Decision CAS-14101-N4P9Y3
15 May 2026

HEALTH & DISABILITY COMMISSIONER
TE TOIHAU HAUORA, HAUĀTANGA

Delayed recognition of uterine rupture

Complaint summary

1. This complaint concerns delayed recognition of a uterine rupture (a tear in the uterus) during an induction of labour. Mrs A (28 years old at the time of events) was admitted to North Shore Hospital, Health New Zealand | Te Whatu Ora – Waitematā (Health NZ) on 1 September 2022 for an induction of labour because she postdates (41 weeks' gestation). Mrs A has raised concerns that a 'she'll be right' attitude during the overnight shift between 1 and 2 September 2022 and a lack of attentive patient-focused care and communication contributed to a delay of over one hour in midwifery staff recognising that she had suffered a uterine rupture.

2. This event resulted in Mrs A having a severe haemorrhage (estimated 5.5L blood loss) and, sadly, Baby A suffered severe hypoxic ischaemic encephalopathy[1] and passed away at home in September 2022. I offer my sincere condolences to Mrs and Mr A for the loss of their child.

3. Having reviewed all the information gathered in relation to this complaint, it is my view that maternal observations and cardiotocography (CTG; used to monitor fetal heart rate (FHR) and uterine contractions) should have been completed at around 4am and that the failure to do so amounted to a breach of Right 4(1)[2] of the Code of Health and Disability Services Consumers' Rights. It is also my view that Health NZ – Waitematā ultimately holds the responsibility for this breach. This report outlines how I have formed these views. From the outset, I would like to be clear that, although maternal observations and a CTG at around 4am may have resulted in earlier identification of the uterine rupture and associated fetal distress, this cannot be known for certain. My role is to determine whether an appropriate standard of care was provided to Mrs A, and I am not in a position to determine whether monitoring and observations at 4am would have changed the outcome.

Background

4. Mrs A was admitted to the birthing suite for induction of labour at 7.30am on 1 September 2022. The first dose of misoprostol[3] (25mcg) was given at 9am, with subsequent doses at 11am, 1pm, 3pm, 5.45pm, 7.15pm, and 9.45pm.

5. Midwifery care of Mrs A was handed over to Registered Midwife (RM) B around 11pm. At 11.48pm, RM B commenced a CTG, which showed a baseline FHR of 130 beats per minute

[1] A brain injury that occurs when a baby's brain doesn't receive enough oxygen or blood flow.
[2] Every consumer has the right to have services provided with reasonable care and skill.
[3] A medication used to induce labour by softening the cervix and stimulating uterine contractions.

Names have been removed (except the midwifery advisor on this case and Health New Zealand | Te Whatu Ora – Waitematā) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

(bpm)[4] with good variability and accelerations. There were some short periods of loss of contact. In light of the absence of established labour and the normal CTG at 11.48pm, the decision was made to proceed with an eighth and final dose of misoprostol, which was given at 12.20am on 2 September 2022. It was noted that, around this time, Mrs A was using a TENS machine[5] and requested additional pain relief. Mrs A was given codeine. The CTG was discontinued, and the plan was for Mrs A to rest and call if she had any concerns.

6. Although it is not documented, Mrs A and her husband stated that, at 3.30am, Mrs A was screaming in agony and RM C entered the room to check on her. Mrs and Mr A reportedly told RM C that Mrs A was experiencing pain in her shoulders and hips and that her contractions were not fully relaxing. They recall that RM C then left the room to get RM B.

7. RM C recalls responding to Mrs A and that Mrs A was 'screaming in agony.' RM C told the Health and Disability Commissioner (HDC) that she then went to the office hub where RM B and Clinical Charge Midwife (CCM) D were and advised them that Mrs A was in a lot of pain and had reported shoulder tip pain. RM C recalls that, before she was called away to an emergency, she made a comment that she hoped Mrs A wasn't bleeding as shoulder tip pain is a sign of bleeding.

8. Around 4am, RM B checked on Mrs A and suggested she shower and use a wheat pack to help with the shoulder tip pain. RM B also gave Mrs A some paracetamol to try to relieve the pain.

9. RM B documented[6] that she had discussed this care plan with RM C and CCM D. However, RM C stated that, although she may have agreed that an initial response would include paracetamol, she was neither involved in nor asked to provide an opinion on the overall care plan for Mrs A after the initial pain relief.

10. None of the midwives involved have any recollection of a report that Mrs A's contractions were not relaxing.

11. After RM B's 4am check on Mrs A, RM B was busy attending to another patient.

12. At 5am, RM B checked on Mrs A while she was in the shower and noted that she appeared exhausted and a bit faint, so she suggested she get out of the shower for observations and a CTG. On examination, RM B found that Mrs A's heart rate was high (138bpm) and temperature was low (35.8°C).[7] A CTG initially showed an FHR around 100bpm (low), but contact was lost many times before a heartrate of 140bpm was picked up. RM B was concerned that this was the maternal heart rate being picked up and sought advice from CCM D. RM B also noted that Mrs A was wincing in pain during a contraction and her uterus was not relaxing between contractions.

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[4] Normal range is 110–160 bpm.

[5] A machine that passes a weak electrical current to the nerves, which can help ease pain.

[6] Retrospectively because of the acuity at 6.20am after the emergency c-section was performed.

[7] 'Normal' ranges have been determined by the maternity early warning system (MEWS) short-stay maternity vital signs chart: MEWS_short-stay_MVSC_Aug2020.pdf.

13. CCM D assessed Mrs A and requested a review from obstetric registrar Dr E. Dr E started Mrs A on intravenous fluids and oxygen and called in the senior obstetric registrar. Around 5.16am, the senior obstetric registrar undertook a bedside ultrasound that found 'free fluid' in the upper abdominal cavity, and a vaginal examination (VE) indicated that Mrs A was 9cm dilated. The senior obstetric registrar's clinical impression at that time was that a placental abruption[8] had occurred. An obstetric emergency was called (around 5.25am), and the decision was made to proceed to emergency caesarean section (c-section). An obstetric consultant was called to attend.

14. At 5.34am, Baby A was born via c-section. During the operation, it was identified that a posterior uterine rupture had occurred with a massive haemorrhage (estimated blood loss of 5.5L).

Further information gathered

Health NZ

15. Health NZ have noted that the discussion between RM B, RM C, and CCM D regarding Mrs A's new hip and shoulder pain around 4am took place in the presence of obstetric registrar Dr E. However, Dr E has stated that she was documenting another assessment at the time the discussion occurred and had assumed the concern was musculoskeletal in nature and did not feel the need to intervene.

16. Health NZ completed an adverse event review (AER), which identified that closer observation after the last dose of misoprostol and subsequently an earlier VE may have prevented this event from occurring. The AER stated that, had checks been more regular between 12.20am and 4am, and at 4am when it was clear that Mrs A was awake, it is likely that Mrs A would have been offered a VE sooner, been transferred to a birthing room, her lead maternity carer midwife would have been called, and closer monitoring of both Mrs A and her baby would then have occurred. However, the AER also notes that the policy at the time only recommended four-hourly checks during induction of labour.[9]

17. The AER noted that the birthing unit was one staff member short, with a charge midwife and two midwives on night shift (compared with Care Capacity Demand Management recommendations, which require a charge midwife and three midwives on night shift), which is likely to have contributed to the staff workload. The AER noted that having one additional midwife on shift could have prevented this event from occurring.

18. The AER also noted that communication between staff was of poor quality and that, although the extent to which this may have caused a delay in the assessment of Mrs A is unclear, it is an area that could be improved.

19. Further, the AER stated that the possible significance of the reported pain in Mrs A's shoulder and hip was not recognised by the staff on duty, and vital signs were not taken before or after escalation of these concerns. The AER stated that any signs or symptoms not

[8] Separation of the placenta from the uterine wall before the baby is born.

[9] Note that, although usual practice would be to not wake a sleeping woman to undertake these observations, this is not relevant in this case because Mrs A was awake.

fitting the usual expected pattern would normally be escalated to the level required to determine a cause. However, shoulder tip pain is a very unusual symptom in labour, and the staff did not make a connection between this and bleeding into the peritoneum as it was not a diagnosis staff were anticipating.

20. In response to this complaint, Health NZ stated that many pregnant women experience a variety of aches and pains related to musculoskeletal changes in pregnancy, and most respond to symptomatic relief such as analgesia, heat treatment, relaxation and massage. Health NZ told HDC that staff assumed the pain was musculoskeletal and that it would be relieved by warm water treatment. Health NZ stated that, with the benefit of hindsight, this shoulder pain was clearly an indication of bleeding into the peritoneum, but unfortunately staff did not immediately make this association.

21. The AER noted that, from the time the obstetric code was called, the emergency response was exemplary.

22. Health NZ has made several changes since the time of events, including:

- Updating the induction of labour guidelines to include two-hourly check-ins overnight to observe for contractions, discuss with the woman/pregnant person any concerns they may have and document them. If the woman/pregnant person is contracting, CTG is to be commenced and a VE considered. If there are any concerns about fetal wellbeing, the frequency of monitoring overnight must be discussed with a registrar or consultant and a plan documented.
- Introducing the MEWS.[10]
- Increased staffing on the birthing suite from one charge midwife and two midwives to one charge midwife and three midwives as per the Care Capacity Demand Management recommendations.
- This case has been discussed at both consultant-level meetings and wider staff meetings and used for staff learning.
- Issued staff with ISBAR communication tool[11] lanyard cards to keep this structured form of communication method at the forefront of their practice.
- Introduced BadgerNet electronic maternity clinical records to improve communication between practitioners.

RM B

23. RM B has confirmed that she was a new graduate midwife in her first six months of practice at the time of events. RM B stated that, since then, she has reflected extensively on what happened and that it has shaped the way she practices today.

[10] A system that supports the recognition of and response to deteriorating women in short-stay/assessment areas of hospitals.

[11] A structured communication tool used in health care to facilitate clear and concise information exchange. ISBAR stands for Identify, Situation, Background, Assessment, Recommendation.

24. RM B stated that, when shoulder pain was reported, she did not link this to a uterine rupture but noted that she was sufficiently concerned to escalate it to the more senior midwives on the shift.[12] RM B stated that, as a junior midwife, she followed the recommendations from the more senior midwives to offer Mrs A paracetamol and suggest a warm shower as they believed the issue was musculoskeletal.

25. With the benefit of hindsight, RM B agrees that a CTG and maternal observations performed at that time could have assisted in earlier recognition of the fetal distress and uterine rupture. She agreed that this was a moderate departure from standard six of the College of Midwives' Standards of Practice[13] by the midwifery team.

26. RM B also referred to the fact that the midwifery team were one staff member down and noted that it was a busy shift because of this and she felt unsupported in her workload. On reflection, she acknowledges that she should have spoken up to ask for further support to ensure safe practice for the women and babies under her care. RM B also stated that she ensured Mrs and Mr A knew where the call bell was and that they could use it to call her at any time but has reflected that she feels she relied too heavily on Mrs and Mr A calling for assistance.

27. RM B told HDC that she has made the following changes to her practice:

- She spends more time in the room observing her patients and checking in frequently, particularly on night shift.
- She continues to follow guidelines, protocols, and the advice of senior midwives closely but now places more emphasis on her own midwifery observations and intuition and will take action if she has any concerns or symptoms that she does not recognise, regardless of the recommendations of others.
- She has improved the accuracy of her documentation, and the ISBAR tool guides all consultations she has with other staff.
- She pays closer attention to the use of MEWS and checks vital signs routinely and any time she is concerned about the wellbeing of a mother or baby.
- Before taking a career break, RM B undertook further training with a clinical coach to upskill and completed the New Zealand College of Midwives' documentation workshop to improve her documentation. Since returning to practice, RM B has also completed a midwifery emergency skills refresher and attended a Fetal Surveillance Education Programme and neonatal resuscitation education days. RM B has also volunteered for clinical coaching shifts to refresh and further develop her labour and birth skills.

[12] CCM D and RM C – although RM C denies she agreed that paracetamol or a shower was the overall care plan and noted that she would not have made a plan that only included pain relief.

[13] Standards of Practice - New Zealand College of Midwives - New Zealand College of Midwives. Accessed 22 August 2025. Standard six: 'Midwifery actions are prioritised and implemented appropriately with no midwifery action or omission placing the woman at risk.'

ACC

28. ACC approved a treatment injury claim for Mrs A's uterine rupture, placental abruption, and intrapartum haemorrhage necessitating a c-section. ACC also approved a treatment injury claim for Baby A for asphyxia, hypoxic ischaemic encephalopathy, and subsequent death.

29. In assessing whether a treatment injury occurred, ACC obtained midwifery advice and specialist obstetric advice. The midwifery advice noted that maternal vital signs should have been taken to assess maternal wellbeing when Mrs A first reported hip and shoulder pain, around 4am. The midwifery advisor concluded that if a more thorough assessment of maternal and fetal wellbeing had been made at that time, it is likely that an earlier diagnosis would have been made, and urgent action and intervention would probably have occurred at least 30 mins earlier. However, ACC's midwifery advisor also stated that it is important to acknowledge that the rarity of uterine rupture means it is not a usual diagnosis that staff could have anticipated and that literature suggests that signs and symptoms of uterine rupture after induction with misoprostol are nonspecific, which makes diagnosis difficult and can lead to delay.

30. The obstetric advice noted that the uterine rupture could not have been prevented but that earlier intervention by the obstetric team could have prevented the sequelae of the uterine rupture, namely the placental abruption, massive blood loss, and Baby A's asphyxia.

In-house midwifery advice

31. To assist in my assessment of this complaint, I sought advice from my in-house midwifery advisor, RM Nicholette Emerson.

32. RM Emerson advised that, even though shoulder pain would not necessarily have been associated with bleeding, it was of sufficient concern to prompt RM B to consult her colleagues. She also advised that a full set of maternal observations and auscultation of the FHR (e.g. via CTG) would have been an appropriate course of action at that time. RM B did not complete these observations, and RM Emerson advised that this represents a moderate departure from accepted midwifery practice. However, RM Emerson noted that the fact that RM B discussed Mrs A's shoulder pain with her colleagues, including the CCM, and neither a set of observations nor a CTG was suggested is a mitigating factor.

33. Further advice from RM Emerson also stated that the deficit in expected guidance from RM C and CCM D to RM B was a moderate departure.

34. RM Emerson noted that this appears to have been a missed opportunity to either reassure or escalate the concerns but acknowledged that it is impossible to determine retrospectively whether a set of maternal observations and a CTG at that time would have changed the outcome.

35. RM Emerson also noted that the actions at 5am were in keeping with accepted midwifery practice.

Responses to my provisional opinions

36. Mrs and Mr A were given an opportunity to comment on my first provisional opinion and made comments that prompted me to seek additional expert advice from RM Emerson and further information from the midwives involved in Mrs A's care. Most notably, Mrs and Mr A emphasised the lack of response to the concerning symptoms Mrs A was displaying at 3.30am. After receiving this further information and advice, I issued a second provisional opinion. Mrs and Mr A had no further comments on my second provisional opinion.

37. Health NZ Waitematā was given an opportunity to comment on both of my provisional opinions and accepted both.

38. RM B was given an opportunity to comment on both of my provisional opinions. She agreed with the findings in my first report, and the further information and comments she provided were incorporated into my second report. RM B had no further comment in response to my second provisional opinion.

39. RM C was given an opportunity to comment on both of my provisional opinions. Her comments in response to my first report were incorporated into the relevant sections of my second report. Notably, she denied that she agreed that paracetamol or a shower was the overall care plan for Mrs A's shoulder tip pain and noted that she would not have made a plan that only included pain relief. RM C accepted my second provisional opinion.

40. CCM D was given an opportunity to comment on both of my provisional opinions. She agreed with the findings of my first report and provided further information that was incorporated into my second report. CCM D did not provide a response to my second provisional opinion.

41. I also note that neither CCM D nor RM C are currently practicing or registered to practice midwifery.

Opinion: Health NZ – Waitematā – breach

42. Having reviewed all the information gathered in relation to this complaint, it is my view that the midwifery care provided to Mrs A on 2 September 2022 amounted to a breach of Right 4(1) of the Code.

43. I acknowledge that uterine rupture during induction of labour is rare and so was not anticipated by the midwifery staff and that shoulder and hip pain in labour is a non-specific symptom, which contributed to the difficulty in connecting this with uterine rupture. However, I accept RM Emerson's advice that, although shoulder and hip pain would not necessarily have been immediately associated with bleeding, RM B was concerned enough to consult with her more experienced colleagues, and a full set of maternal observations and auscultation of the FHR (via CTG) would have been an appropriate course of action at that time. I also accept RM Emerson's advice that these observations not being completed represented a moderate departure from accepted midwifery practice and was a missed opportunity to either reassure or escalate the concerns.

44. RM Emerson further advised that, by not suggesting observations be taken before concluding that musculoskeletal pain was responsible for Mrs A's shoulder tip pain, there was a deficit in the expected guidance from RM C and CCM D to RM B, which amounted to a moderate departure from accepted midwifery practice. I accept this advice. However, I acknowledge that RM C denies agreeing that paracetamol and a shower was the overall care plan in response to the shoulder-tip pain and that she recalls commenting that she hoped Mrs A was not bleeding as shoulder-tip pain could be a symptom of this. I note that RM B's documentation from that night states that she had discussed the care plan with RM C and CCM D. I also note that neither RM B nor CCM D noted that any comment was made about the shoulder-tip pain being a possible sign of bleeding, and there is nothing in the documentation to suggest that this was considered. On balance, I accept it is possible that RM C made a comment about the possibility of bleeding, but if this comment was made, it was not communicated effectively to RM B or CCM D and was therefore not considered. Further, I accept that RM C was present for at least part of the conversation that took place with RM B and CCM D (before being called away to an emergency), but her level of involvement in the discussion is not clear.

45. Overall, I consider that a reasonable standard of care would have been for maternal observations and a CTG to have been completed around 4am. I also consider that the responsibility for this not occurring ultimately lies with Health New Zealand for the following reasons. RM B was a junior midwife (registered for approximately 6 months at the time of events) who sought guidance from the more senior midwives on the shift. The guidance provided to RM B also fell below the accepted standard as there was no suggestion that observations be taken before concluding that Mrs A's shoulder tip pain was musculoskeletal. As such, the responsibility to initiate maternal observations and a CTG around 4am was not RM B's alone but shared by the midwifery staff on that shift.

46. I also note that Health NZ's AER identified that communication between staff was of poor quality and that the birthing unit was one midwife short that night. I am concerned that being one midwife short likely created a greater workload and increased time pressure on the midwifery staff (particularly as this was a 25% reduction in staffing) and that poor communication would have exacerbated any existing risks of things being overlooked.

47. In summary, I consider that Mrs A was not provided services with reasonable care and skill as the failure to complete maternal observations and a CTG around 4am was a moderate departure from accepted practice. As outlined above, I consider that Health NZ is ultimately responsible for this departure. I therefore find that Heath NZ Waitematā breached Right 4(1) of the Code.

Recommendations

Health NZ – Waitematā

48. I recommend that Health NZ – Waitematā provide a written apology to Mrs and Mr A for the lack of observations being taken around 4am and overall delayed recognition of uterine rupture. The written apology is to be sent to HDC within three weeks of the date of this report for forwarding to Mrs and Mr A.

49. I acknowledge that Health NZ has made several changes as a result of these events. I am satisfied that the changes to the induction of labour guidelines, introduction of MEWS, increased staffing on the birthing suite, discussion of this case among staff for educational purposes, and changes made to improve communication between staff will assist in preventing a recurrence.

50. I note that the AER recommended that this case be written up in a medical journal for others to learn from but that this has not been completed. Health NZ has advised that the Associate Clinical Director of Obstetrics at the time of events, has agreed to undertake the writing of a case report with an aim to have it published in the *Australian and New Zealand Journal of Obstetrics and Gynaecology*. As acceptance for publication is not within Health NZ's control, Health NZ proposes to disseminate the case through alternative means if possible (including the RANZCOG Network or the National Maternity Network) if the case report is not to be published within a reasonable timeframe. I recommend that Health NZ provide a progress update to this Office on the case report and its publication/dissemination within 6 months of the date of this report.

RM B

51. I note that, as at April 2024, RM B is no longer working for Health NZ as a midwife but does hold a current practising certificate. In my first provisional opinion, I recommended that, in recognition of her relative inexperience, RM B reflect on her practice in light of this report and report back to HDC on any changes she has made or will make to her practice (including any further training she has undertaken) within six weeks of the date of this report. RM B provided this reflection in her response to my first provisional opinion.

Follow-up actions

52. A copy of this report will be sent to the Midwifery Council under section 59(4) of the Health and Disability Commissioner Act 1994. The Midwifery Council may determine whether RM B is required to undertake any further training and whether RM C or CCM D are required to undertake any additional training should they return to clinical practice.

53. A copy of this report with details identifying the parties removed, except my in-house midwifery advisor, and Health NZ – Waitematā will be placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

Rose Wall
Deputy Health and Disability Commissioner

Appendix A: In-house midwifery advice to the Commissioner

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

'CONSUMER: [Mrs A] ([Baby A])

PROVIDER: North Shore Hospital Staff Midwives

FILE NUMBER: C24HDC00418

DATE: 18 February 2025

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1. Thank you for the request that I provide clinical advice in relation to the complaint from Mrs [A] about the care provided by NSH [North Shore Hospital] staff midwives. In preparing the advice on this case, to the best of my knowledge I have no personal or professional conflict of interest. I agree to follow the Commissioner's Guidelines for Independent Advisors.

2. I have reviewed the documentation on file:
   - Complaint from [Mrs A] via the National Health and Disability Advocacy Services
   - Te Whatu Ora Waitematā Response and enclosures, including clinical records, staffing template, patient episode-acuity report, WDHB Massive Transfusion Protocol.

3. Background: [Mrs A] was 28 years old and in her first ongoing pregnancy in 2021, having had two miscarriages. She had a history of hypothyroidism but normal thyroid-stimulating hormone (TSH) during this pregnancy. She was group B streptococcus positive, and her body mass index was normal, at 21. The pregnancy was under the care of a lead maternity carer midwife. The Maternal Serum Screening (MSS1) was low risk; however, the nuchal translucency was increased and therefore was followed by non-invasive prenatal testing (NIPT) and a referral to Maternal Fetal Medicine (MFM). [Mrs A] was discharged from MFM following her normal anatomy scan with no further action required. A postdates induction of labour (IOL) was scheduled for 41 weeks' gestation. [Mrs A] was known to have a uterine fibroid and a large for gestational age (LGA) baby. [Baby A] measured on the 97th centile on scan at 39 weeks +4 days.

   IOL was commenced at 41 weeks' gestation, and eight doses of misoprostol were given. [Mrs A] went on to experience a ruptured uterus and massive blood loss. [Baby A] was born by emergency Caesarean and was flat at birth, requiring full resuscitation. [Baby A] was severely asphyxiated with severe hypoxic ischemic encephalopathy (HIE). Subsequently, [Baby A]'s care entered a palliative pathway. Sadly, he died at 20 days of age [in] September 2022. [Mrs A] accepts the tragic event of uterine rupture; however, her complaint regards the failure of the staff midwives to recognise and respond in a timely manner. She states that, in the meeting with Waitematā, the Obstetrician advised that "Had the midwives acted earlier, it is possible that [Baby A] may still be alive." Despite

the conclusions of the Waitematā internal investigation, [Mrs A] remains unhappy with the inclusion of a new midwife being assigned to the induction room.

> *"… Our experience being induced at North Shore Hospital began with very high-quality treatment and we were extremely pleased with the level of care we received between 7am and 7pm. This consisted of a range of clinical observations and regular checks into our physical and mental wellbeing. Our midwife during the day took the time to get to know us and it was clear they genuinely cared about us and our son. We believe that the horrific outcome of our induction process, which led to the death of our son, [Baby A], was the result of negligent and 'she'll be right' care during the night. While the uterine rupture itself was an unavoidable tragedy, more attentive patient-focused care and improved communication between staff during the night would have caught the rupture sooner and made all the difference for our son. It is our hope that the experience from that night and the findings from this report would challenge all midwives and associated medical staff to approach every shift with the knowledge that, as parents, we are placing the lives of our babies in your hands."*

In writing this advice, I acknowledge the profound trauma and loss of precious [Baby A] and extend my heartfelt sympathy. I hope this report addresses some of the unanswered questions for Mrs [A], Mr [A], and their whānau.

4. Advice request: Can you please review the midwifery care provided overnight and advise on the standard of the midwifery care based on what the team knew at the time and whether it departed from acceptable standards and, if so, the extent of the departures.

As outlined above, this was Mrs [A]'s first ongoing pregnancy, and she was scheduled to have an IOL at 41 weeks' gestation. During the course of the day of induction, [Mrs A] was given seven doses of misoprostol as per protocol. [Mrs A] was satisfied with the care she received during the course of the day, and her complaint is centred on the overnight care.

Following the seventh dose of misoprostol at 10pm, a vaginal examination demonstrated an uneffaced cervix that was 1cm long and that [Baby A]'s head was high (labour had not established). Amniotic membranes (waters) were intact.

Mrs [A]'s care was handed to RM [B] at 11pm. At 12.20am, RM [B] introduced herself and has documented that [Mrs A] was struggling with painful contractions and requested codeine. This was given as charted at 12.00am.

A CTG was commenced at 12.21am, and the CTG is documented to have demonstrated all the features of a CTG within normal parameters.

An eighth dose of misoprostol was given as charted. RM [B] has then recorded that she was leaving [Mrs A] to rest but that she to call if anything was needed.

3.30am: According to the Adverse Event Review, [Mrs A] and her husband report that they alerted that contractions were not completely relaxing. This has not been documented in the clinical notes.

4am: RM [B] has documented that [Mrs A] is struggling with shoulder and hip pain. It is documented that [Mrs A] describes the pain as crampy. Shower and warm pack suggested, paracetamol is given as charted.

Of note

- Page 2 of the Waitemata adverse event review report states that Mrs [A]'s shoulder and hip pain was discussed by RM B with the clinical charge midwife (CCM) RM D in the presence of a registrar, Dr [E].
- RM [B]'s retrospective documentation records at approximately 4.30am that she discussed the shoulder and hip pain with both an RM colleague, RM [C], and the CCM, who both suggested [Mrs A] take some paracetamol.
- RM [B] returned to check on [Mrs A] at 5am and describes her in the retrospective clinical documentation as still in the shower and looking exhausted. RM [B] suggested that [Mrs A] get out of the shower for a CTG and maternal observations. [Mrs A] is described as looking "a bit faint." Maternal observations were temperature 35.8 (abnormal – MEWS 1), blood pressure 127/75 (normal range – MEWS 0), maternal heart rate 138bpm (abnormal – MEWS 3), and oxygen saturation on air (98 – normal range – MEWS 0).

Maternity Early Warning System (MEWS)

https://www.hqsc.govt.nz/resources/resource-library/maternity-early-warning-system-mews-short-stay-maternity-vital-signs-chart-mvsc/

The national maternity early warning system (MEWS) short-stay maternity vital signs chart supports the recognition of and response to deteriorating women in short-stay/assessment areas, such as women's assessment units, postnatal wards for low-risk women, or other short-stay units.

The short-stay maternity vital signs chart is designed for midwives and nurses to use for any pregnant woman, or recently pregnant woman (from pregnancy test positive up to and including 42 days after the pregnancy ends), who is assessed as requiring observations of vital signs for assessment or for a short-stay period.

https://www.hqsc.govt.nz/our-work/improved-service-delivery/patient-deterioration/workstreams/maternity-early-warning-system/

The system includes:

- *a standardised maternity vital signs chart (or electronic equivalent) with an early warning score*
- *a localised escalation pathway.*

Mrs [A]'s MEWS score was 4 following observations. This was based on the maternal heart rate and maternal temperature. The guidance for escalation of a MEWS score in the "pink zone" (maternal heart rate in this instance) indicates that the patient is likely to deteriorate quickly. Obstetric and CCM review is advised within 20 minutes.

The CTG was attached, and initial fetal heart rate recording was 100bpm (abnormal). The clinical notes record (lots of) loss of contact (this means it was difficult for the CTG to pick up fetal heart rate continuously). The fetal heart rate was then picked up at 140bpm (normal), and RM [B] was concerned that the CTG was now picking up the maternal heart rate (which had been 138bpm). RM [B] palpated a contraction and documents that it did not appear to "ease off." [Mrs A] confirmed that the contraction had not fully "eased."

RM [B]'s actions in asking [Mrs A] to leave the shower and to undertake maternal observations and CTG were reasonable. It was also reasonable to be concerned that the CTG was not picking up the fetal but maternal heart rate.

RM [B] left the room to request the opinion of the CCM. RM [B] records in the retrospective notes that she was concerned about the CTG, maternal pulse and that [Mrs A] "doesn't seem right."

From this point, care escalated rapidly with alerting the registrar, a bedside scan, a 777 obstetric code red, and transfer to theatre. This was followed by [Baby A]'s birth by emergency caesarean, activation of the massive blood loss protocol, and [Baby A]'s full resuscitation.

The actions at 5am are in keeping with accepted midwifery practice with no departures identified.

The issues raised in the complaint are regarding:

1) Earlier recognition and escalation by overnight midwifery staff
2) The inclusion of a new midwife in the clinical area of induction.

It is not clear from the adverse event report whether RM [B] was a new midwife, so I am unable to comment on this.

At 4am, [Mrs A] is documented as cramping in the shoulder and hip. Shoulder pain is noted to be a very unusual symptom during induction; however, this was thought to be musculoskeletal pain at the time.

RM [B] did not complete a set of maternal observations and a CTG at this point. The pain was thought to be muscular, and Panadol, hot shower, and a heat pack was suggested.

It is unclear whether there were one or two instances where RM [B] has discussed the shoulder and hip pain with her colleagues. The adverse events review states that RM [B] had a discussion with the CCM in the presence of the obstetric registrar at 4am. RM [B]'s

clinical documentation at 4am records the pain but no record of having discussed this with any colleagues.

Retrospective clinical documentation records RM [B] having discussed Mrs [A]'s hip and shoulder pain at (about) 4.30am with the CCM and another RM colleague.

In forming an opinion, the following has been considered

- The purpose of staying in hospital during IOL is to be monitored
- RM [B] did escalate her concerns to her colleagues, and neither a full set of maternal observations nor a CTG was suggested.

It is impossible to determine retrospectively whether a set of maternal observations and a CTG at 4.30am would have changed the outcome. It does seem reasonable, however, to have performed a set of maternal observations and listen to the fetal heart rate at 4.30am. This may have provided reassurance or clinical indication to escalate concerns.

Whilst RM [B] did not undertake the observations, it is noted that she discussed her concerns with the CCM and a colleague, and this was not suggested.

The IOL policy provided states:

> *Arrange obstetric review if any concerns at any stage of the induction process.*

It is noted that the Waitematā policy regarding misoprostol IOL has been reviewed and updated (April 2024) to include the following:

> *Monitoring women/pregnant people being induced with misoprostol*
>
> *1. Doses of misoprostol must only be given if the CTG is normal. If there are any concerns with the CTG, discuss with the clinical midwife manager (CCM) and/or RMO/SMO*
>
> *2. MEWS profile should be used for vital signs prior to onset of labour. For IOL, this is 4 hourly but maybe required more often depending on clinical risk factors.*
>
> *3. After 8 doses* ***or at midnight****, encourage the woman/pregnant person to rest.*
>
> *4. Overnight, undertake 2-hourly check-ins, observe for contractions, discuss with the woman/pregnant person any concerns they may have and document in MCIS.*

5. If contracting, commence CTG and consider vaginal examination. If there are any concerns about fetal wellbeing, the frequency of monitoring overnight must be discussed within an RMO/SMO and a plan documented in MCIS.

6. Observations and MEWS should be continued overnight as per MEWS profile.

Note: low-dose oral misoprostol reaches peak serum levels within 30 minutes. It has a half-life of 90 minutes and duration of action of approximately 2 hours.

Summary

It cannot be confirmed from available information whether RM [B] was a new practitioner.

There appears to have been a missed opportunity to either reassure or escalate concerns. A full set of maternal observations and auscultation of the fetal heart would have been an appropriate course of action at 4.30am. In not doing so, there is a moderate departure from accepted midwifery practice.

It is noted that shoulder and hip pain would not necessarily have been associated with bleeding; however, they were symptoms that prompted RM [B] to consult her colleagues.

NZCOM Midwives Handbook for practice
Standard Six
Midwifery Actions are prioritised and implemented appropriately with no midwifery action or omission placing the woman at risk
Identifies deviations from the normal, and after discussion with the woman, consults and refers as appropriate.

Mitigating factors include that discussion with colleagues had taken place and there was no recorded suggestion that maternal observations or fetal heart auscultation take place.

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

Further advice from RM Emerson

'CLINICAL ADVICE – MIDWIFERY

CONSUMER: Mrs [A]

PROVIDER: North Shore Hospital Midwives

FILE NUMBER: C24HDC00418

DATE: 2 September 2025

1. Thank you for the request that I provide additional clinical advice in relation to the care provided to Mrs [A] by North Shore midwives. 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:

   - Response to PO from Mrs [A]
   - Response and reflection from RM [B]
   - Response from Health NZ

   Additional advice request

1. **Mrs [A]'s statement that shoulder tip pain is commonly taught in midwifery training as a potential flag for uterine rupture, and the texts she has referred to.** Shoulder tip pain may be present in midwifery texts; however, ANY symptom of concern that is being reported during IOL warrants a full set of maternal/fetal observations, including abdominal palpation and CTG. These findings form the basis of the level and urgency of any required escalation. The observations also provide the basis of an emerging trend or an indicator of a differential diagnosis.

2. The standard of midwifery care provided to [Mrs A] by Health New Zealand (ie, taking into account systems issues identified by Health NZ, the junior status of RM [B], and the involvement of RM [C] and CCM [D] with regard to the reported shoulder tip pain).

3. If [Mrs A] did report that her contractions were not fully easing at 3.30am, should this have prompted further action by the midwifery staff, either as a stand-alone issue or combined with the reported shoulder tip pain.

   The reporting of contractions not easing would be considered a stand-alone red flag for uterine rupture or uterine hyperstimulation. There is a differing account of Mrs [A]'s experience at 3.30am, with [Mrs A] stating that she was screaming in agony and reporting shoulder tip pain and contractions that were not relaxing. She states that, at approximately 3.30am, RM [C] heard her screaming and entered the room.

Assessment was delegated to RM [B]. In RM [B]'s response to the PO, she acknowledges that vital signs and assessment were warranted but refutes that contractions "not easing" were reported to her at 3.30am.

It is agreed that vital signs and assessment of maternal/fetal wellbeing were warranted but not carried out by RM [B]. A moderate departure from accepted midwifery practice has been identified. She has reflected on this, taken responsibility, and subsequently changed her practice.

RM [B] notes that observations and assessments were not recommended by senior staff; however, she acknowledges that the deviation from accepted practice is a reflection on her practice and takes responsibility for that.

On further reflection of my original advice, the following has been considered

- RM [B] was in her first week in the birthing suite, having graduated 6 months previously.
- Although the responsibility to undertake observations sat with RM [B], she sought advice and guidance from both senior colleagues, RM [C] and CCM [D].
- CCM [D] and RM [C] assumed musculoskeletal pain and did not suggest or undertake a set of observations, abdominal palpation, or confirmation of fetal wellbeing.

On further consideration, in seeking support, a fundamental expectation would be to suggest baseline observations be undertaken before concluding musculoskeletal pain was responsible for Mrs [A]'s distress. On this basis, there is an identified deficit in expected guidance from RM [C] and CCM [D] to RM [B]. This amounts to a moderate departure from accepted midwifery practice.'