Decision 21HDC00711
24 July 2025

HEALTH & DISABILITY COMMISSIONER
TE TOIHAU HAUORA, HAUĀTANGA

System failures result in unsafe staffing levels and inadequate fetal monitoring

1. This Office received a complaint from Mr A about the antenatal care provided to his wife, Mrs A, at Waitākere Hospital in Month1, YearA. Sadly, Mrs A's baby passed away in utero and was stillborn. I extend my sincere condolences to Mrs A and Mr A for the loss of their daughter.

2. At 8pm in mid Month1, YearA, Mrs A (then aged in her late twenties) presented to Waitākere Hospital for assessment at 40 weeks and 3 days' gestation. She was in early labour (2–3 contractions in 10 minutes) and reported reduced fetal movements.[1] CTG[2] monitoring was considered abnormal[3] as there was an absence of fetal heart rate (FHR) accelerations and, initially, a couple of shallow decelerations.[4]

3. Consultant obstetrician Dr B considered that the CTG was not indicative of fetal hypoxia[5] and recommended continued CTG monitoring until the trace became normal. There were no concerns for the baby. Mrs A's midwife had told Dr B that Mrs A's antenatal scans at 31 and 35 weeks' gestation were normal, and that a further scan was to be done in a few days' time. However, Dr B mistakenly understood that a scan had been undertaken 'a few days ago' with normal findings.

4. At 9pm Mrs A's care was handed over to registered midwife (RM) C, who explained to Mrs A and Mr A how to use the bedside telephone to contact her directly if they had any concerns. Dr B reviewed the CTG trace at around 9.40pm. There were no FHR accelerations, but all other features were within normal limits. It was concluded that although the CTG was abnormal, the absence of decelerations with uterine activity indicated that no fetal hypoxia was occurring. Dr B recommended that if there was no improvement (ie, if the CTG did not normalise), Mrs A should stay overnight for intermittent CTG monitoring.

5. At around 10.30pm the CTG was discontinued to allow Mrs A to take a walk and have dinner. The CTG trace was reviewed by Dr B. At 10.35pm RM C documented in the clinical records

[1] Mrs A had also reported reduced fetal movements two days prior to this. Initially, the CTG showed reduced variability with one 'small deceleration', but this normalised after Mrs A drank water. She was discharged home.
[2] Cardiotocography (CTG) continuously records the fetal heart rate and uterine contractions. It is widely used in pregnancy to assess fetal wellbeing.
[3] A normal CTG has the following features:
— Baseline rate 110–160 beats per minute (bpm)
— Baseline variability of 6–25bpm
— Accelerations 15bpm for 15 seconds
— No decelerations
[4] The last deceleration was noted to be at 8.15pm.
[5] Reduced oxygen supply to a baby in utero.

Names (except Health New Zealand|Te Whatu Ora Waitematā) have been removed to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name. Relevant months and years are referred to as Month-1–Month2 and YearA–YearB to protect privacy.

that the plan was for 'CTG to go back on in [one] hour or before if concerned'. Dr B told HDC that at this time she did not feel that there was enough evidence to warrant an emergency Caesarean section delivery, and she wanted to continue observations.

6. The CTG was not recommenced until 6.50am the next morning. No fetal heartbeat could be found, and subsequently it was confirmed that Mrs A's baby had passed away.

7. There are differing versions of events as to why CTG monitoring was not repeated overnight.

8. RM C told HDC that she showed Dr B the CTG trace at 12.15am while Dr B was sitting in the Charge Midwife hub. RM C recalls that Dr B commented that the FHR variability 'was ok' and there were no decelerations, and that Mrs A could be 'bedded down' for the night. RM C's contemporaneous note in the clinical records documents at 12.15am: 'Above CTG reviewed by Dr B. Dr B satisfied with trace for [Mrs A] to bed down for the [evening] and CTG again early morning.' A sticker above this entry summarises the CTG findings for the period 8pm–10.30pm (discussed above).

9. On the other hand, Dr B told HDC that she recalls RM C asking at 10.30pm if Mrs A could be 'bedded down' for the night. Dr B said that she responded 'no' and advised that Mrs A would require repeat CTGs, especially if her contractions became stronger. This is consistent with the plan documented by RM C at 10.35pm. Dr B said that she had no further communications with RM C overnight. Dr B noted that the last CTG ended at 10.30pm and stated that it is 'simply impossible' that she would have changed her management plan without there being new information regarding fetal wellbeing.

10. Dr B said that in the hours after her conversation with RM C at 10.30pm, she was involved in the care of 'one woman after another' requiring obstetric input and intervention. Waitākere Hospital's policy at the time was for a second obstetrician to be called if two obstetric interventions were required concurrently. Dr B said that although this was a busy night, the interventions required were sequential, so a second obstetrician was not called.

11. RM C saw Mrs A a few times throughout the night. There is conflicting evidence about what occurred during these interactions. Mr A's recollection of events suggests that he and Mrs A conveyed to RM C their concerns for the wellbeing of their baby, including blood spotting and reduced fetal movements, and requested monitoring be recommenced. On the other hand, RM C's recollection suggests that she was not told of any concerns aside from Mrs A mentioning that she had blood spotting when she went to the toilet. Mr A's and RM C's accounts are set out below.

12. Mr A told HDC that he and Mrs A asked to recommence the CTG after they returned from their walk and dinner, and that RM C told them that Mrs A needed to rest. It is not clear whether this was before or after RM C had documented the new plan to 'bed down' for the night. Mr A's statement places this conversation sometime between 12am and 1am at 40 weeks 4 days' gestation. RM C has not commented on Mr A's statement that he and Mrs A asked for monitoring to recommence at this time.

13. Mr A told HDC that at around 1am Mrs A told RM C that she had had some blood spotting and that she could not feel the baby moving, and that they asked if monitoring should recommence. Mr A said that RM C reassured them that everything was normal.

14. On the other hand, RM C recalls passing Mrs A in the hall (it is not clear whether Mr A was present) and that Mrs A told her that she had had 'a few spots' of blood on wiping but no blood on her pad. RM C's statement does not mention Mrs A reporting reduced fetal movements or requesting monitoring at this time. RM C said that she reassured Mrs A that a small amount of spotting in early labour is normal and asked Mrs A to save any pad that had bleeding on it for assessment.

15. Mr A told HDC that RM C visited Mrs A in her room at around 3–4am while, he said, '[Mrs A] was still in pain and couldn't sleep at all throughout this night'. RM C told HDC that she visited Mrs A's room, where Mrs A was lying on her side with 'no signs of active labour and no concerns voiced'.

16. RM C's documentation, written in retrospect at 7.43am the next morning, records that in the night Mrs A reported 'a small amount of blood' and that she was 'paining' but did not appear distressed. There is no mention of reduced fetal movements.

17. Throughout the night Mr A attempted to reach RM C via the beside telephone but was unable to make contact. Subsequently it was identified that RM C's telephone had been switched to 'block caller mode' accidentally.

18. Following the events, Health New Zealand|Te Whatu Ora (Health NZ) Waitematā completed an Adverse Event Review (AER). The AER noted that RM C and Dr B presented materially different versions of events. The following care delivery problems were identified:

- The CTG was not indicative of fetal hypoxia but should have been repeated overnight.
- There was miscommunication between staff about the timing of the antenatal scan and plan of care.
- Dr B's workload was heavy, and a second on-call specialist was not called in. This resulted in compromised communication and documentation. The 'threshold' for calling in the second senior medical officer (SMO) was where two obstetric interventions were required concurrently.
- The failure of the bedside telephone made communication between family and staff difficult.

19. Dr B told HDC that if she had understood that a scan was to be taken in the next few days (rather than that a scan had been taken in the past few days), she may have performed a bedside scan to check the amniotic fluid volume, but this would not have changed her management plan for Mrs A that evening. Dr B stated that Mrs A's fundal height was appropriate for term, which indicated that clinically, growth appeared to be adequate.

Responses to provisional decision

20. Health NZ, Dr B, and Mr A were each given the opportunity to comment on my provisional decision. Their comments have been incorporated into this decision where appropriate.

Opinion

21. It is important to note that it is the role of HDC to determine whether Health NZ provided Mrs A with an appropriate standard of care in Month 1, YearA. It is not the role of HDC to determine causation or whether the outcome may have been different had any of the issues identified not occurred. My decision has been made with this in mind.

Opinion: Dr B – adverse comment

22. Regarding the conflicting accounts of RM C and Dr B, RM C provided a detailed account of the alleged 12.15am discussion and this is corroborated by her contemporaneous note in the clinical documentation. In cases where there are conflicting accounts, I place great reliance on the contemporaneous clinical notes, and I cannot fathom why RM C would document a new plan of care from Dr B if this discussion did not take place. On the other hand, Dr B does not recall a 12.15am discussion. While I acknowledge that in the normal course of events Dr B would not have changed the plan of care without new clinical information, by her own account the demands on Dr B that evening were considerable and, as indicated by Health NZ's AER, seemingly beyond one SMO's capacity to manage safely.

23. In weighing up the evidence, I find RM C's account compelling. Accordingly, I consider it more likely than not that RM C did discuss the CTG findings with Dr B at 12.15am, and that RM C's understanding of the care plan was as documented contemporaneously in the clinical notes. While I am not in a position to conclude why Dr B has a different account, I am alarmed that Dr B appears to have been dealing with responsibilities beyond one SMO's capacity such that she may not have been alert or sufficiently engaged in the conversation with RM C to be able to provide appropriate advice or recall that the discussion took place.

24. It is clear from Dr B's response and Health NZ's AER that CTG monitoring should have been repeated overnight, and I am critical that this did not occur. As Dr B was responsible for Mrs A's care planning and the care plan was inappropriate, in my view Dr B bears some responsibility for this failure. However, I consider this is mitigated by Health NZ's failure to ensure that Dr B was adequately supported to call in a second SMO, as outlined below.

25. Lastly, I accept that if Dr B had correctly understood that a growth scan was planned to be taken in the next few days (rather than that a scan had been taken in the past few days), this would not have changed her plan of care. Nevertheless, I am concerned that this miscommunication occurred, and I consider this serves as a reminder of the importance of accurate information sharing between care providers.

Opinion: Health New Zealand Waitematā – breach

26. Under Right 4(2) of the Code of Health and Disability Services Consumers' Rights (the Code),[6] Health NZ had a duty to ensure that services provided to Mrs A at Waitākere Hospital complied with relevant standards. At the time, this included the Health and Disability Services Standards 2008 (HDS Standards).[7] The HDS Standards are designed to establish safe and reasonable levels of services for consumers, and to reduce the risk to consumers from those services.

27. Under Standard 2.2 of the HDS Standards, Health NZ was required to ensure that 'the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate and safe services to consumers'. Further, under Standard 3.6 Health NZ was required to ensure that 'consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes'. Standard 3.6 supports Outcome 3 of the HDS Standards that 'Consumers participate and receive … services that are planned, coordinated and delivered in a timely and appropriate manner'.

28. It was Health NZ's responsibility to ensure that sufficient levels of skilled and experienced staff were in attendance to ensure the provision of safe, timely, and competent care. This included having adequate policies in place to guide staff on the appropriate threshold for calling in a second on-call obstetrician. The AER indicates that a key factor in the failure to undertake intermittent CTG monitoring was that Dr B's busy workload resulted in compromised communication about the plan of care, yet the workload that evening did not meet Waitākere Hospital's threshold for calling a second obstetrician. On this basis, I consider that the miscommunication that resulted in inadequate CTG monitoring was a systemic failure for which ultimately Health NZ is responsible at an organisational level.

29. Further, Mrs A and Mr A had been asked to use the bedside telephone if they had any concerns, but the failure of the system meant that they were unable to do so. It is not possible to know whether further monitoring would have been undertaken if Mr A's calls had not been blocked. Nevertheless, I am critical that the bedside telephone system did not work, and I consider that this was a barrier to the provision of timely and safe services. I also acknowledge that it would have been a frustrating and distressing experience for Mrs A and Mr A to be unable to reach hospital staff when they had concerns about the wellbeing of their baby.

30. For these reasons, I consider that Health NZ failed to ensure that the service provided to Mrs A was managed in an effective manner to ensure the provision of timely, safe, and appropriate care to Mrs A and her baby, in accordance with Mrs A's assessed needs. As such, I find that Health NZ failed to comply with Standard 2.2 and 3.6 of the HDS Standards, and, accordingly, breached Right 4(2) of the Code.

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[6] Right 4(2) states: 'Every consumer has the right to have services provided that comply with legal, professional, ethical, and other relevant standards.'

[7] Health and Disability Services Standards NZS 8134.1:2008 was replaced by Ngā Paerewa Health and Disability Services Standard on 28 February 2022.

31. Additionally, I have considered the differing recollections of Mr A and RM C regarding what information was conveyed to RM C on the night of 40 weeks 3 days' to 40 weeks 4 days' gestation. Unfortunately, owing to the differing accounts, uncertainty about whether Mr A was present for all discussions, a lack of contemporaneous clinical documentation, and the time that has passed since events, I am not able to make a finding about precisely what information was conveyed to RM C during this period. Accordingly, I am unable to comment on whether RM C was presented with a clinical picture that should have prompted further monitoring, assessment, or obstetric consultation. I do, however, consider that there may have been missed opportunities to undertake further CTG monitoring during this period.

32. Accordingly, I remind RM C that irrespective of the plan of care, midwives are expected to be alert to changes in the clinical picture that may necessitate clinical reassessment of a woman and her baby. Further, I remind RM C of the importance of listening to patients as active participants in their care. Their intuition should not be discounted.

33. Lastly, as a result of this investigation, I considered Waitākere Hospital's policy for management of women with reduced fetal movements. The policy is dated Month 2, Year B (after the events of this complaint).[8] It lists several risk factors for stillbirth[9] and recommends further investigations if any of these risk factors are present, followed by obstetric review if any of the investigation findings are abnormal. The policy does not list maternal ethnicity as a risk factor for stillbirth, despite babies born to mothers of certain minority ethnic groups having been repeatedly identified as being at higher risk of stillbirth[10] in the Perinatal and Maternal Mortality Review Committee's (PMMRC) annual reports.[11] I acknowledge that, in Mrs A's case, obstetric review was sought, and had there been policy guidance about certain minority ethnic groups being at higher risk for stillbirth, it is unlikely to have changed Mrs A's management. Nevertheless, this case presents an opportunity to consider whether maternal ethnicity should be considered when assessing a woman's risk of stillbirth.

34. Health NZ's AER recommended the following remedial actions:

- A formal register to be kept on CTG credentialling of all obstetricians, and a mandatory expectation for yearly credentialling established.
- Use of a case review for documentation education.
- A review of the threshold for calling in a second on-call obstetrician, taking a wider view of patient safety rather than simply simultaneous demands.

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[8] Health NZ advised that the Reduced Fetal Movement Policy was new in Year B and there were no previous iterations of it.

[9] These were: maternal age >40 years; maternal smoking, alcohol and/or drugs; body mass index >30; IVF pregnancy; no antenatal care; previous stillbirth; diabetes; hypertension/pre-eclampsia; fetal growth restriction/small for gestational age; post-term pregnancy >41 weeks.

[10] Compared with those born to New Zealand European mothers.

[11] https://www.hqsc.govt.nz/resources/resource-library/sixteenth-annual-report-of-the-perinatal-and-maternal-mortality-review-committee-te-purongo-a-tau-tekau-ma-ono-o-te-komiti-arotake-mate-pepi-mate-whaea-hoki/

- De-activation of call blocking on all phones used by women/couples, to prevent accidental call blocking.

35. In light of the above, I recommend that Health NZ:

a) Provide a written apology to Mrs A and Mr A for the breach of the Code identified in this report. The apology is to be sent to HDC within three weeks of the date of this report, for forwarding to Mr A.

b) Within one month of the date of this report, provide HDC with evidence (eg, training material and attendance records) that this case has been used for documentation education for staff at Waitākere Hospital.

c) Within one month of the date of this report, confirm to HDC that the call-blocking function has been de-activated on all telephones used by women/couples to contact staff, and confirm whether there have been any further instances of calls being blocked since the events of this complaint.

d) Within one month of the date of this report, provide HDC with a copy of the updated policy/guidance on the threshold for calling in a second on-call obstetrician and confirm whether this is being adhered to in practice.

e) Use this case as a basis for education/training on clinical communication between practitioners. Evidence confirming the content of the education/training (eg, training material) and delivery (eg, attendance records) is to be provided to HDC within six months of the date of this report.

f) Consider whether to amend its reduced fetal movements policy to include maternal ethnicity as a risk factor for stillbirth (in particular, of certain minority ethnic groups as identified by the PMMRC) and advise HDC of the outcome of this consideration, and provide a copy of any new/amended policy, within six months of the date of this report.

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

Rose Wall
Deputy Health and Disability Commissioner