HEALTH & DISABILITY COMMISSIONER
TE TOIHAU HAUORA, HAUĀTANGA

Failure to investigate placental abnormality and intrauterine growth retardation during pregnancy

1. On 13 July 2022, the Health and Disability Commissioner (HDC) received a complaint from Mrs A and Mr A about the care Health New Zealand | Te Whatu Ora Southern (Health NZ) provided to Mrs A in September and October 2021 while Mrs A was pregnant with their son, Baby A. Sadly, Baby A was stillborn in late September 2021 at 31 weeks' gestation. Mrs and Mr A raised concerns that the clinicians at Southland Hospital did not investigate and act upon the possibility of a placental abnormality[1] during her pregnancy.

2. This case highlights the importance of potentially concerning diagnostic findings being readily accessible and therefore known to the treating obstetrician to ensure they can make an informed decision on the ongoing management of the pregnancy. This case also reinforces the importance of locum clinicians being fully orientated to the clinical setting they are working in to equip them to work effectively.

3. I acknowledge the extremely difficult time Mrs and Mr A have been through and extend my sincere condolences to them and their whānau for the loss of Baby A. By placing this complaint, Mrs and Mr A want to ensure that processes and systems within the antenatal clinic at Southland Hospital are improved so their experience is not repeated.

Information gathered

4. Mrs A had become pregnant via in vitro fertilisation.[2] In late August 2021 (at 26 weeks' 4 days' gestation), Mrs A underwent a growth scan because her lead maternity carer (LMC) recognised that her previous scan on 11 August had shown growth under the 5th percentile[3] and a possible intrauterine growth restriction (IUGR).[4] The scan on 30 August showed that the fetus was small, with an abdominal circumference on the 17th percentile[5] and biparietal diameter[6] under the 2nd percentile.[7] The amniotic fluid volume[8] and doppler ultrasound scan (doppler)[9] were normal. Recommendations were made for further serial growth scans[10] and dopplers, and a repeat scan was booked for 14 September 2021. Mrs A's LMC

[1] Any issue with the structure, function, or location of the placenta during pregnancy.
[2] A fertility treatment that involves fertilising an egg with sperm in a laboratory to create an embryo, which is then transferred to the uterus.
[3] A fetal growth below the 5th centile may indicate a fetus that is small for its gestational age.
[4] When a baby does not grow at a normal rate in the womb, resulting in a weight below the 10th percentile for its gestational age.
[5] A normal range for fetal abdominal circumference is between the 10th and 90th percentiles for a given gestational age.
[6] A measurement of the widest part of the fetal skull.
[7] The normal range is between the 10th and 90th percentile for a given gestational age.
[8] Amount of liquid surrounding a fetus.
[9] To measure blood flow in the fetus.
[10] A series of repeated ultrasound scans (usually performed every two to four weeks) to monitor fetal growth and wellbeing during pregnancy.

referred her for a specialist consultation because of these findings. It appears that it was not possible to immediately schedule a face-to-face specialist appointment.

5. On 8 September 2021, Mrs A had a phone consultation with an obstetrician and gynaecologist consultant from Southland Hospital. They reviewed Mrs A's medical history and most recent scans, and the consultant organised a TORCH screen[11] blood test for unexplained IUGR. The subsequent TORCH screen showed no current infection.

6. Mrs A underwent an ultrasound scan on 14 September 2021. The opinion section of the report stated: 'Probable IUGR with AC [abdominal circumference] significantly below the 5th centile on the ASUM[12] chart … Normal amniotic fluid and dopplers.' However, the body of the report stated that '[t]he ductus venosus[13] A wave[14] is approaching the baseline.' This is an abnormal doppler finding but was not included in the opinion section of the sonographer's report. Health NZ told HDC that standard management for IUGR is weekly ultrasound with dopplers; if any abnormal dopplers are identified, then twice-weekly dopplers are performed. If these doppler results worsen, or maturity is reached, the baby should be delivered. Health NZ accepts that none of this was done.

7. On 22 September 2021, Mrs A was seen in the Antenatal Clinic at Southland Hospital by Dr B, locum obstetrician and gynaecologist. Health NZ told HDC that there was often 'little opportunity for orientation for locums in the obstetrics and gynaecology department as the service has been critically short staffed.' In response to the provisional opinion, Health NZ also noted the 'extreme pressure' under which the department was working at the time whilst trying to manage COVID-19.

8. Dr B discussed the results of the TORCH screen with Mrs A. According to Mrs A, 'it became apparent during this consultation that he had no idea about any of my history as he did not have my notes available. I had to share my own LMC notes … which he barely glanced at.' In response to the provisional opinion, Mrs A said that Dr B brushed off her concerns when she tried to stress to him that her LMC and sonographer were 'very concerned' about fetal growth.

9. The clinic letter Dr B subsequently drafted states that Mrs A reported good fetal movements, that, clinically, the uterine size was compatible with the gestation of 29 weeks, and that the fetal heart rate was heard. The fetal heart rate was not recorded, and, in response to the provisional opinion, Mrs A told HDC that she did not report 'good fetal movements.' Dr B documented in the clinic letter that the fetal weight was at the 10th percentile[15] on the

[11] A blood test used to screen for infections that can cause complications in pregnant women and harm to a developing fetus.
[12] A growth chart used to track fetal growth based on standard ultrasound measurements, such as head circumference, abdominal circumference, and femur length.
[13] A blood vessel in the fetus that connects the umbilical vein to the inferior vena cava, allowing highly oxygenated blood and nutrients from the placenta to bypass the liver and flow directly to the heart.
[14] Corresponds to fetal atrial contraction and is the lowest point in the wave form. Reversal of the A wave (ie, crossing the baseline) is always abnormal.
[15] Small for gestational age, with the fetus being smaller than 90% of fetuses at the same gestational age.

GROW chart[16] and that the liquor volume[17] and dopplers were normal. Mrs A's blood pressure was noted as slightly elevated, so Dr B requested pre-eclampsia[18] blood tests. Dr B wrote: '[Mrs A] is having another [ultrasound] scan next week, and I advised her that so long as the [fetal] growth is trending upwards and the other parameters are normal, we will carry on up to 37 weeks.' A review was planned for two weeks later. Health NZ told HDC that, given the reassuring findings, 'Dr B felt there were no compelling reason[s] to admit Mrs A or to arrange any other investigation that day'.

10. Health NZ told HDC that, in retrospect, further investigations should have been undertaken when Dr B saw Mrs A on 22 September 2021. However, it noted that Dr B's actions were based on the findings in the opinion section of the ultrasound scan report from 14 September 2021, which did not include the abnormal finding recorded in the body of the report. Health NZ told HDC: '[I]f the body of the report had been reviewed, different action could have been taken and an [ultrasound scan] ordered that day.' In summary, Health NZ acknowledged that the ultrasound scan report summary that Dr B relied on during his consultation with Mrs A did not contain the crucial information about the abnormal doppler and that appropriate action was not taken after the abnormal doppler result. Health NZ told HDC: 'In retrospect, we wish we had intervened with an earlier [ultrasound scan]. It may have prevented this tragedy.'

11. In response to the provisional opinion, Mrs A told HDC: 'I would expect someone in Dr B's position to have fully read the scan report and not just the 'opinions section' at the end so he could make a fully informed decision.'

12. Mrs A contacted her LMC on 26 September 2021 because of decreased fetal movements. Mrs A was referred to Southland Hospital, where she had an ultrasound that, sadly, confirmed the loss of Baby A. Mrs A underwent a delivery via caesarean section[19] and remained an inpatient until her discharge from hospital on 2 October 2021.

13. Mrs A said that, after the loss of Baby A, she was told she would be seen in the antenatal clinic at Southland Hospital in six months for a debrief with clinical staff once the autopsy results had been received. Mrs A said that, despite following up, by July 2022 (9 months later) she had not received a follow-up appointment. Health NZ said it sincerely apologises for the delay in arranging a follow-up appointment for Mrs A. It said that the service had been under immense pressure and had been challenged by long waiting lists. In summary, Health NZ said:

> 'In these circumstances, this appointment should have been actioned immediately. We are saddened to hear the delay in follow-up care has had an effect on Mrs A and her family and … we are working on implementing processes to ensure patients who experience the loss of a child are followed up in a timely manner.'

[16] A clinical growth chart used to track the height and weight of a fetus against percentiles.
[17] The volume of amniotic fluid surrounding a fetus during pregnancy.
[18] A serious pregnancy condition that develops after 20 weeks' gestation and is characterised by high blood pressure and often protein in the urine or other signs of organ damage.
[19] A surgical procedure to deliver a baby through an incision in the mother's abdomen and uterus.

Changes made

14. Health NZ stated that an adverse event review was not undertaken at the time. It said that Mrs A's clinical records were reviewed both as part of the routine Obstetric Morbidity and Mortality meeting and by the obstetrics clinical lead.

15. In an update to HDC dated September 2025, Health NZ said it has made significant improvements to the obstetric service provided at Southland Hospital since 2022. Health NZ referred to the robust administration procedures it has introduced, including new personnel and a fully recruited team of eight consultants. Health NZ stated that it now only ever uses regular and well-orientated locum staff, and a locum induction and orientation guide has been established with the assistance of a regular well-experienced locum since this event.

Responses to provisional opinion

Mrs and Mr A

16. Mrs and Mr A were given the opportunity to comment on the 'information gathered' section of the provisional opinion. Where relevant, their comments have been incorporated into this report. In addition, Mrs and Mr A told HDC:

> 'We understand that as humans we all make mistakes and that in order to progress, we need to own it, fix it and learn from it. Although there is nothing that can be done to fix losing our precious son, Baby A, there are learnings that can be taken from our experience, to help improve our health system for other expecting mothers … We left the hospital that day feeling dismissed, not listened to and feeling really uneasy about the situation. What could we do? He was the obstetrician. We had finally been able to see a specialist after delays, I just wish it was someone who did their job properly so our son could have had a fighting chance.'

Health NZ

17. Health NZ was given the opportunity to comment on the provisional opinion. Where relevant, its comments have been incorporated into this report. Health NZ accepted most of the findings in the provisional opinion and made some comments on the proposed recommendations. Of note, Health NZ accepted the lack of a formal orientation for its locum medical staff at the time and accepted the opinion's criticism of this. However, it also highlighted that 'the more important aspect was the failure of the locum SMO to follow New Zealand guidelines in the management of babies small for their gestational age.'

Opinion

Failure to appropriately manage abnormal ultrasound findings and IUGR – breach

18. Under Right 4(1) of the Code of Health and Disability Services Consumers' Rights (the Code), Health NZ had a duty to ensure that Mrs A received services with reasonable care and skill when her LMC referred her with unexplained IUGR in September and October 2021. This did not happen. In my view, several factors contributed to the shortcomings in her care. I consider that these shortcomings represent systemic failures for which ultimately Health NZ is responsible at an organisational level. First, it seems that several Southland Hospital staff were involved in not identifying and escalating the ultrasound abnormality sooner. Second, after the abnormal result was identified, no appropriate action was taken to respond to the IUGR. The locum obstetrician did not follow the standard treatment for IUGR, and further

investigations were not undertaken when Mrs A was seen in antenatal clinic on 22 September 2021.

19. I proposed to Health NZ that I find it in breach of Right 4(1) of the Code, as Health NZ had acknowledged the deficiencies in the care provided, as outlined above. Health NZ accepted this proposed breach finding.

20. Health NZ referred to its obstetrics department at the time as being critically short-staffed, and in response to the provisional opinion stated that the department was also working under 'extreme pressure' at the time because of the COVID-19 pandemic. This meant there was little opportunity for it to provide adequate orientation and support to its locum clinicians. While I acknowledge the challenges faced by Health NZ at the time of the events, I consider it was Health NZ's responsibility to ensure its locum clinical staff were appropriately orientated to their working environment to ensure the provision of safe, timely, and competent care. For these reasons, I find Health NZ in breach of Right 4(1) of the Code for failing to provide care to Mrs A with reasonable care and skill.

Delay in follow-up appointment – adverse comment

21. Health NZ accepted that it failed to provide a timely follow-up appointment to Mrs A after the loss of Baby A, citing resourcing issues. Although I appreciate Health NZ was short of staff and that this impacted on service delivery, it is disappointing that greater effort was not made to communicate with Mrs A over this time to reassure her that she would have a meeting as soon as possible. Mrs A made multiple attempts to follow up with the service herself, and it is very clear from her efforts that an opportunity to discuss the autopsy findings with clinicians was important to both her and her husband and integral to their grieving process. I suggest that the delay and lack of communication from Health NZ only added to the significant distress Mrs and Mr A were already experiencing. I acknowledge the changes that have since been implemented by Health NZ in this respect, including that there is now a separate wait list for patients who have experienced loss.

Further comment

22. The Te Tāhū Hauora Health Quality & Safety Commission 'National Adverse Events Reporting Policy 2023' aims to enhance safety in healthcare by promoting healing, learning, and improvement after adverse events and near misses in health and disability services in New Zealand. It focuses on improving consumer and healthcare worker safety. This current policy came into effect on 1 July 2023 and replaced the National Adverse Events Reporting Policy 2017. The 2017 policy also supported a nationally consistent approach to reporting, reviewing, and learning from adverse events.

23. I note that Southland Hospital did not undertake an adverse event review after the stillbirth of Baby A. In my opinion, this was a valuable opportunity for its obstetric service to learn from this episode and make the necessary changes to its systems and processes to help prevent a repeat of Mrs and Mr A's tragic loss. This is an objective Mrs and Mr A sought to achieve by bringing their concerns to the attention of HDC in the first place. The completion and reporting of a high-quality adverse event review to Te Tāhū Hauora Health Quality & Safety Commission would also have allowed for greater visibility to be given to the circumstances surrounding this case and, in my opinion, possibly facilitated wider learnings to be disseminated at a national level.

Recommendations and follow-up actions

24. I recommend that Health New Zealand | Te Whatu Ora Southern:

- provide an apology to Mrs and Mr A for the failings identified in this report. I note that, at the outset of this process, Mrs and Mr A sought a meeting with the Obstetrics Department at Southland Hospital to discuss the circumstances surrounding Baby A's stillbirth. I acknowledge the passage of time, but I request that Mrs and Mr A be given a further opportunity to meet face-to-face to receive their apology. If they decline the offer of a meeting, a written apology is to be provided to HDC within three weeks of the date of this report for forwarding to Mrs and Mr A;

- provide an update to HDC on the effectiveness of the changes it has made to its obstetric service since this event (referred to under paragraph 13 of this report). This update is to be provided to HDC within three months of the date of this report;

- distribute an anonymised version of this report to internal radiology personnel, including sonographers, and external suppliers of obstetric ultrasound, to remind them of the importance of escalating critical obstetric ultrasound findings as appropriate and ensuring the summary findings section of the radiology report accurately reflects the findings recorded in the body of the document; and

- use an anonymised version of this report to remind clinicians working in the obstetrics department of the importance of routinely reviewing radiology reports in their entirety, including the body of the document.

  Evidence of this training is to be provided to HDC within six months of the date of this report.

25. A copy of this report with details identifying the parties removed, except Health New Zealand | Te Whatu Ora Southern and Southland Hospital, will be placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes and will be forwarded to Te Tāhū Hauora Health Quality & Safety Commission for their information.

Rose Wall
Deputy Health and Disability Commissioner