgency is mitigated by the assumptions RM B held from previous experience, this does not absolve RM B of all responsibility for this event. RM B's assumption that Pacific Radiology would call regarding any urgent findings is fair; however, I consider that RM B's assumption that there were no issues with the scan, despite not having received the actual scan result, is unfounded. RM B failed to follow up with Pacific Radiology over the course of two days, despite understanding the significance of the scan, and noting at least four instances within 5 and 6 Month9 in which she was 'bothered' about the delay. Reassurance should not come from the absence of information, but following confirmation of fact, and it was RM B's duty to have the

[16] 17HDC01980, 19HDC01820, 19HDC00333.

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appropriate information on hand to make a sound clinical judgement call that was not based on assumptions.

63. In response to the provisional opinion, RM B claimed that the discrepancy in her access to reports compared to resident medical officers (who can access the reports digitally through online portals) affects her capability to retrieve results as an ordering practitioner. I recognise that there may be room to improve digital accessibility of reports at a systemic level, but I do not consider that this alters a midwife's responsibility for monitoring and following up on scan results with the resources available.

64. Although I accept that Pacific Radiology's processes should have facilitated RM B receiving the report in a timely fashion, I remain of the view that RM B, as the requestor, still held the ultimate responsibility to be proactive about following up on the result, considering the nature of the scan and the experience she held. Accordingly, I find that RM B breached Right 4(1) of the Code with respect to the care she provided to Ms A.

Changes made since events

Pacific Radiology

65. Since these events, Pacific Radiology has made the following system changes to the processing of reports:

a) Urgent reports are now highlighted by the reporting radiologist for referrers to be telephoned by administration staff, generally within 30 to 60 minutes of the result being reported.

b) Interface-generated referrer codes are marked as 'inactive' and prevented from selection by frontline staff daily.

c) A report is run daily to check that each report has been distributed and to flag any reports that do not have a valid recipient or referrer listed.

d) A new system is being implemented across the Pacific Radiology Group, which hides the interface-generated referrer codes from the normal referrer lookup list used by frontline staff to avoid them being selected/used.

66. The clinical case was also reviewed at Radiologist Peer Learning to highlight the issues raised and to minimise the risk of a similar event occurring again. The matter was discussed with relevant administration staff.

67. Pacific Radiology has also employed a part-time consultant obstetrician and maternal fetal medicine specialist with an ultrasound qualification to report on some of the obstetric ultrasound scans and upskill sonographer staff.

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RM B

68. RM B has undertaken further education and training, including:

a) Considering all practice guidance and guidelines suggested by RM Emerson, as well as the latest NZCOM policy and Health NZ guidelines;

b) Incorporating PSANZ Decreased Fetal Movement clinical practice guidelines into her practice;

c) Completing a health coaching certificate in March 2022 to enhance communication skills; and

d) Applying for access to Pacific Radiology's Intele Viewer database to access reports after hours.

69. RM B has also improved aspects of her practice, such as:

a) Reducing her caseload to postnatal women, and limiting involvement in comprehensive pregnancy care;

b) Prioritising actions based on the 'clinical picture' rather than previous experience;

c) Requesting that all women text the date and time of their appointments to follow up within two hours or before the end of the day; and

d) Ensuring a closed communication loop for all scans, appointments, blood tests, and other relevant matters.

70. RM B has also followed up with recommendations to the Health NZ clinical lead regarding suggestions around systems changes to avoid a similar situation in the future.

Recommendations

Pacific Radiology

71. I recommend that Pacific Radiology:

a) Provide a written apology to Ms A for the breach of the Code identified in this report and send this to HDC within four weeks of the date of this report, for forwarding to Ms A.

b) Provide an update on the implementation of its new referrer code system and evaluate the effectiveness of the system by conducting an audit of the identification of inactive referrer codes over a three-month period, and provide HDC with the outcome report with any corrective actions within three months of the date of this report.

RM B

72. I recommend that RM B provide a written apology to Ms A for the breach of the Code identified in this report and send this to HDC within four weeks of the date of this report, for forwarding to Ms A.

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Follow-up actions

73. A copy of this report with details identifying the parties removed, except Pacific Radiology and the advisor on this case, will be sent to the Midwifery Council of New Zealand, and it will be advised of RM B's name.

74. A copy of this report with details identifying the parties removed, except Pacific Radiology and the advisor on this case, will be sent to the New Zealand College of Midwives, the National Maternity Monitoring Group, Health NZ, the Director-General of Health (Manatū Hauora | Ministry of Health), and the Perinatal and Maternal Mortality Review Committee, and will be placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

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Appendix A: In-house clinical advice to Commissioner

The following in-house clinical advice was obtained from RM Nicky Emerson, Midwifery Advisor:

'**CLINICAL ADVICE — MIDWIFERY**

CONSUMER	**:**	[Ms A]
PROVIDER	**:**	[RM B]
FILE NUMBER	**:**	C21HDC00168
DATE	**:**	16 August 2022

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1. Thank you for the request that I provide clinical advice in relation to the complaint from [Ms A] about the care provided by [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:**

   Documents provided
   Complaint from [Ms A] 26 [Month9]
   Complaint response from LMC [RM B] (clinical notes included)
   Clinical notes from [Health NZ]
   Response from Pacific Radiology [2021]
   Response from [Dr D] (Pacific Radiology) [2021]
   Comments from [an obstetric gynaecologist at Health NZ]
   Post mortem and placental pathology 9 [Month9]

Background: [Ms A] was in her first on going pregnancy and booked with LMC [RM B]. Estimated date of delivery was 27 [Month8]. There was no medical or surgical history of note, BMI was raised at 27. The pregnancy progressed without event however during [Ms A's] pregnancy the placenta was low lying. The placenta had moved away from the cervix sufficiently enough at 38 weeks gestation for the Obstetricians to consider vaginal birth a viable option. On 5 [Month9], [Ms A] had a post-dates scan at 41 weeks + 2 at Pacific Radiology, and the sonographer told [Ms A] that the baby was healthy however there was low amniotic fluid. [Ms A] said she was anxious however the sonographer said that this was quite normal for the stage of pregnancy, and she would send the report urgently and call [Ms A's] midwife. On the same day, [Ms A] sent her midwife, [RM B], a text to say she had her scan, however did not mention the low amniotic fluid. [RM B] did not receive a phone call from Pacific radiology and the report was mistakenly sent to another recipient by Pacific Radiology.

On 7 [Month9], [Ms A] experienced contractions and some spotting/bleeding. At 8.53am, she texted [RM B] who then spoke to her over the phone, and [Ms A]

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mentioned at the time that her amniotic fluid had been low in the scan. [Ms A] also mentioned that the baby had moved around a lot the previous night and normally moves around in the morning too, but the movements have been a little reduced that morning. [RM B] instructed [Ms A] to sit down and do whatever usually elicits baby movements, and to call back within an hour if the baby's movements were still reduced.

[RM B] called Pacific Radiology to follow up on the scan not received. Pacific Radiology informed her that the report had been coded incorrectly, and was sent elsewhere. [RM B] said she checked her EDI at 9.01am and the report was not there yet, and as reports are normally distributed on the hour she knew it would not be available until after 10am. [RM B] continued her routine antenatal clinic and checked for results at 10.49am. [RM B] had not heard from [Ms A] about the baby movements so assumed they had returned to normal, and on reading the scan noted the reduced amniotic fluid and called an O&G registrar … for advice. [The O&G registrar] recommended seeking an acute CTG in the delivery suite immediately. After confirming that there was space in the delivery suite, [RM B] called [Ms A] at 10.55 to go to the hospital for a CTG as soon as possible. [RM B] said there was no mention in the phone call of the baby's movements not being present, and [Ms A] attended promptly. Sadly when [Ms A] attended her CTG it was discovered that [Baby A] had no heartbeat. At 12.07pm [RM B] was advised of this and she finished up her antenatal appointment and went to the delivery suite to see Ms and [Mr A]. She checked if [Ms A] wanted her present for the birth and requested another staff midwife double check this to ensure it was not a coerced response. [Ms A] confirmed she wanted [RM B] to attend. [Ms A] was induced on 8 [Month9] and birthed [Baby A] at 12.05am on 9 [Month9].

Following the birth, [Ms A] requested that [RM B] withdraw from her care, and care was handed over to the hospital midwifery team.

Advice Request

1. In your experience, what are expectations on an LMC for following up on scan results?
2. After receiving information that [Ms A's] 41-week scan showed low amniotic fluid and she was experiencing spotting and decreased fetal movement on 7 [Month9], did [RM B] act appropriately and with sufficient urgency in obtaining the scans and sending [Ms A] to hospital for further testing?
3. Do you have any concerns or criticisms about [RM B's] actions on 7 [Month9]?
4. Do you have any comments on reporting being made available hourly on the EDI database?
5. Could or should [RM B] have obtained copies of the scans faster than she did on 7 [Month9]?

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1. In your experience, what are expectations on an LMC for following up on scan results?

In answering the question above, it is important to differentiate between a routine scan such as an anatomy scan, and a scan ordered to obtain specific information. In both cases urgent findings are generally communicated by phone to the referrer. It could be argued that a post-dates scan is a routine scan however it is also a scan to establish whether the pregnancy can safely continue. In order to establish whether the pregnancy can continue safely one of the components of a post-dates scan is to establish the volume of amniotic fluid surrounding the baby. Adequate amniotic fluid acts as a protective buffer supporting fetal movements, blood volume and nutrition.

[RM B's] documentation 8 [Month8] states that she had a discussion with the obstetrician regarding whether it was acceptable to order a post-dates scan at 41+2 days as the 41 week gestation fell on a [public holiday weekend]. It was agreed that this was acceptable in the context of the normal pregnancy. Midwifery contemporaneous documentation records that arrangements were made for scan and obstetric review as a back-up if a scan slot was not available in the community at 41+2 weeks gestation.

[Ms A] was able to book a community scan at Pacific Radiology on 5 [Month9] (41weeks +2) and she informed [RM B] by text message. Following the scan at 12.34pm [Ms A] texted [RM B], she did not mention that the amniotic fluid level was low or that the sonographer at Pacific Radiology was intending to phone [RM B] and send the report urgently.

Of note: [Ms A] was concerned regarding the low fluid level but was reassured by Pacific Radiology that there were other reassuring parameters in the scan, they would phone [RM B] and send the report urgently. [RM B] notes that [Ms A] did not alert her to expect a phone call or that the amniotic fluid was low. [RM B] also acknowledges that it was not [Ms A's] responsibility to convey this information. In my opinion, the responsibility did not rest with [Ms A] but with Pacific Radiology and [RM B] to follow up. It is understandable though that both [Ms A] and [RM B] might have felt falsely reassured.

[RM B] states that *"I sync'd my phone 2–3 times this afternoon/evening looking for the results of this scan over the course of the afternoon. No report in my EDI — this is unusual but not impossible given that the workload for the scanners is large especially given the [public holiday] weekend — and I hadn't had a phone call to alert me to this fact. If I had of known the report findings I would have had [Ms A] seen acutely … for a CTG and a plan around delivery".* Pacific Radiology report *"Our sonographer completed the Kailo ultrasound worksheet as usual. In the notes section of the worksheet the sonographer noted 'patient booked for induction on Friday, will be talking to midwife today'. She then sent the scan to the radiologist worklist, marked for urgent reporting." This referrer coding error [led] to the ultrasound pregnancy scan report not being sent to [RM B] … until 08.52 [on] 7 [Month9] when the report was requested by phone. We sincerely apologise for this coding error.*

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Pacific Radiology states … reasons for not telephoning included: *that [Ms A] would be talking to her midwife later in the day; that the report would be distributed urgently; and the expectation that the midwife would be actively following up the report.*

In forming an opinion I have considered the above information, I have also considered the following:

New Zealand Midwifery Council — Competency Two

2.2 confirms pregnancy, if necessary; orders and interprets relevant investigative and diagnostic tests, carries out necessary screening procedures, and systematically collects comprehensive information concerning the woman's/wahine health and well-being.

NZ Obstetric Ultrasound guidelines (2019) file:///H:/Downloads/new-zealand-obstetric-ultrasound-guidelines-2019-dec19%20(2).pdf page 85 have a category of orange for Anhydramnios (no amniotic fluid). The reporting alerts colour coding are defined on page 3. Orange category requires phone discussion with the referrer before the woman leaves the department to determine management (same day management is usually required).

Insufficient amounts of amniotic fluid during pregnancy is called oligohydramnios; the absence of amniotic fluid is called Anhydramnios. Oligohydramnios can compress the fetus and umbilical cord reducing the delivery of oxygen to the fetus.

[Ms A's] report stated there was oligohydramnios and not Anhydramnios however the amniotic fluid was very low and has been subsequently referred to in the clinical notes on 3 occasions

- 7 [Month9 by the] Obstetric Consultant as Oligo/Anhydramnios.
- Anhydramnios deepest vertical pocket (DVP) 0.8mm at 41+2 weeks
- and significant oligohydramnios

A retrospective study by Zilberman et al (2021) concluded that the amniotic fluid index (AFI) of = 0–20mm was classed as severe. Of note: SDP (single deepest pocket) DVP (Deepest vertical pocket) and AFI (Amniotic Fluid index) are measures of the deepest pocket of amniotic fluid. Oligohydramnios is defined in NZ Ministry of Health. (2012). Maternity referral guidelines.
https://www.health.govt.nz/system/files/documents/publications/referral-glines-jan12.pdf. No pool depth equal or greater than 2cm or an amniotic fluid index <7. An obstetric consultation in this instance is required.

According to Pacific Radiology …, if an urgent result needs to be notified to a midwife this would typically be actioned by the reporting radiologist via a telephone call to the midwife at the time of reporting/verification. *Assessment of urgency includes using clinical judgement and taking into account expected course of events on the day of the*

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examination. In this instance an urgent report was expected to be sent to the midwife but no telephone call was made to the midwife on the day of the scan.

In summary, Pacific Radiology indicated to [Ms A] that they would send the report urgently and they would be phoning [RM B]. The report was sent to the incorrect recipient by Pacific Radiology. Whilst [RM B] has departed moderately from accepted practice in not following up the report on the same or following day, in my opinion this is partly mitigated by a reasonable expectation and previous experience indicating urgent results are phoned through to the referrer. In addition, [RM B] notes that she had checked for the results but considered they may have been delayed by the previous [public] holiday period.

2. **After receiving information that [Ms A's] 41-week scan showed low amniotic fluid and she was experiencing spotting and decreased fetal movement on 7 [Month9], did [RM B] act appropriately and with sufficient urgency in obtaining the scans and sending [Ms A] to hospital for further testing?**
3. **Do you have any concerns or criticisms about [RM B's] actions on 7 [Month9]?**

With the benefit of hindsight perhaps the Midwifery care delay could be criticised however in my opinion the following information gathering was reasonable prior to Obstetric consultation.

- Low amniotic fluid exists on a continuum and it was reasonable to expect a phone call from Pacific Radiology if the amniotic fluid was severely low. In my opinion it was reasonable for [RM B] to secure a copy of the scan report prior to Obstetric consultation and hospital assessment. Whether there was sufficient urgency in obtaining the report is discussed in question 5 below.
- Spotting or bleeding can be an indication of cervical changes and the onset of labour. [RM B] phoned [Ms A] following the text message to establish the nature of the spotting/bleeding before deciding on next actions. In the context of a low lying placenta, a phone call was particularly appropriate. The bleeding appeared to be minimal and had ceased.
- Decreased fetal movements were reported and [RM B] advised [Ms A] to stop current activity and pay attention to the movements and to phone back in an hour if the movements remained reduced. Current midwifery practice does not support this action however this advice was common previously.

"The New Zealand College of Midwives (NZCOM) Assessment and promotion of fetal well-being during pregnancy" practice guideline (2021) https://www.midwife.org.nz/wp-content/uploads/2021/05/Assessment-and-promotion-of-fetal-wellbeing-during-pregnancy.pdf contains the following statement

There is no evidence to support advice to stimulate the fetus with food or drink or by requesting the wahine to call back after a period of rest and concentrating on fetal movement. This statement is supported by the NZ Clinical practice guideline for the care

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of women with decreased fetal movements for women with a singleton pregnancy from 28 weeks' gestation (2019) https://sanda.psanz.com.au/assets/Uploads/Element-3-DFM-Clinical-Practice-Guideline.pdf which states the following

Recommendation 2b. *Presentation should not be delayed through efforts to stimulate the baby with food or drink or by requesting women to phone back after a period of concentrating on fetal movement.*

The guideline further states

Recommendation 6b. *The timeframe to perform this investigation will depend on the woman's preferences, clinical urgency, presence of risk factors and service capability. 6c where ultrasound findings are abnormal, discuss with a senior obstetrician.*

In summary, in my opinion it was reasonable to obtain a copy of the scan, discuss bleeding and fetal movements with [Ms A] prior to Obstetric discussion and referral for assessment. There was an additional risk factor of a reducing fetal growth. The estimated fetal weight had decreased from the 75th centile at 34 weeks and 3 days gestation to the 50th centile at 37 weeks and 1 day gestation. Whilst the reduction in growth did not meet the threshold for referral, it did warrant monitoring and checking. I am critical of the advice to wait and monitor movements however [Ms A] did not report back after an hour to confirm reduction in fetal movements. I am critical that the scan was not obtained with more urgency however the degree of reduced amniotic fluid was not known and it cannot be retrospectively determined whether these factors would have impacted outcome.

6. **Do you have any comments on reporting being made available hourly on the EDI database?**

I have no comment to make on this aspect however it is my understanding that results are released in batch lots.

7. **Could or should [RM B] have obtained copies of the scans faster than she did on 7 [Month9]?**

With the benefit of hindsight and with the knowledge of outcome it is understandable that [RM B] could be criticised for not obtaining the scan results sooner on 7 [Month9] however as outlined above she made an assumption that the amniotic fluid levels were not critical as she had not been phoned. As outlined above, scan results are available in batches. I am critical of the time it took to get results however the care throughout the pregnancy was thorough and [RM B] had discussed the bleeding/spotting with [Ms A] by phone and had not heard back regarding ongoing reduced movements.

Summary

Firstly I extend my heartfelt condolences to both [Ms A] and her partner … for the loss of their precious baby daughter, [Baby A]. In the writing of this report there does not

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appear to be a single factor that has resulted in the outcome. I hope this report addresses some remaining questions. In my opinion, midwifery care had been proactive and of a high standard throughout the pregnancy and had met all accepted midwifery standards up until 5 [Month9]. There was a series of assumptions and events from 5 [Month9] that contributed to the very sad outcome.

The responsibility to follow up on the scan results rested with both Pacific Radiology and [RM B], however the following assumptions resulted in the delay of a potential opportunity for earlier intervention.

- Pacific Radiology indicated to [Ms A] that they would be sending the report urgently and would phone [RM B]
- Pacific Radiology report was sent to an incorrect recipient and not received by [RM B] or by the hospital antenatal clinic.
- Pacific Radiology assumed that because the report had been sent urgently and the scan results were not deemed immediately life threatening that a phone call to [RM B] was not necessary.
- [RM B] assumed based on previous experience she would receive/or would have received a phone call from Pacific radiology to report any urgent results.
- [RM B] checked several times for the scan results and when they were not received that day, attributed this to holiday period heavy work load … She did not immediately follow up as she assumed she would have been called if there was a significant concern.

Of note: Both Pacific Radiology and [RM B] indicate that they assumed that [Ms A] might have conveyed the concern regarding the low amniotic fluid in the conversation between [Ms A] and [RM B] on the day of the scan, 5 [Month9]. My observation in no way suggests that any responsibility should have rested with [Ms A] or that she should have understood the significance of the scan findings. The comment is only included to highlight the series of contributing assumptions. This has been acknowledged by [RM B].

From a midwifery perspective, in my opinion there is a moderate departure from accepted practice in [RM B] not following up the scan results the following day. The mitigating factors have been outlined above in question one. In addition it is no longer accepted midwifery practice to delay assessment of reduced fetal movements by recommending a period of close observation, however in this instance it is impossible to ascertain whether this would have impacted outcome. It may be valuable for [RM B] to familiarise herself with “*The New Zealand College of Midwives (NZCOM) Assessment and promotion of fetal well-being during pregnancy” practice guideline (2021)* and “*NZ Clinical practice guideline for the care of women with decreased fetal movements for women with a singleton pregnancy from 28 weeks’ gestation (2019)”*

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Nicholette Emerson, BHSc, PG Dip-Midwifery
Midwifery Advisor
Health and Disability Commissioner

…

Expert advice requested

Could you please review [RM B's] response to your report and advise whether this has changed any of your findings. If so, please provide any reasoning for this change.

Could you also provide further information about your criticism on page 6 of your original report relating to the NZCOM 2021 guideline about [RM B's] advice to [Ms A] on 7 [Month9] to stop her current activity and phone back in an hour if the fetal movements had remained reduced?

The reason for this clarification is that the NZCOM 2021 guideline appears to have been published and applied after the events of [Month9] for [RM B], and the SANDA and PSANZ's decreased fetal movement guideline (2019) appears to come from Australia.[] I acknowledge this might have applied in both jurisdictions as a practical guideline and that you have stated this advice was common previously.

NZCOM 2021 Guideline

- If we accept that the NZCOM guideline was published following the birth and remove the NZCOM 2021 guideline and refer to other available guidelines at the time
- [Health NZ] Guideline on Fetal Movements 2016 *When a woman presents with RFM, assessment should be undertaken as soon as practicable.*
- [Health NZ] Maternity 2019 *Assessment of DFM complaints should be undertaken as soon as possible and within 2 hours.*
- *There is no evidence to support advice to stimulate the fetus with food or drink or by requesting the wahine to call back after a period of rest and concentrating on fetal movement.* This statement is supported by the NZ Clinical practice guideline for the care of women with decreased fetal movements for women with a singleton pregnancy from 28 weeks' gestation (2019). This guideline is supported by PSANZ, RANZCOG and Australia & New Zealand Neonatal Network Clinical practice guideline DFM (psanz.com.au). All women who contact their health care provider with a concern about fetal movements should be invited to the health service for immediate assessment.
- *Presentation should not be delayed through efforts to stimulate the baby with food or drink or by requesting women to phone back after a period of concentrating on fetal movements.*

  SANDA and PSANZ — and the SANDA and PSANZ's decreased fetal movement guideline (2019) appears to come from Australia. I acknowledge this might have

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applied in both jurisdictions as a practical guideline and that you have stated this advice was common previously.

- PSANZ is the Perinatal Society of Australia and **New Zealand**.
- Clinical Practice Guideline for the care of Women with Decreased Fetal Movements 2019 is endorsed by The Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG) and Australia & New Zealand Neonatal Network. Clinical practice guideline DFM (psanz.com.au)
- Whether [RM B] responded to your concerns appropriately?

  It was reasonable to question the validity of the NZCOM reference.
- Was there a departure from the standard of care and or accepted practice, how significant a departure (mild, moderate, or severe) do you consider this to be? How would it be viewed by your peers? Alternatively, this could be an adverse comment per your original advice.
- Any other relevant comment you wish to make.

  I accept that the NZCOM guideline 2021 may have come out after the birth in [Month9] so we can remove this as a reference however there are numerous guidelines prior to 2021 (above) that endorse the need to assess decreased fetal movements without delay. I accept that [RM B] was gathering relevant information regarding the scan and would be open to an adverse comment in the context as opposed to a departure.

…'

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