Decision 21HDC02225
29 May 2025

HEALTH & DISABILITY COMMISSIONER
TE TOIHAU HAUORA, HAUĀTANGA

Pregnant woman with high BMI not referred to obstetrician

1. In March 2021 Mrs A was in the last trimester[1] of her pregnancy with her first child and under the care of a lead maternity carer (LMC), registered midwife (RM) B. On 3 March 2021 RM B sent a non-acute referral to Health New Zealand|Te Whatu Ora (Health NZ) requesting that an anaesthetist see Mrs A due to her high body mass index (BMI) (40.5). The referral was acknowledged by Health NZ; however, RM B received no further response.

2. Despite having a BMI of over 40 at her initial consultation with RM B in September of 2020, Mrs A was not referred to an obstetrician. The Ministry of Health (MOH) referral guidelines[2] available at the time note that the condition of morbid obesity, defined as a BMI greater than 40, requires the LMC to recommend transfer of clinical responsibility to a specialist (obstetrician) and may also include a consultation with an anaesthetist.

3. RM B told HDC that she was not aware of the referral guidelines relating to a patient's high BMI until 3 March 2021, and she referred Mrs A as soon as she became aware of the guideline requirement. Having reflected on this case, RM B acknowledged that Mrs A qualified for transfer of care to a specialist as opposed to a consultation with the anaesthetic team. RM B assumed that the referral would be viewed by the obstetric team prior to forwarding to the anaesthetic team for a consultation. It was her expectation that Health NZ would contact her if it was considered necessary for Mrs A to see a specialist, and RM B acknowledged that she should have followed up to ensure that the referral had been actioned appropriately. Although she does not intend to practise as an LMC again, RM B told HDC that she has reviewed the referral guidelines extensively and understands her responsibilities during the referral process should the situation arise again.

4. On 18 May 2021 Mrs A was two days past her delivery due date. That afternoon she sent a text message to RM B as she was worried about a reduction in fetal movement. She was advised by RM B to monitor movement and keep in touch. That same evening, Mrs A sent a text stating that she had felt active movement. The next day Mrs A had a post-dates growth scan. RM B received the result the same day. The growth measurements were high but within normal parameters, and the fundal height[3] was measuring larger than dates.[4]

5. On Friday 21 May 2021 Mrs A attended an antenatal appointment with RM B. Mrs A was now five days overdue. RM B discussed sending a referral for induction, to which Mrs A agreed. RM B then sent a semi-acute referral for induction of labour (IOL) to Health NZ. The referral stated that Mrs A had experienced reduced fetal movement over the past few days.

[1] A full-term pregnancy has three trimesters approximately 13 weeks long.
[2] Guidelines for Consultation with Obstetric and Related Medical Services (Referral Guidelines) 2012.
[3] Measurement between the top of the uterus and the pelvic bone.
[4] The uterus is bigger than expected based on the last menstrual period. There can be several reasons for this, including incorrect dates, fetal growth acceleration, maternal diabetes, and fetal abnormality.

Names have been removed to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

Mrs A told HDC that this was not correct, as the reduced fetal movement occurred after the referral had been sent. RM B disputed that the information was false and referred HDC to the text messages of 18 May 2021. She acknowledged that she could have been clearer that reduced fetal movement was not an immediate concern but said that potentially it was relevant clinical information.

6. At the time of the referral, Health NZ was experiencing a full network outage, including email. Consequently, RM B faxed the referral multiple times and made several follow-up phone calls between 21 and 23 May 2021 to ensure that it had been received. On 23 May 2021 RM B was informed that the referral had not been received and therefore, she hand-delivered it to Health NZ on Monday 24 May 2021. That day Health NZ confirmed that it had located the referral and would be in contact.

7. The consultant obstetrician reviewed the referral on 24 May 2021 and phoned Mrs A to discuss the plan for IOL as soon as possible. That afternoon, before the IOL could be arranged, Mrs A texted RN B to report reduced fetal movement. RM B arranged for CTG[5] monitoring to be undertaken in the community at 7.00pm that evening. The CTG showed an absent variability trace,[6] and Mrs A was sent to a public hospital urgently.

8. The CTG remained unchanged at 9.00pm, and a subsequent artificial rupture of membranes (ARM) was performed, which showed thick meconium.[7] Baby A was delivered via emergency Caesarean section at 10.40pm. Following initial resuscitation measures, she was transferred to neonatal intensive care. Baby A was diagnosed with hypoxic ischaemic encephalopathy (HIE), neonatal seizures, and a grade 3 intraventricular haemorrhage (brain bleed).

9. The midwifery scope of practice in New Zealand states:

> '[A] midwife understands, promotes and facilitates the physiological processes of pregnancy and childbirth, identifies complications that may arise in mother and baby, [and] accesses appropriate medical assistance … When women require referral, a midwife provides midwifery care in collaboration with other health professionals.'

10. The MOH referral guidelines available at the time of these events clearly outline situations where referral to specialist services is appropriate and whether the referral should be for consultation or transfer of care. In my view, RM B had a responsibility to be familiar with the MOH referral guidelines and the requirement to recommend transfer of care to an obstetrician for women with a BMI over 40.

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[5] Cardiotocography (CTG) is used during pregnancy to monitor fetal heart rate and contractions. Most commonly it is used in the third trimester to monitor fetal wellbeing and for early detection of fetal distress.
[6] A lack of fetal heart rate baseline fluctuation is considered absent variability. Absent variability is most often a sign of a severely compromised fetus. Fetal compromise can be the result of poor oxygenation.
[7] The earliest stool passed by an infant normally retained in the infant's bowel until after birth. Sometimes it is expelled into the amniotic fluid prior to birth, and the stained amniotic fluid is recognised as a possible sign of fetal distress.

11. Mrs A was provided with a copy of the 'facts gathered' section of this report and given the opportunity to comment. Mrs A told HDC that she had no comments.

12. RM B was provided with a copy of my provisional opinion and given an opportunity to comment. RM B advised that she accepted my findings.

13. RM B failed to follow established MOH guidelines and refer Mrs A to an obstetrician appropriately during the early stage of her pregnancy when it became apparent that she had reached the criteria of morbid obesity. Accordingly, I find that RM B breached Right 4(2)[8] of the Code of Health and Disability Services Consumers' Rights.

14. I acknowledge RM B's reflection and sincere apology to Mrs A and her family included in her response letter to HDC. In response to my provisional decision, RM B provided a formal written apology to Mrs A for the deficiencies identified within the report.

15. I note that RM B has changed career and no longer holds a practising certificate with the Midwifery Council of New Zealand (MCNZ). I recommend that should RM B reapply for a practising certificate, MCNZ consider whether a review of competence is necessary.

16. A copy of the sections of this report that relate to RM B will be sent to MCNZ.

17. A copy of this report with details identifying the parties removed will be sent to MCNZ and the New Zealand College of Midwives and placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

Rose Wall
Deputy Health and Disability Commissioner

[8] Every consumer has the right to have services provided that comply with legal, professional, ethical, and other relevant standards.