Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

Waikato DHB breached Code for services provided to pregnant woman
19HDC02310

Waikato District Health Board (DHB) (now Te Whatu Ora Waikato) has breached the Code of Health and Disability Services Consumers' Rights (the Code) for not providing services with reasonable care and skill to a pregnant woman.

The woman, who was 12 weeks pregnant with twins, presented at the emergency department with headaches and nausea. She required acute management of early onset hypertension for her pregnancy, but there was no effective plan for close monitoring in the community.

The woman was later admitted to hospital for monitoring, due to concerns about intrauterine growth restriction and an abnormal heart rate in one of the twins. The woman remained in hospital until the delivery of her babies.

It was subsequently confirmed that only one fetal heartbeat was present, and the woman was told that one of her babies had passed in utero. That same day the twins were delivered by emergency Caesarean section and attempts to resuscitate one of the twins were not successful. The other baby was born in good condition.

The woman told HDC that when she learned one of her babies had died, she told medical staff she needed to ensure they had whānau to care for them while she was unable to. Whānau were not notified, nor was a cultural support person sourced to be with the woman (who is Māori) while she worked through the immediate aftermath of losing her baby.

Rose Wall, Deputy Health and Disability Commissioner, found Waikato DHB breached Right 4(1) of the Code which gives all consumers the right to have services provided with reasonable care and skill.

Ms Wall accepted the circumstances were challenging, but the cumulative deficiencies in the care provided amounted to the breach.

She was critical of Te Whatu Ora Waikato's care following the first ED review when an effective plan was not made for close monitoring in the community. She was also critical that medical input was not sought when two separate heartbeats could not be identified clearly, and of the decision over whether to deliver the babies early.

Ms Wall recommended Te Whatu Ora Waikato provide a written apology, train staff on the management and monitoring of hypertension and pre-eclampsia in twin pregnancies and provide HDC with a copy of its cultural/kaupapa training framework,

outlining how the practice of tikanga with patients and their whānau is developed with all hospital staff.

30 October 2023

ENDS

Editor's notes

The full report of this case will be available on HDC's website. Names have been removed from the report to protect privacy of the individuals involved in this case.

The Commissioner will usually name providers and public hospitals found in breach of the Code, unless it would not be in the public interest, or would unfairly compromise the privacy interests of an individual provider or a consumer.

More information for the media, including HDC's naming policy and why we don't comment on complaints, can be found on our website here.

HDC promotes and protects the rights of people using health and disability services as set out in the Code of Health and Disability Services Consumers' Rights (the Code).

Health and disability service users can now access an animated video to help them understand their health and disability service rights under the Code.

In 2021/22 HDC made 402 recommendations for quality improvement and providers complied with 98% of those recommendation.

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