Decision 21HDC01180
6 August 2025

HEALTH & DISABILITY COMMISSIONER
TE TOIHAU HAUORA, HAUĀTANGA

Care of pregnant woman following ultrasound scan

1. On 30 May 2021, the Health and Disability Commissioner (HDC) received a complaint from Miss A regarding the maternity care she received at the then Waitematā District Health Board (subsequently referred to as Health NZ Waitematā) and a private radiology provider (Provider1).

Background

2. Miss A's first baby was born by Caesarean section in 2019.

3. In 2020 Miss A became pregnant with her second baby. The estimated date of delivery was 6 June 2021. Sadly, Miss A's baby, Baby A, was stillborn in May 2021.

4. Miss A's lead maternity carer (LMC) was registered midwife (RM) B. A routine ultrasound scan (USS) on 18 January 2021 identified that Miss A had a uterine fibroid[1] that measured 6.9cm. The Guidelines for Consultation with Obstetric and Related Medical Services (Referral Guidelines) 2012[2] state that fibroids require an obstetric consultation.

5. In response to the provisional opinion, RM B stated that Miss A attended a routine antenatal appointment on 23 February 2021, during which a referral to the obstetric team at Waitematā was discussed. RM B provided evidence that initially she sent an incomplete referral (to discuss a vaginal birth after Miss A's previous Caesarean section (a VBAC)) followed by a further referral, which included information about the uterine fibroids. However, when sending the second referral, RM B entered the email address incorrectly, and so the full referral was not received by Health NZ Waitematā. The incomplete referral was acknowledged and accepted by Waitematā, but RM B did not pick up on her error, as she thought she had received acknowledgment of the second referral.

6. RM B stated that because of her email input error, primarily Miss A was referred for an obstetric review due to her previous Caesarean section but, despite that, as part of that appointment it would be expected that Miss A's full history and scans to date would be reviewed and would provide the basis for recommendations for care in her pregnancy. The anatomy scan report documents the presence of a fibroid, and therefore that information was available to the obstetrician providing the secondary consultation.

7. On 7 April 2021, some nine weeks after the routine USS, Miss A had a telephone consultation with obstetric registrar Dr C at the North Shore Hospital VBAC clinic, during which they discussed the risks of a vaginal delivery. There is no record that the fibroid identified on the USS was considered or discussed at this appointment. However, in response to the

[1] A benign growth in the uterus.
[2] Ministry of Health, *Guidelines for Consultation with Obstetric and Related Medical Services (Referral Guidelines)*. Wellington: Ministry of Health, 2012.

provisional opinion, Miss A said that the fibroid was discussed during the consultation. She said that she was told that the fibroid was located at the top of the uterus and had not caused any complications in her previous pregnancy. She said that she raised concerns and enquired about scans and was advised that she would receive some scans, but no follow-up arrangements were made.

Provider1

8. On 18 May 2021, RM B requested a further USS for suspected fetal growth restriction.[3] The referral has 'Growth' ticked but no specific comment about fetal growth restriction.

9. In response to the provisional opinion, Miss A said that from 28 weeks' gestation she had repeatedly requested that RM B arrange a USS, but no USS was arranged until she reached 37 weeks' gestation, and it took a further 10 days to obtain an emergency USS appointment. However, the comment in the antenatal records on 18 May 2021, 'Growth scan due to fundal measurement tailing', is the first recorded indication of concern.

10. In response to the provisional opinion, Provider1 stated that there was no mention of suspected fetal growth restriction in the referral. It said that the referral was routine, with no urgency or clinical concerns indicated by the referrer.

11. Miss A underwent a growth USS at Provider1 on 26 May 2021, at 38+3 weeks' gestation. The USS was reported by radiologist Dr D.

12. Miss A stated that the sonographer told her that she had a small healthy baby, and that there was nothing to worry about. In response to the provisional opinion, Miss A told HDC that a student sonographer mentioned difficulty locating a pocket of amniotic fluid, but no follow-up was initiated.

13. Sonographer Mr E said that he and a student sonographer conducted Miss A's USS. They marked the case as 'URGENT', but he could not recall any details. He stated that 'urgent' meant that there was a clinical concern, and normally they would inform the radiologist first, then tell the patient that there was a concern and advise them to contact their LMC or caregiver for more details. Mr E stated that he would never make a comment like 'a small healthy baby' or 'nothing to worry about'. Neither Mr E nor the student recall whether they contacted the radiologist. Dr D stated that the USS showed normal interval growth with an estimated fetal weight (EFW) of 2935g. She said that when scans are performed in the community (ie, not in hospital), Provider1 does not have access to the customised growth chart (CGC), so they use a population-based chart and recommend that the LMC plot the EFW on a CGC. Dr D reported that the right-sided fibroid measured 8.6cm at that stage.

14. Dr D's report states:

> 'CONCLUSION: Active fetus with normal liquor volume[4] and normal interval growth. The estimated fetal weight lies between the 10th and 50th centiles on a population-based

[3] A fetus smaller than expected for the stage of pregnancy.
[4] Amniotic fluid — the water-like substance that surrounds the fetus.

chart (Hadlock). Please plot the EFW on a customised growth chart. Liquor volume is low, with a largest measurable pocket of 1.7 x 2.9 cm.'

15. Provider1 and Dr D acknowledged that the report's conclusion states both that there was normal liquor volume and that the liquor volume was low, and they apologised for the contradictory report.

16. Dr D stated that 'active fetus with normal liquor volume' is the beginning of her standard normal report, and the comment of 'normal liquor volume' should have been removed, but this was not identified by her at the time of drafting her report nor corrected at the time she edited it.

17. RM B's CGC plotted that Baby A was under the 10th centile for EFW. RM B received a text from Miss A after the USS saying that she was told by the sonographer that her baby was measuring as being small and asking whether she should be concerned. RM B replied that she would let her know once she had seen the radiologist's report. RM B stated that she thought that if there was anything seriously concerning, the sonographer would have let her know.

18. Dr D said that the New Zealand Obstetric Ultrasound Guidelines[5] contain 'reporting alert' recommendations, and 'low amniotic fluid volume' is not included in the guidelines as a finding requiring 'urgent' contact, nor is it included in the 'same day' findings list. She said that if there had been an additional abnormal finding, that would have prompted her to contact the LMC, but as the growth measurements and the Doppler ultrasound[6] results were normal, she was reassured that the LMC did not need to be contacted urgently. Dr D did not contact RM B.

19. On 26 May 2025 at 4.59pm, Miss A sent a text message to RM B saying that the sonographer had advised that the USS results would be available to her LMC the following day. Miss A said that this indicated that no urgency was communicated by the sonographer regarding the scan findings, and no advice was given for her to contact her LMC. On 27 May 2021, Miss A called RM B to say that she had not felt her baby move since she had had the USS the previous day. RM B told Miss A that she would follow up the radiologist's report, call the hospital, and get back to her.

20. RM B then rang Provider1 and requested that a copy of the radiologist's report be sent urgently. RM B also rang North Shore Hospital Maternity Services to arrange for Miss A to be seen. As North Shore Hospital was at full capacity, RM B was told to send Miss A to Waitākere Hospital Maternity Services.

Waitākere Hospital

21. Health NZ Waitematā told HDC that when it became clear that North Shore Hospital would not be able to accommodate new maternity admissions safely, a short-term plan was

[5] Ministry of Health. New Zealand Obstetric Ultrasound Guidelines. Wellington: Ministry of Health, 2019. www.tewhatuora.govt.nz.

[6] A type of ultrasound imaging that measures blood flow.

instigated to accommodate acute assessments at Waitākere Hospital until North Shore Hospital had capacity. The usual staffing for Waitākere Hospital Maternity Services was one senior medical officer (SMO), so a registrar was sent from North Shore Hospital to Waitākere Hospital to assist.

22. RM B said that she spoke to a staff member, who she believed was the Clinical Charge Midwife (CCM) at Waitākere Hospital, about sending Miss A for an acute assessment for reduced fetal movements. RM B said that they discussed that the USS the previous day had reported low amniotic fluid (oligohydramnios) and that the EFW plotted under the 10th centile on the CGC. RM B stated that she offered to email the CGC to Waitākere Hospital but was told that this was not necessary.

23. Health NZ Waitematā stated that it believes that RM B spoke to the assessment midwife, RM F. RM F has no recollection of having had a phone conversation with RM B regarding the USS and the CGC. Health NZ Waitematā stated that there is no reason why a copy of the CGC would be declined, as this would save work for the staff in replotting the chart. RM F said that it would be her usual practice to request the original CGC, which is required to record the centile of the baby, once born. There is no record of RM B's conversation with the midwife.

24. RM B then rang Miss A and told her that she needed to go to Waitākere Hospital and to pack a bag and be prepared for staff to talk to her about an induction of labour. RM B said that she did not attend the assessment as it is not standard practice for the LMC to attend an acute assessment, and also Waitākere Hospital is some distance from where she practises on the North Shore, and she needed to be available for her caseload.

25. In response to the provisional opinion, Miss A told HDC that she presented to Waitākere Hospital and explained why she was there and what RM B had advised in terms of an induction or Caesarean section. Miss A said that she was told that only one medical officer was on duty and that any intervention would require transfer to North Shore Hospital.

26. Dr G was the on-call SMO at Waitākere Hospital on 27 May 2021, and the obstetric registrar sent from North Shore Hospital was Dr H. Dr H told HDC that at that time he was in his second year of Obstetrics & Gynaecology training at North Shore Hospital. Dr H said that on the afternoon of 27 May, the on-call SMO at North Shore Hospital asked him to go to Waitākere Hospital for the afternoon because North Shore Hospital antenatal assessments had been diverted there due to capacity issues.

27. After Miss A arrived at Waitākere Hospital, a cardiotocograph (CTG)[7] was performed. The CTG showed a normal baseline rate (the average heart rate within a 10-minute window) with good variability (the variation of the fetal heart rate from one beat to the next) and accelerations (increases in baseline heart rate). Early in the CTG there was a single unprovoked prolonged deceleration (abrupt decrease in the baseline fetal heart rate of greater than 15bpm for more than 15 seconds) with slow recovery and no accelerations

[7] Measures the fetal heart rate and monitors any contractions of the womb.

immediately following the deceleration. There was a later period with a lack of accelerations and reduced variability, followed by a further period of normal CTG with accelerations.

28. Miss A stated that Dr G came into the room, asked questions, and monitored the CTG. Miss A said that Dr G did not introduce herself, and she assumed that Dr G was another midwife. Miss A said that she explained to Dr G that she had had low fetal movements and that a USS the previous day had shown a low amniotic fluid volume and a small baby. Miss A stated that she also explained that her LMC had advised her to take a hospital bag and that someone would talk to her about having an induction of labour or a Caesarean section.

29. Miss A stated that Dr G came into the room multiple times after that and reviewed the CTG just after Baby A's heart rate had a large drop. Miss A said that the response from hospital staff to the drop in heart rate was to tell her that she needed to be monitored for another hour. She stated that neither RM F nor Dr G indicated concern, and Dr G said that 38+4 weeks' gestation was too early to deliver the baby. Dr G told HDC that Miss A's CTG on arrival was reviewed by RM F, who asked Dr G to review the CTG when there was a deceleration. Dr G recalls being introduced as the on-call obstetrician who was there to review the CTG. Dr G said that in order to provide some context when reviewing the CTG, she asked about the gestation and the reason for the CTG, but she did not obtain a detailed history or perform an examination. She said that her objective when reviewing the CTG was to evaluate whether any acute intervention was required.

30. Dr G said that she was aware that the radiologist's report was contradictory in stating both 'liquor volume low' and concluding 'normal liquor volume and normal interval growth'. As the USS had been performed in the community and the images were not available to be reviewed in the hospital, her view was that the best course would be to repeat the USS with the benefit of adding the Doppler ultrasound results to verify the previous radiologist's report findings.

31. Dr G concluded that Miss A's CTG was within normal limits. She said that when she entered the room, there was a single prolonged deceleration that was returning to baseline. Dr G asked for the CTG to be continued and returned to review the CTG again later. She said that there were no further decelerations and the CTG had returned to normal, which indicated that there were no signs of acute fetal distress and emergency delivery was not required.

32. Dr G said that she made no entry in Miss A's records because she did not perform an initial assessment, and she expected that a full assessment would be performed by Dr H. When Dr H arrived, Dr G told him that she had reviewed the CTG as there had been a deceleration, but the CTG had since improved.

33. Dr H said that he reviewed Miss A's antenatal investigations on the computer and asked RM F to retrieve the CGC and biometry charts (fetal measurements from the USS). RM F gave Dr H blank charts, and he filled them in himself using information from the USS the previous day, as well as an earlier USS. Subsequently, he learnt that he had incorrectly plotted the EFW on the CGC on the 50th centile rather than the 10th centile.

34. Dr H then spoke to Miss A and took her history, and upon sighting her CTG he explained to her that a deep, prolonged deceleration that is slow to recover was concerning, especially as she was not in labour. He said that he told her that in the setting of reduced fetal movements and oligohydramnios, she would require surveillance and likely a discussion around delivery planning. He also explained that he would recommend that she return that evening for a repeat CTG. Prior to leaving the room, he advised her that if she had any further concerns about fetal movements before her next planned follow-up, she should return to the hospital for an acute assessment and CTG.

Discharge

35. Dr H discussed his findings with Dr G. Dr H gave Dr G a verbal history of Miss A's presentation, and they reviewed the radiologist's report and growth charts together and both noted the conflicting information about the amniotic fluid volume.

36. Dr G stated that as the baby's growth had been plotted on the 50th centile,[8] the USS appeared to report normal amniotic fluid volume, and the CTG had returned to a normal pattern, she considered that it was safe for Miss A to be discharged with a plan to review her in two days' time, or sooner if Miss A had continuing concerns. Dr H asked RM F to convey this plan to Miss A.

37. At 1.30pm on 27 May 2021, a Waitākere Hospital midwife called RM B and told her that the obstetric plan was for Miss A to have a CTG on Saturday (29 May) and also a USS and CTG on Monday (31 May). RM B said that she asked the midwife whether the doctors were aware that the baby was below the 10th centile and had low amniotic fluid volume. She said that the midwife confirmed that they were aware and reported that Miss A had been assessed, things were normal, and Miss A had been feeling the baby move since arriving for monitoring. RM B said that the midwife reported that the SMO had been consulted, Miss A was having some abdominal tightenings, and Miss A had been advised to return to the hospital for monitoring if labour became established or if she had further concerns about the baby's movements.

Subsequent events

38. On Friday 28 May 2021, Miss A presented to North Shore Hospital as she could not feel her baby move.

39. Dr H told HDC that he used the bedside USS and found that there was no fetal heartbeat present. He asked the on-call SMO, to confirm that there was no heartbeat. Sadly, Baby A had died.

Dr G — further comment

40. Dr G said that Waitākere Hospital is staffed by one SMO, with no registrars or house surgeons. On 27 May 2021, when Miss A and two other patients from North Shore Hospital arrived at Waitākere Hospital for acute assessment, the acuity[9] of Waitākere Hospital was already very high. North Shore Hospital maternity was at full capacity, but the capacity of

[8] See above — this was an error.
[9] The level of patient need.

the medical staff at Waitākere Hospital was not taken into consideration. The on-call obstetricians at North Shore Hospital and the Waitākere Hospital clinicians were not consulted or informed of the diversion order. They became aware of it only when patients started to arrive from North Shore Hospital. At that point, Dr G requested that the on-call obstetrician at North Shore Hospital send the obstetrics assessment registrar from North Shore Hospital to assess the patients diverted to Waitākere Hospital.

Dr D — further comment

41. Radiologist Dr D stated that she can understand how the conflicting statements in her report caused initial confusion. However, she said that her report clearly states in the body of the report and in the conclusion that liquor volume was low, with the addition of both measurements of the deepest vertical pocket,[10] including the width, to highlight that this was not a normal-sized pocket. As a result, she was surprised that the final conclusion drawn from her report was that the amniotic fluid volume was normal.

Adverse event report

42. The Health NZ Waitematā adverse event report (AER) identified the following issues in the care it provided to Miss A:

- Staff misinterpreted that the radiologist had reported that the amniotic fluid volume was normal.
- The EFW reported from the USS was plotted incorrectly as at the 50th centile when the actual centile was below 10.
- The significance of the reduced fetal movements was not appreciated — there was documentation that there had been reduced fetal movements for one week, which is very significant in the context of a small fetus.
- Initially the CTG was abnormal, then it reverted to a normal pattern. In the context of the above information, the initial abnormality was clinically significant.
- North Shore Hospital was at capacity at the time, and Waitākere Hospital was asked to provide acute maternity assessments for both sites until further notice.

ACC

43. ACC obtained external clinical advice from obstetrician & gynaecologist Dr I. Dr I advised that the system for urgent reporting of an abnormal scan was not followed. The USS should have been reported urgently and the LMC notified. However, Dr I considered that the amniotic fluid level should have been reported as normal, not low, as per the New Zealand Obstetric Ultrasound Guidelines.[11]

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[10] A specific area within the amniotic sac where amniotic fluid is present.

[11] In response to the provisional opinion, Provider1 told HDC that it does not agree with the conclusion that Provider1 failed to contact the LMC when the USS results were abnormal, and that this advice is conflicting in that an isolated finding of low fluid volume did not meet the NZ Obstetric Ultrasound Guidelines for urgent or abnormal notification to the referrer. In the absence of other findings of concern during the scan, or in the absence of clinical concerns raised by the referrer, there were not any other extenuating concerns that would prompt the radiologist to make urgent contact with the referrer.

44. Dr I advised that the uterine fibroid required an obstetric consultation under the Referral Guidelines, but there was no documentation or plan by the secondary team until the time of Miss A's acute presentation. Dr I said that the fibroid should have been discussed at the VBAC clinic with a plan made around fetal growth and delivery. Any plan should have included serial growth scans in the third trimester. Dr I stated that it is not possible to have an accurate symphysis–fundal height measurement [12] and to track fetal growth appropriately with a 69–86mm fibroid. Dr I noted that if a third trimester growth scan had occurred, the small for gestational age (SGA) baby may have been detected earlier.

45. Dr I stated that it would be standard practice at a VBAC assessment to review the antenatal USS reports, which documented a large uterine fibroid that might have an impact on the pregnancy and delivery. Dr I said that it would be within the minimum standard of care of a registrar to recognise and document the fibroid, and that not acknowledging, documenting, or making a plan for the fibroid was below the standard of care for a registrar trained in the New Zealand system. Dr I stated that a third trimester growth scan should have been arranged or recommended on the basis of that alone.

46. Dr I noted that it is documented in multiple locations that the LMC was concerned that the baby was small and tried to communicate that to hospital staff. He said that if it was known that Baby A was small, then the clinical management of the acute presentation would have been different, as an SGA baby with reduced fetal movements, low amniotic fluid volume, and an abnormal CTG would have led to admission, if not delivery. Dr I stated: '[U]nfortunately, there were multiple chances to identify an SGA baby, but these were not identified or followed through.'

47. Dr I said that the registrar incorrectly plotted the CGC, but he should have realised that this baby would plot on the CGC as being small.

48. Dr I advised that as it is unusual to have a normally grown baby with reduced amniotic fluid volume, Miss A should have been assessed for ruptured membranes, with an urgent amniotic fluid and Doppler USS or a bedside USS ordered. Dr I stated that to not exclude ruptured membranes was below the standard of care expected of a registrar. Dr I said that this assessment would not have led to an urgent delivery but would have led to further assessment and investigation. She stated that in the context of a normally grown baby, there can be a temporary reduction in amniotic fluid, and low fluid should always be followed up to ensure that levels return to normal (in the absence of ruptured membranes).

49. However, Dr I noted that the registrar identified that the CTG was abnormal and needed further management, including possible delivery, and correctly elevated the case to the consultant.

Responses to provisional opinion

50. Provider1, RM B, and Health NZ Waitematā were given the opportunity to comment on the provisional report.

[12] The distance between the pubic bone and the top of the uterus.

RM B

51. RM B stated that sending the referral to the incorrect address was a one-off uncharacteristic error that was not indicative of her usual practice, and she apologised for the error. RM B's further comments have been incorporated into this report where appropriate.

Provider1

52. Provider1's comments have been incorporated into this report where appropriate.

Health NZ Waitematā

53. Health NZ Waitematā advised that it had no comments to make. Health NZ (national office) advised that it accepts the proposed recommendation to review the protocols in place for new maternity admissions, stating that it acknowledges 'the importance of ensuring safe and effective management of acute maternity assessments, particularly in the context of capacity constraints in public hospitals'.

Miss A

54. Miss A was sent the 'information gathered' section of this report. Her comments have been incorporated as appropriate. In addition, she stated:

> 'The lack of attention, repeated mistakes, and poor communication throughout my care have caused irreparable harm. These human errors ultimately led to the death of my baby. I did everything I could to raise concerns and advocate for my wellbeing and that of my baby, but I was not heard … This has not only been a clinical failure but a deeply personal tragedy that has left lasting emotional and psychological damage. I hope that this reaches the outcome it deserves so that no other mother or family has to experience the same preventable heartbreak.'

Opinion: Introduction

55. At the outset I express my condolences to Miss A for the tragic loss of Baby A. I acknowledge that the events on 28 May 2021 were traumatic for Miss A and her whānau, and that Miss A has sought answers to her questions about what happened and whether Baby A's death could have been prevented.

56. In considering the care provided to Miss A, I have taken into account the AER findings and the ACC expert advice provided by Dr I, as well as the other evidence available to me. In my view, several errors led to a failure to recognise the extent to which Baby A was at risk, and I consider that Health NZ Waitematā failed Miss A and Baby A.

Opinion: Health NZ Waitematā — breach

57. On 18 January 2021, a USS identified that Miss A had a uterine fibroid measuring 6.9cm. On 7 April 2021, she spoke to Dr C in the VBAC clinic, but there is no record that the risks posed by the fibroid were discussed or a plan put in place. I note that Dr I advised ACC that the fibroid should have been discussed at the VBAC clinic, and a plan made around the fetal growth and delivery, which should have included serial growth scans in the third trimester. I agree that if further monitoring of fetal growth had taken place in the third trimester, the SGA baby may well have been identified earlier.

58. On 27 May 2021, RM B contacted Waitākere Maternity Services to discuss Miss A's presentation. RM B believes she spoke to the CCM and told her that the USS the previous day had reported low amniotic fluid volume and that the EFW plotted under the 10th centile. She said that she offered to email the CGC to Waitākere Hospital, but the offer was declined.

59. In contrast, Health NZ Waitematā stated that RM B spoke to RM F. I am unable to make factual findings about to whom RM B spoke, but I accept that she did attempt to draw attention to Miss A's risk factors and offer to send the CGC. This was another missed opportunity to detect that the baby was SGA.

60. When Miss A arrived at Waitākere Hospital, a CTG was performed and there was a single prolonged deceleration with slow recovery and no acceleration immediately following the deceleration. There was a period with a lack of acceleration and reduced variability followed by a further period of normal CTG with accelerations. The AER stated that in the context of low amniotic fluid volume and an SGA baby, the initial CTG abnormality was clinically significant. However, it appears that this was not recognised because Dr G believed that the amniotic fluid volume was normal, and the baby was not SGA.

61. The CTG was reviewed by Dr G, who obtained some information about Miss A but did not obtain a detailed history or perform an examination. Dr G made no clinical records. She was aware that the radiologist's report was contradictory. Dr H discussed low amniotic fluid volume with Miss A, but Dr G believed that the amniotic fluid volume was normal. Dr I said that as it is unusual to have a normally grown baby with reduced amniotic fluid, Miss A should have been assessed for ruptured membranes, with an urgent amniotic fluid and Doppler USS or a bedside USS. I agree, particularly in light of the contradictory information.

62. Dr H filled in the CGC and biometric charts. Unfortunately, he incorrectly plotted the EFW on the 50th centile rather than the 10th centile. Dr H discussed his findings with Dr G but, as the baby's growth had been (incorrectly) plotted as at the 50th centile, the radiologist's report appeared to report normal liquor volume, and the CTG had returned to a normal pattern, Dr G considered it safe for Miss A to be discharged with a plan to review her in two days' time. As stated in the AER, the significance of the reduced fetal movements was not appreciated, as Dr G was not aware that the baby was SGA.

63. Subsequently, RM B reiterated to a Waitākere Hospital midwife that the baby was below the 10th centile and had low amniotic fluid volume. She said that the midwife confirmed that the doctors were aware of this, and that the SMO had been consulted. This was incorrect and was another missed opportunity to alert the doctors to the baby being SGA.

64. I consider that overall, the care provided to Miss A by Health NZ Waitematā was inadequate. No action was taken in light of the large fibroid; information that was provided by the LMC was not passed on; there was a failure to recognise that a normal-sized baby was unlikely to have low amniotic fluid volume; and it was not recognised that Baby A was an SGA baby because the EFW was plotted on the CGC incorrectly. These errors were made by multiple staff, for which I hold Health NZ Waitematā responsible.

65. Accordingly, I find that Health NZ Waitematā failed to provide services to Miss A with reasonable care and skill and breached Right 4(1)[13] of the Code of Health and Disability Services Consumers' Rights (the Code).

Opinion: Provider1 — adverse comment

66. Regarding Provider1 staff having failed to contact the LMC when the USS results were abnormal, Provider1 stated that an isolated finding of low fluid volume did not meet the NZ Obstetric Ultrasound Guidelines for urgent or abnormal notification to the referrer. Provider1 said that in the absence of other findings of concern during the scan or clinical concerns raised by the referrer, there were no other extenuating factors that would prompt the radiologist to make urgent contact with the referrer.

67. I accept that submission, but I am critical that Dr D reported both that the fetus had normal amniotic fluid volume and that the amniotic fluid volume was low.

Opinion: RM B — educational comment

68. RM B did intend to refer Miss A for an obstetric consultation in light of the fibroid, as required by the Referral Guidelines. However, RM B entered the incorrect email address, and so the full referral was not received by Health NZ.

69. RM B was aware that initially she had sent an incomplete referral (followed up by a further referral). In these circumstances, I consider that it would have been prudent for RM B to check that the information in the second email would be included with the referral. However, I do acknowledge that it would be expected that the obstetric team would review all the details on the clinical record.

Changes made since this event

70. There is now a dedicated Assessment Midwife email inbox at Waitākere Hospital.

71. Issues with ultrasound scanning are now recorded in the organisational risk register. A survey of consumer experience has been undertaken to provide further information to the Ministry of Health on this issue.

72. The MCIS (Maternity Clinical Information System), which has an integral growth chart, has been implemented.

73. Contingency plans are in place for using beds at Waitākere Hospital when North Shore Hospital is full, and vice versa.

74. Dr D has adjusted her practice to take extra care when editing reports prior to verification.

75. Provider1 has strengthened its urgent/abnormal reporting process to ensure that when abnormal findings or urgent issues are identified, they are escalated back to the referrer as soon as possible.

[13] Right 4(1) states: 'Every consumer has the right to have services provided with reasonable care and skill.'

Recommendations

76. I recommend that within three weeks of the date of this opinion, Health NZ Waitematā, Provider1, and RM B separately apologise to Miss A for the breach of the Code and the criticisms in this opinion. The apologies are to be sent to HDC for forwarding to Miss A.

77. I recommend that within three months of the date of this opinion, Dr G and Dr H each undertake additional education on person-centred care and effective communication with health consumers and complete the HDC online modules for further learning: https://www.hdc.org.nz/education/online-learning/. Evidence of attendance at related training and completion of the online modules is to be provided to HDC.

78. I recommend that Health NZ take this opportunity to review the protocols followed for accommodating new maternity admissions in public hospitals where there are capacity issues, to ensure that acute assessments are managed safely. Health NZ will be asked to report back on any planned changes arising from its review.

Follow-up actions

79. A copy of this report with details identifying the parties removed, except Health NZ Waitematā and Waitākere Hospital, will be sent to the Royal Australian and New Zealand College of Obstetricians & Gynaecologists, the Royal Australian and New Zealand College of Radiologists, the New Zealand College of Midwives, the Perinatal and Maternal Mortality Review Committee, and the Midwifery Council of New Zealand. A partly anonymised version of the report, with details identifying the parties removed except Health NZ Waitematā and Waitākere Hospital, will be placed on the HDC website (www.hdc.org.nz) for educational purposes.