# Investigation report

## Review of the quality of health services provided by the Townsville Hospital and Health Service

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**Investigation report—Review of the quality of health services provided by the Townsville Hospital and Health Service**

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# Introduction

This report relates to a Health Quality and Complaints Commission (HQCC) investigation into the quality of health services provided by Townsville Hospital and Health Service (HHS) to Mrs A between 12 January 2013 and 29 January 2013, and the circumstances surrounding the stillbirth of her baby (Baby B). The investigation became mine on 1 July 2014 under the transition arrangements at Part 21 of the *Health Ombudsman Act 2013*.

# 1. Transition of complaint to the Health Ombudsman

A written complaint was made by Mrs A on 18 February 2013 to the HQCC regarding the circumstances surrounding the stillbirth of her baby on 29 January 2013 at the Townsville Hospital Birth Centre (THBC).

At the time of the transition of this matter to me on 1 July 2014, the majority of the investigation inquiries had been finalised by the HQCC and a draft investigation report completed. In addition to identifying systemic issues with the overall management of Mrs A by THBC, the HQCC draft investigation report also highlighted issues related to the professional performance of two registered midwives (RM1 and RM2) in respect to the care provided to Mrs A at THBC.

On 26 June 2014 the HQCC provided copies of the draft investigation report to Townsville HHS and to both midwives, inviting their response to the proposed recommendations and adverse comments within the document. The HQCC advised Townsville HHS and the two RMs that any response should be addressed to my office due to the pending transition of the state health complaint functions from 1 July 2014.

On 17 July 2014, my office received a request from the two RMs for a copy of various documents forming appendices to the draft investigation report in order to respond to the following issues:

1. RM1 for practicing outside the scope of midwifery in respect to the taking and interpretation of an ultrasound on 12 January 2013.
2. RM1 for the failure to properly record, and keep records, of an ultrasound and cardiotocography (CTG) undertaken at the THBC on 12 January 2013.
3. RM2 for the failure to properly follow accepted practice for reported reduced foetal movement on 24 January 2013.
4. RM2 for the failure to properly record, and keep records, of the examination and discussion with the duty obstetrician in respect to Mrs A on 23 January 2013.
5. RM2 for the failure to follow up an ultrasound appointment for Mrs A.

On 21 August 2014, following a further review of the matter, my office advised RMs 1 and 2 that the information in the investigation report had been referred to the Australian Health Practitioner Regulation Agency (AHPRA) for its consideration, as the issues associated with RMs 1 and 2 were related to performance failures associated with standard practice and policy. My office advised the two RMs that I did not intend to take any further action in respect to them.

After referring the two RMs to AHPRA, the remaining issues to be dealt with were:

- The failure by THBC to properly monitor, diagnose and treat her condition, which she believed directly contributed to her baby's death.
- The level of communication and coordination of services at THBC in relation to the arrangement of a scan on 29 January 2013.

# 2. Background to the complaint

On 8 January 2013, Mrs A attended a routine antenatal examination at the Bowen Hospital undertaken by a local RM, who raised concerns about the patient's fundal height. The Bowen RM contacted THBC and spoke with RM1, who was relieving for Mrs A's primary care provider, RM2. The Bowen RM outlined her concerns and was advised by RM1 that RM1 would contact Mrs A.

The Bowen RM subsequently spoke with a doctor at Bowen Hospital in respect to their concerns about the fundal height and, as a result of the discussion, the doctor completed a request for an ultrasound to be undertaken. When the Bowen RM contacted Mrs A about the ultrasound appointment, the Bowen RM was advised a scan would be taken at THBC by RM1.

On 12 January 2013, Mrs A was examined by RM1 at THBC, where a physical, ultrasound and CTG examination found no issues associated with the pregnancy or the Amniotic Fluid Index (AFI) level.

On 23 January 2013, Mrs A attended THBC where RM2 (her primary care provider) undertook an examination and review because RM2 was concerned about the fundal height. After discussion with RM1, the matter was then brought to the attention of the Director of Obstetrics who recommended a formal ultrasound be taken. Mrs A advised the midwives that she was temporarily living in Townsville until the birth of the baby and provided her new address details.

On 24 January 2013, Mrs A visited the THBC and spoke with RM2 about the scan and was told she would be advised of the appointment time. Mrs A also raised concerns with RM2 about reduced movement by the baby and was told that 'it was normal close to the end' and not to be concerned as the baby was down in the pelvic area and there was less room to move around.

An appointment for a scan was made for 29 January 2013, at Townsville Hospital. At 3 pm on 29 January 2013, Mrs A underwent an ultrasound at Townsville Hospital where she was advised that her baby did not have a heartbeat. Labour was induced and the baby was delivered stillborn at 10.15 pm on 29 January 2013, being 39 weeks old.

The clinical records document that Mrs A did not want an autopsy; however, a magnetic resonance imaging (MRI) body scan undertaken post-mortem which indicated 'Post Mortem MR in a case of still birth at term with associated polyhydramnios'.

On 18 February 2013, Mrs A submitted a written complaint and supporting documentation to the HQCC which outlined her concerns with her treatment at THBC and the actions of RM1 and RM2. The HQCC commenced an investigation on 14 October 2013.

# 3. Health Quality and Complaints Commission investigation

During the course of the HQCC investigation evidence was obtained from a number of sources, including:

- the complaint and supporting documentation submitted by Mrs A on 18 February 2013
- various submissions from TressCox Lawyers (TCL), acting on behalf of Townsville HHS, including provision of:
  - cause of death certificate dated 29 January 2013 and neo-natal intensive admission records
  - Prime Clinical Incident report
  - Mrs A's medical records
  - Mrs A's pregnancy health record
  - medical imaging records including post mortem MRI
- submissions and documentation provided by Roberts & Kane Solicitors (RKS) on behalf of RMs 1 and 2
- clinical opinions from Dr C and Dr D, two medical practitioners with a specialty in obstetrics and gynaecology
- interview of Bowen RM at Bowen Hospital
- additional information from Mrs A and Mr A
- submissions from Townsville HHS which included:
  - a Root Cause Analysis (RCA) dated 12 June 2013
  - various maternity and neonatal clinical guidelines.

## 3.1 Response from Townsville Hospital and Health Service

During the assessment and investigation process, the HQCC received a number of submissions and supporting documentation from TCL on behalf of Townsville HHS as follows:

- On 8 May 2013, Townsville HHS provided documentation including copies of the cause of death certificate, neo-natal records of Baby B and Mrs A's medical records.
- On 14 May 2013, Townsville HHS provided submissions supporting their assertion that Mrs A had received comprehensive care throughout her pregnancy and support subsequent to her stillbirth.
- On 18 September 2013, in response to questions from the HQCC, Townsville HHS stated that there was no formal record of the bedside scan performed on 12 January 2013 as the scan was not required as part of the clinical investigation or clinical assessment. The scan was performed for comfort measures only.
- On 9 December 2013, Townsville HHS provided copies of the RCA report and a number of guidelines and procedures relevant to neonatal care.

- On 10 March 2014, Townsville HHS provided submissions associated with specific questions related to:
  - the differences associated with clinical assessment, examination, management and/or recording between a formal and comfort scan
  - policies/guidelines in relation to undertaking formal or comfort scans
  - policies/guidelines in respect to the use of scans to determine AFI levels
  - policies/guidelines in relation to the recording of any examination and/or comment associated with scans during antenatal checks
  - Mrs A's Pregnancy Health Record for 8 January 2013, which highlighted a symphysis fundal height of 43cm and a notation record from Bowen Hospital 'to see Birth Centre for r/u next week', and the difference in the Townsville HHS response of 18 September 2013 and 14 May 2013.
  - the variance of AFI levels noted in the Pregnancy Care Record from 4 January 2013 until 20 January 2013 in comparison with the level noted at THBC on 12 January 2013
  - advice or information of discussion between RM2 and the duty obstetrician on 23 January 2013 as it related to AFI level and a proposed scan and whether the obstetrician was advised of the previous recorded AFI levels
  - policies/guidelines in respect to reported 'reduced foetal movement' and associated appropriate action
  - the defined scopes of practice for midwives at THBC and the undertaking, interpreting and commenting on scans during routine antenatal checks.

## 3.2 Response from RM1

On 16 August 2013, RM1 provided the HQCC with a copy of their submission to AHPRA (via legal counsel RKS). In summary RM1 provided details relevant to their care of Mrs A as follows:

- On 9 January 2013 RM1 received a telephone call from a midwife at the Bowen Hospital who requested a review of Mrs A after being assessed as having increased fundal height.
- RM1 had seen Mrs A on 12 January 2013 and completed an antenatal check which included taking a bedside ultrasound which was described as informal and taken as a reassurance measure in support of RM1's clinical evaluation. RM1 advised Mrs A that the baby was growing appropriately.
- RM1 saw Mrs A at about 39 weeks when asked by RM2 for a second opinion about clinical findings which indicated a fundal height of 42 centimetres. RM1 confirmed RM2's findings and this was discussed with the duty obstetrician who agreed an ultrasound was required, though not urgently.

### 3.3 Response from RM2

On 23 August 2013, RM2 provided the HQCC with a copy of their submission to AHPRA (via legal counsel RKS). In summary, RM2 provided details relevant to their care of Mrs A as follows:

- RM2 examined Mrs A on 23 January 2013 and became concerned by an increased fundal height of 42 centimetres and sought a review of Mrs A by RM1.
- RM2 had also discussed their concerns at a meeting with the duty obstetrician, who recommended an ultrasound followed by a medical review in the Antenatal Day Assessment Unit.
- RM2 had communicated the obstetrician's advice to Mrs A.
- On 31 January 2014 RM2, through legal counsel RKS, provided a written response to AHPRA in response to a request for further information which included:
  - When Mrs A was reviewed at her scheduled antenatal visit on 23 January 2013 she had not reported decreased foetal movements.
  - On 24 January 2013, when Mrs A attended the birth centre to have travel documents signed, RM2, in response to questions about foetal movements, had not sent her home to count movements (as the usual practice was to arrange a CTG when there are reported foetal movements of less than 10 movements in 12 hours).

## 4. Independent clinical opinions

### 4.1 Dr C

During the HQCC assessment process a clinical opinion was sought from Dr C, who provided the following advice:

- Without a post mortem or cause of death, it could not be concluded that an ultrasound or any other investigation performed prior to the loss would have provided information to prompt intervention.
- Dr C had concerns about the clinical management of Mrs A in respect to her antenatal care by the RMs (in particular, the lack of follow-up of ultrasound appointments and review when reduced foetal movement was reported).

### 4.2 Dr D

During the HQCC investigation process a clinical opinion was sought from Dr D, who provided the following advice:

- The ultrasound scan performed by RM1 was part of the clinical assessment of the pregnancy and ought to have been documented in the case notes.
- There was no criticism of the way the scan was performed.
- The scan was an appropriate way of assessing foetal wellbeing.

# 5. Health Quality and Complaints Commission principal issues and findings

The principal issues and findings within the draft investigation report were:

*Whether Mrs A underwent appropriate overall assessment, investigation, monitoring and treatment in respect to her antenatal care.*

The HQCC found that there had been issues in respect to some practices associated with the THBC midwifery model of care related to oversight or peer review which affected the ability to identify potential problems during antenatal care.

*The action, or lack of action, taken in respect to concerns raised about the fundal height by the midwife at the Bowen Hospital on 8 January 2013, in conjunction with the circumstances associated with the bedside scan and CTG undertaken on 12 January 2013 at THBC and, the failure to record the results.*

The HQCC noted the reasons both RM1 and RM2 provided for there being no formal records made of the bedside scan undertaken on 12 January 2013, in conjunction with the difference in the opinions of the independent clinicians about the performance of ultrasounds. The HQCC concluded that it is evident that the use of ultrasound forms part of an examination and should be undertaken by a suitably qualified practitioner, with the results being properly recorded. In this case, there was record of the ultrasound or CTG although RM1 had undertaken both tests.

*The policy/scope of practice around midwifery and 'bedside scans'.*

The HQCC identified that the undertaking of bedside/comfort scans, or indeed any form of ultrasound, was outside the scope of practice for midwives. The HQCC investigation highlighted a significant variance in the gestational measurements recorded by RM1 on 12 January 2013 in comparison to those undertaken by other practitioners both prior to and after that date, which tended to support the requirement for suitably trained persons to undertake ultrasounds.

*The failure associated with the appointment process for a scan at Townsville Hospital on 29 January*

The HQCC identified that Townsville HHS had incorrectly sent advice to Mrs A regarding an appointment for a scan at Townsville Hospital on 29 January 2013 to her residential address in Bowen after her change of address had been recorded on 23 January 2013.

# 6. HQCC proposed recommendations

In June 2014, the HQCC completed a draft investigation report into its investigation of the quality of healthcare provided to Mrs A and, on the basis of the evidence obtained during the investigation made the following preliminary recommendations:

1. To provide a copy of the draft investigation report to AHPRA in respect to RM1 and RM2 including:
    a. RM1 for practicing outside the scope of midwifery in respect to the taking and interpretation of an ultrasound on 12 January 2013.
    b. RM1 for the failure to properly record, and keep records, of an ultrasound and CTG undertaken at the THBC on 12 January 2013.
    c. RM2 for the failure to properly follow accepted practice for reported reduced foetal movement on 24 January 2013.
    d. RM2 for the failure to properly record, and keep records, of the examination and discussion with respect to Mrs A on 23 January 2013.
    e. RM2 for failure to follow up an ultrasound appointment for Mrs A.
2. The HQCC endorsed the recommendations associated with the RCA.
3. The HQCC also made the following recommendations:
    a. Townsville HHS implements appropriate policy and guidelines in respect to the undertaking and/or use of ultrasounds by midwives.
    b. Townsville HHS reviews the current Medical Imaging Request appointment process in respect to validation of address and notification timeframes.
    c. Townsville HHS review current policy and guidelines in relation to reduced foetal movement and ongoing refresher training for relevant staff.
    d. Townsville HHS reviews the current policy and guidelines in respect to midwifery care and the possible inclusion of a 36 week review of women in the THBC by an obstetrician as part of normal antenatal care.

# 7. Response from Townsville Hospital and Health Service to the Health Quality and Complaints Commission recommendations

On 26 June 2014, the HQCC provided a copy of its draft report to Townsville HHS inviting a response in relation to any comments, findings and the proposed recommendations.

By way of a written response dated 29 July 2014, Townsville HHS submitted that it was not possible to conclude that the management of Mrs A's pregnancy contributed to the death of her baby and, in support, referred to the following comments of Dr D, in particular: '…*I have no evidence that the hospital's management had any direct effect on the death of the baby and therefore the pregnancy outcome*'. In essence Townsville HHS submitted that both Drs C and D concluded that, without a cause of death, the death could not be attributed to the care provided by Townsville HHS.

## 7.1 Townsville Hospital and Health Service response to the lessons learned and the recommendations made in the RCA report

Townsville HHS provided a submission to the HQCC in relation to the RCA report.

### Health Ombudsman's analysis/conclusion

In my view, the submission indicates that Townsville HHS have complied with two RCA recommendations, have not complied with one recommendation and was yet to comply with one recommendation.

## 7.2 Townsville Hospital and Health Service response to the recommendations proposed within HQCC draft report

*Townsville HHS implements appropriate policy and guidelines in respect to the undertaking and/or use of ultrasounds by midwives.*

Townsville Hospital has not formally approved or endorsed a policy with respect to midwives undertaking or using ultrasounds. A process was underway to formally approve a *Point of care Ultrasound* guideline and the guideline had been provided as a resource document for Townsville HHS. '*There is no scope of practise documented for midwives to perform formal ultrasound scans within this recommendation'*.

### Health Ombudsman's analysis/conclusion

Steps have commenced to formally approve a guideline regarding the taking of ultrasounds. This process is still underway and while the relevant recommendation has not yet been implemented in full, work has commenced toward the approval and endorsement of a relevant policy/guideline.

In my view, Townsville HHS has not yet complied with the HQCC draft recommendation.

*Townsville HHS reviews the current Medical Imaging Request appointment process in respect to validation of address and notification timeframes.*

Townsville HHS Medical Imaging Department has reviewed its services, including a review of business rules and these had been updated and improvements identified. All changes of address provided by a patient are now recorded in a Queensland Health Patient Management System at the time the information is provided.

### Health Ombudsman's analysis/conclusion

A review has been undertaken by the Medical Imaging Department with updates and improvements made to ensure that patient information is updated electronically within the patient management system.

In my view, Townsville HHS has complied with the HQCC draft recommendation.

*Townsville HHS review current policy and guidelines in relation to reduced foetal movement and ongoing refresher training for relevant staff.*

The policy and guidelines regarding reported reduced foetal movements has been reviewed and procedures implemented, namely *Management of women who report Decreased Foetal Movements (DFM)* and a Quality Activity Report *Education Plan for new WPI Decreased Fatal* [sic] *Movements*. A copy of the relevant documents were attached to the submission.

The guideline itself makes reference to risk factors and the improvement of the outcome of care for women with DFM.

The Quality Activity Report indicates this policy has been communicated with relevant staff by email, at in-service meetings, in communication books, at unit meetings and a flow diagram placed in all birth suite room folders.

### Health Ombudsman's analysis/conclusion

There is now a policy relating to the management of reports of DFM and this has been disseminated to relevant staff in a number of forums.

In my view the submission indicates that Townsville HHS has complied with the HQCC draft recommendation.

*Townsville HHS reviews the current policy and guidelines in respect to midwifery care and the possible inclusion of a 36 week review of women in the THBC by an obstetrician as part of normal antenatal care.*

A policy review was conducted by the Midwifery Director at Townsville Hospital in July 2014. The model of care utilised by THBC is a Midwifery Continuity of Care model of care for low risk pregnancies and a number of policies and protocols are used as reference guides for the ongoing review of the model. This model, with an interdisciplinary collaborative approach, facilitates midwifery-led care even when complications arise. '*Continuity of midwifery care is valuable and safe for women with varying levels of risk in their pregnancy*' and those with complex needs may particularly benefit from this model of care. Weekly collaborative case reviews with obstetricians ensure that a woman is referred *'to the appropriate care giver at the appropriate time, as the complexity of the women's needs arise'*.

A change to include a defined 36 or 40 week visit is not required as part of a woman's normal care at the birth centre which only provides care for low risk pregnancies. Ongoing review of performance data will ensure safe care for women and their families at the birth centre.

#### Health Ombudsman's analysis/conclusion

Pursuant to the draft HQCC recommendations, Townsville HHS has advised it has reviewed the policy surrounding the model of care utilised at Townsville Hospital and that it has determined that the inclusion of a 36 week review is not required as part of a woman's routine care.

In my view, Townsville HHS has complied with the HQCC draft recommendation in conducting the review and I accept the Townsville HHS view that the 36 week review is not necessary.

# 8. Conclusion

## 8.1 Systemic issues and recommendations

A review and analysis of the response from Townsville HHS indicates that there has been general overall consideration and compliance with the RCA and draft HQCC recommendations.

On the basis of the information reviewed, I am of the view that Townsville HHS has adequately considered the various issues surrounding the care of Mrs A and has implemented appropriate measures to enhance the quality of care (while accepting any risk associated with those areas where changes were deemed unnecessary).

On the basis of the information provided by Townsville HHS, I am of the view that is no need for further monitoring by my office of the implementation of the recommendations.

## 8.2 Performance issues—RM1 and RM2

With respect to RM1 and RM2, I determined that the performance issues raised in the HQCC investigation did not reach the threshold of serious misconduct and, accordingly, on 25 August 2014 a copy of the HQCC draft investigation report was provided to AHPRA for consideration of any further action.

Both AHPRA and the practitioners have been advised of my decision to close the matter.

Leon Atkinson-MacEwen
**Health Ombudsman**

11 December 2014

*Please note: on 12 January 2018 information in this report was redacted and the amended report approved by the Acting Health Ombudsman Andrew Brown.*