Decision 21HDC01744
27 November 2025

HEALTH & DISABILITY COMMISSIONER
TE TOIHAU HAUORA, HAUĀTANGA

Inadequate assessment leading to delayed diagnosis of ectopic pregnancy

1. Miss A submitted a complaint to the Health and Disability Commissioner (HDC) regarding the care provided to her by clinical staff at North Shore Hospital (Health New Zealand | Te Whatu Ora – Waitematā) on 7 and 8 July 2021. Miss A was experiencing pain on the right side and heavy vaginal bleeding when she was instructed to present to North Shore Hospital Emergency Department (ED) after an ultrasound scan reported findings consistent with an ectopic pregnancy.[1] Clinical staff at North Shore Hospital discharged Miss A after an overnight stay and referred her to Auckland Hospital for follow-up of a suspected miscarriage.

2. Miss A continued to experience pain on the right side, heavy bleeding, and high levels of pregnancy hormones in her blood tests. On 11 July 2021, Miss A experienced extreme pain from an ectopic pregnancy in her right fallopian tube. She required surgery to remove her fallopian tube.

3. Miss A considers that her traumatic experience could have been avoided had sufficient checks been undertaken to clear her of an ectopic pregnancy and had she received a proper diagnosis at North Shore Hospital.

Background

4. Miss A told HDC that she experienced pain in her uterus and light spotting on 18 June 2021 and heavier bleeding with cervical pain and pelvic cramps on 23 June 2021. On 30 June 2021, Miss A visited her general practitioner (GP), where she had her Mirena[2] removed.

5. Miss A told HDC that she continued to experience 'excruciating pain' on her right side after the Mirena was removed. On 5 and 6 July 2021, Miss A called her GP, noting that she was still bleeding very heavily with pain. Miss A's GP ordered a blood test, including human chorionic gonadotropin (hCG)[3] to test for pregnancy. The pregnancy test returned a positive result.[4]

6. On 7 July 2021, Miss A's GP called her to discuss the positive pregnancy test and advise that there was a possibility of miscarriage or ectopic pregnancy because the Mirena would have been in place during the development of the pregnancy. Miss A's GP made an urgent referral on the same day to a private radiology service for an ultrasound to investigate the matter further.

[1] An ectopic pregnancy is a condition where a fertilised egg implants outside the uterus, usually within the fallopian tubes. They are considered a medical emergency and need to be treated and/or removed.
[2] A brand of hormonal intrauterine device to provide long-term birth control/contraception until it is removed.
[3] The level of hCG in the blood confirms pregnancy and/or can be used to diagnose certain conditions.
[4] An hCG level of 1,050IU/L, where the reference range is <5IU/L.

7. On 7 July 2021, the private radiology service performed a transabdominal and transvaginal ultrasound scan at 1:53pm. The report notes a reasonably small volume of complex fluid in the pouch of Douglas[5] and an adnexal mass measuring up to 57mm. The findings were noted as consistent with a 'right-sided tubal ectopic [pregnancy] with blood in the pouch of Douglas.' In light of these findings, Miss A was instructed to go directly to the North Shore Hospital ED, and clinical records note that the findings were discussed over the phone with Dr B, gynaecology senior medical officer (SMO) at the North Shore Hospital ED.

8. Health New Zealand | Te Whatu Ora (Health NZ) Waitematā told HDC that Dr B accepted Miss A for assessment as, given the verbal radiology findings, history of recent removal of an intrauterine device, and heavy bleeding, she felt there was a 'high risk' of an ectopic pregnancy. Dr B could not determine clinical urgency over the phone, and because a ruptured ectopic pregnancy can result in a surgical emergency, the decision was made to evaluate Miss A at North Shore Hospital rather than her domiciled Auckland City Hospital. Dr B told HDC that she 'made it clear' to North Shore Hospital ED staff that she believed there was a high risk of an ectopic pregnancy.

7–8 July 2021 admission: North Shore Hospital

9. On 7 July 2021, Miss A was admitted to the North Shore ED at 4:02pm, which was during shift handover. The provisional diagnosis is recorded as '?Ectopic [pregnancy]'. On arrival, Miss A was seen by a senior house officer[6] (SHO) who assessed her as stable. Pelvic and abdominal examinations were performed, and a repeat pregnancy test and blood tests were requested. The SHO then attended handover and reported the results of the physical assessment.

10. SMO Dr C was present during handover. Dr C specialised in diagnostic ultrasounds in women and reviewed the ultrasound scans. Dr C did not see any evidence of a pregnancy in the uterus and noted an ovoid mass that was possibly a tubal pregnancy (ectopic pregnancy) or a blood clot. Dr C told HDC that the differential diagnosis included ectopic pregnancy, tubal abortion, clot from a uterine miscarriage, and pregnancy of unknown location (PUL).[7] According to Dr C there was not yet enough clinical information to determine a diagnosis.

11. Dr B told HDC that she looked at the images and did not change her provisional diagnosis that Miss A had a suspected ectopic pregnancy. Her provisional diagnosis was handed over to the next team with a plan to manage Miss A as a PUL (this includes the possibility of an ectopic pregnancy). The pregnancy hormone (hCG) blood test results were not yet available. Miss A was admitted overnight, and the hCG blood test was to be repeated because a decreasing level would indicate a failing pregnancy.

12. Dr B stated that she was surprised to subsequently learn that the SHO had interpreted the handover discussion to mean that a miscarriage was more likely to have occurred. Health

[5] Deep space within the lining of the abdominal cavity of the female pelvis located between the uterus and rectum. It is the lowest part of the pelvic cavity, and a place where fluids collect.
[6] Health NZ Waitematā told HDC that the on-call SMO did not see Miss A as the SMO would only see her if there was a concern.
[7] A positive pregnancy test where it is unclear whether the pregnancy is inside or outside the uterus. This includes an ectopic pregnancy but may also include a viable uterine pregnancy not visible on scan or a miscarriage.

NZ Waitematā stated that a misunderstanding occurred and as a result Miss A was incorrectly advised that her bleeding was more in keeping with a failed uterine pregnancy and reassured that she had most likely had a miscarriage. Despite the misunderstanding, Miss A was managed as a PUL. Further management was then handed over to the on-call gynaecology team for the next shift. Health NZ Waitematā told HDC that the on-call gynaecology SMO did not see Miss A because a plan of care had been established, and there were no further concerns.

13. On 8 July 2021, Miss A was assessed in the morning by a medical officer of special scale, who noted minimal bleeding, decreasing hCG levels,[8] and no abdominal pain. Health NZ Waitematā told HDC that it was appropriate to provide conservative management overnight as Miss A had decreasing hCG levels and was in a stable condition. They said that, because emergency surgery was not required, it was appropriate for Miss A to be transferred to her regional hospital, which was Auckland City. The doctor suggested that Miss A be transferred to the Auckland Women's Assessment Unit (WAU) for further management. Health NZ Waitematā said that Miss A preferred to be discharged to her parent's house with outpatient follow-up at the Early Pregnancy Assessment Unit (EPAU).[9] Health NZ Waitematā accept that the advice provided the previous day with the reference to a miscarriage may have influenced Miss A's decision to opt for outpatient monitoring. The doctor contacted the registrar at WAU and the on-call gynaecology SMO to discuss Miss A's case.

14. On 8 July 2021, Miss A was discharged at 12:19pm with a primary diagnosis of 'pregnancy of unknown location likely miscarriage'. The discharging clinician provided safety netting advice that Miss A was to see her GP or visit Auckland City Hospital[10] if she developed heavy bleeding, fever, abdominal pain, and/or concerning vaginal discharge. The discharging clinician told HDC that she did inform Miss A that an ectopic pregnancy was still a possibility and that Miss A had asked what the doctor had thought was on the right side of her scan. The discharging clinician explained that they could not confirm an exact diagnosis, but they did not think it looked typical of an ectopic pregnancy. Health NZ Waitematā accepts that Miss A should have been made more aware of the risks of conservative management of a possible ectopic pregnancy and the importance of presenting to Auckland City Hospital if she experienced further pain.

15. Miss A was referred to the EPAU for follow-up and a repeat ultrasound scan with urgency (noted as to be seen within 2–7 days). A red alert note stating: 'Suspected ectopic pregnancy needs to be discussed with Gynaecology Registrar' was documented on the referral.

9–10 July 2021: Auckland City Hospital

16. Health NZ – Te Toka Tumai Auckland told HDC that the EPAU does not manage ectopic pregnancies except in the context of a follow-up after definitive treatment. As the Health NZ Waitematā impression was that of a PUL, the referral was directed to EPAU rather than

[8] The initial test result was 1,151U/L, which decreased to 984U/L.
[9] Nurse-led outpatient service at a clinical centre (Health NZ – Te Toka Tumai Auckland) designed to facilitate protocol-led care for complications of early pregnancy.
[10] Because Auckland City Hospital is Miss A's domiciled hospital, as opposed to North Shore Hospital.

to the WAU. Medical oversight is provided by an SHO, who is supported by an on-call registrar based at the WAU at Auckland City Hospital.

17. On 9 July 2021, Miss A called EPAU in the morning because she was experiencing pain. The registered nurse advised Miss A to present to the Auckland City Hospital ED for further review, but Miss A called back later in the day to say that she did not present to the ED as her pain had subsided. The registered nurse advised Miss A to present to the ED if the pain returned or the bleeding caused concerns, to get an hCG test the next day, and that an ultrasound would be booked for 12 July 2021.

18. The registered nurse then contacted the WAU registrar, who discussed Miss A's condition with an SMO, who recommended that Miss A present urgently if she was experiencing pain. If pain-free, Miss A was to present to the WAU the next morning for a review. The registrar attempted to contact Miss A three times but was unable to reach her or leave a message. The EPAU nurse also made multiple unsuccessful attempts to contact Miss A and her next of kin.

19. On 10 July 2021, Miss A attended[11] the WAU for blood tests. The attending nurse told HDC that she recalls[12] Miss A's vitals as being normal and that she called an SHO, who was busy on the ward.[13] The nurse then contacted the registrar, who was in theatre. After discussing Miss A with the nurse, the registrar said to allow Miss A the choice of waiting to be reviewed or to go home and return if there were any concerns.

20. Health NZ – Te Toka Tumai Auckland told HDC that the absence of clinical notes from the 10 July clinic means it cannot comment further on whether or why the diagnosis of an ectopic pregnancy and/or surgical intervention was not considered on this date. However, retrospective notes written by the attending nurse on 25 September 2021 state "we didn't know the exact location of her pregnancy; we would treat her as ectopic pregnancy and monitor her closely & her blood levels until it returns to normal. Miss A wanted to know more about the ectopic preg[nancy], which I explained". Miss A was scheduled for an ultrasound scan on Monday 12 July 2021.

11 July 2021: Auckland City Hospital ED

21. At 8:12am on 11 July 2021, Miss A presented to the Auckland City Hospital ED with increasing right-sided lower abdominal pain. The clinical records noted Miss A's recent history of vaginal bleeding, a positive pregnancy test, and the 7 July 2021 ultrasound results.

22. At 8.45am, Miss A was seen by a gynaecology SMO, who noted Miss A's symptoms, previous imaging, and clinical history. Health NZ – Te Toka Tumai told HDC that the gynaecology SMO discussed the probable diagnosis of an ectopic pregnancy with Miss A based on her clinical history, examinations, and recent ultrasound result. The gynaecology SMO recorded that Miss A would 'not be for conservative management due to pain [and] size of [right] tubal

[11] Health NZ – Te Toka Tumai Auckland told HDC that this was following a call with a registered nurse, but there are no clinical records to confirm this.
[12] Health NZ – Te Toka Tumai Auckland informed HDC that clinical records from the 10 July 2021 appointment are missing, with no explanation. The following statements are retrospective statements made by the attending nurse.
[13] 10 July 2021 was a Saturday, and available staff numbers were lower than on weekdays.

mass' and that Miss A should proceed straight to surgery. At 10.18am, Miss A underwent surgery to remove her right fallopian tube.

23. Health NZ – Te Toka Tumai Auckland told HDC that it is 'very regretful' about the events and acknowledges that, in hindsight, the ectopic pregnancy could have been diagnosed earlier. Health NZ – Te Toka Tumai Auckland also stated that the abnormal ultrasound finding of a right-sided adnexal mass of 57mm, the slowly declining hCG levels, and intermittent pain were 'probably sufficient to justify surgical intervention' on 9 or 10 July 2021 and that '[w]hile an earlier diagnosis would not have avoided the surgical procedure and the removal of the fallopian tube, it would have avoided the emergency care required on the morning of [11] July 2021.'

Subsequent events

24. Health NZ – Te Toka Tumai Auckland discussed Miss A's case at a gynaecology multidisciplinary meeting on 20 August 2021, noting a 3-day delay in diagnosing Miss A's ectopic pregnancy, with contributory factors being staff lacking relevant knowledge and skills, delayed emergency response, inadequate communication between WAU staff, and failure to follow recommended best practice.

Responses to provisional decision

Miss A

25. Miss A was provided with a copy of the 'facts gathered' section of my provisional report and given an opportunity to comment. Miss A is pleased that Health NZ acknowledged that staff lacked the relevant knowledge and skill and is looking forward to moving on from this experience.

Health NZ – Waitematā

26. Health NZ – Waitematā was provided with a copy of my provisional report and given an opportunity to comment. Health NZ advised that it accepts my decision and recommendations.

Health NZ – Te Toka Tumai Auckland

27. Health NZ – Te Toka Tumai Auckland was provided with a copy of my provisional report and given an opportunity to comment. Health NZ advised that it accepted two of my provisional recommendations and provided information on system changes, which I have included in this report where relevant. I am satisfied that the changes made have eliminated the need for any further recommendations.

Decision: Introduction

28. After the removal of her Mirena, Miss A continued to have persistent abdominal pain and bleeding. Urgent ultrasound imaging reported a potential ectopic pregnancy, and Miss A was instructed to attend the North Shore Hospital ED. On 7 July 2021, she was assessed by clinical staff and managed conservatively, then discharged home a day later. Miss A communicated with the WAU on 9 and 10 July 2021 regarding her symptoms, but no further actions were taken until Miss A attended the Auckland City Hospital ED on 11 July 2021, where she underwent surgery to remove a fallopian tube containing an ectopic pregnancy.

29. In reaching my decision, I have considered independent clinical advice from Dr John Short, obstetrician and gynaecologist **(Appendix A)**.

Health NZ Waitematā – breach

30. On 7 July 2021, Miss A was referred to the North Shore Hospital ED after an ultrasound report had clearly noted a potential 'right-sided tubal ectopic [pregnancy] with blood in the pouch of Douglas'. These findings were discussed with the receiving SMO, who confirmed to HDC that her understanding was that of a potential ectopic pregnancy and that she had conveyed this understanding when handing over Miss A's care to other staff. Despite this, subsequent clinical staff did not adequately consider an ectopic pregnancy as the primary diagnosis, which affected the ongoing management of Miss A's care.

31. My advisor, Dr Short, advised that the diagnosis of ectopic pregnancy was clear based on the 'symptoms, risk factors, ultrasound findings and hCG pattern' and that the assessment by the two SMOs involved in Miss A's care on 7 and 8 July 2021 was inadequate as they did not appear to have personally reviewed Miss A or considered the surrounding risk factors for an ectopic pregnancy. I also note Health NZ – Te Toka Tumai Auckland's statements that the referral being sent to the EPAU rather than the WAU reflected the impression of a PUL (rather than an ectopic pregnancy) and that the gynaecology SMO who assessed Miss A at the Auckland City Hospital ED on 11 July 2021 also recognised a tubal ectopic pregnancy from the same ultrasound findings.

32. Health NZ Waitematā guidelines on managing ectopic pregnancies require surgical management for patients presenting with severe, ongoing abdominal pain, and an adnexal mass larger than 5cm. Expectant management is appropriate for patients with minimal symptoms, hCG <1,500 IU/L (ideally <1,000 IU/L), adnexal mass <3cm on transvaginal ultrasound, and no significant free fluid in the pouch of Douglas. Miss A had an adnexal mass measuring up to 5.7cm, a small volume of fluid in the pouch of Douglas, and an initial hCG level of 1,151 IU/L. I am critical of the investigation, diagnosis, and treatment of Miss A during her North Shore Hospital ED admission. I find that it was inappropriate for Miss A to be managed with a 'wait and see' approach. In my opinion, surgical intervention should have occurred at an earlier stage, as per Health NZ Waitematā guidelines. Accordingly, the decision to discharge Miss A on 8 July 2021 was inappropriate.

33. Dr Short also advised that the safety netting advice provided to Miss A on discharge was inadequate and that the potential seriousness of Miss A's condition was not properly emphasised to her. Health NZ Waitematā accepts that there was a 'miscommunication' at handover, where clinical staff falsely reassured Miss A about a miscarriage without clearly stating that an ectopic pregnancy was still a possibility and did not provide a full explanation of the risks of conservative management of a possible ectopic pregnancy. I consider this contributed to Miss A's care not being appropriately escalated for surgical intervention. It is possible that Miss A would have sought an earlier assessment and been more responsive to the clinicians who attempted to contact her on 9 July 2021, had she been fully informed of the potential diagnosis and the risks of conservative management.

34. Dr Short advised that the cumulative effects of the above deficiencies in care represent a severe departure from accepted standards. I accept Dr Short's advice.

35. In summary, I am critical of the care Health NZ Waitematā provided to Miss A in its disregard for the clear potential diagnosis of an ectopic pregnancy (leading to conservative management) and inappropriate discharge with inadequate safety netting advice that falsely reassured Miss A. Although Health NZ Waitematā provide that the clinicians at the time had considered the diagnosis of an ectopic pregnancy, I consider that adequate weight was not given to this provisional diagnosis, which is supported by the contemporaneous clinical records and the treatment options considered and discussed with Miss A. It appears that there were aspects of miscommunication, both between clinicians and with Miss A; however, I do not consider that this absolves Health NZ Waitematā from its duty of care, and I therefore consider that it breached Right 4(1)[14] of the Code.

Health NZ – Te Toka Tumai Auckland: adverse comment

36. Following discharge on 8 July 2021, Miss A's care was handed over to Health NZ – Te Toka Tumai Auckland for follow-up and further management. Miss A called the WAU on 9 July 2021 because of pain but decided against presenting to the ED because her pain had subsided. Miss A attended the WAU on 10 July 2021 for blood tests and was sent home without being properly assessed by the on-call SHO or SMO.

37. First, I recognise that the earlier mismanagement of Miss A's symptoms at Health NZ Waitematā may have impacted her subsequent assessment at Health NZ – Te Toka Tumai. However, I consider that proper triage and a more critical analysis of the referral information would have prompted Health NZ – Te Toka Tumai to manage Miss A's care differently. I am critical of the apparent shortfall in appropriate investigation and management of Miss A's symptoms on 9 July 2021 but consider this shortcoming in care is mitigated by the clear safety netting advice provided to her and the multiple recorded attempts by clinical staff to contact her on 9 July 2021 to discuss her care. I also acknowledge that Miss A (albeit operating under a misunderstanding of the severity and associated risks of her condition) made the decision not to present to ED on this day.

38. My primary concern relates to the care provided to Miss A on 10 July 2021, when she was not seen by the on-call registrar or SMO before being discharged, and to the fact that there were no clinical records to document the discussions and decisions made on this day. Health NZ – Te Toka Tumai Auckland told HDC that, if Miss A had attended Auckland City Hospital on 9 July 2021, a 'critical analysis of the available information and an earlier diagnosis would' have been made. However, it is unclear why these actions were not taken the following day on 10 July 2021 when Miss A attended WAU. I am critical of this oversight and the lack of key clinical documentation regarding the 10 July 2021 clinic, which limits my ability to fully assess the care provided on this date. Dr Short advised that the above deficiencies in care represent a mild departure from accepted standards.

[14] The right to have services provided with reasonable care and skill.

In summary, I am concerned that Health NZ – Te Toka Tumai Auckland did not take further actions to critically assess the information received to appropriately manage Miss A's subsequent care and that aspects of these decisions were not appropriately documented. However, I consider that the prior actions of Health NZ Waitematā, the clear attempts by clinical staff to provide safety netting and follow-up advice, and the immediate appropriate action taken on Miss A's presentation on 11 July 2021 serve to mitigate the shortcomings in care.

Changes made

39. Health NZ Waitematā told HDC that, since the events, it has checked the SHO handbook to ensure red flags for an ectopic pregnancy are clearly highlighted and ensured that ectopic pregnancies are covered early in SHO teaching. It has also advised that it will ensure that a registrar or SMO will review all women who remain with a diagnosis of PUL after initial scans and blood tests, and it will look into updating the discharge documentation specific to women discharged with a PUL to include specific safety netting advice.

40. Health NZ – Te Toka Tumai Auckland transitioned to an electronic patient management system in October 2024 and now uses TrakCare to monitor patient progress throughout their time in WAU. Te Toka Tumai Auckland Hospital is also working to implement eNotes to replace handwritten clinical notes across all inpatient areas by 1 July 2026, ensuring contemporaneous record keeping and removing the risk of lost paper documentation. A dedicated electronic Gynaecology Assessment Note, which is visible in the Regional Clinical Portal, has replaced the use of paper notes for patients awaiting follow-up.

41. Additionally, a new role, Acute Gynaecology Clinical Nurse Specialist, was created in 2023. These are senior gynaecology nurses who are primarily based in WAU and assess gynaecology patients, providing support to resident medical officers and WAU gynaecology nurses, as well as liaising with EPAU.

Recommendations

42. I recommend Health NZ Waitematā:

    a. Provide a written apology to Miss A for the breach of the Code and deficits identified in this report. This apology is to be sent to HDC within 3 weeks of the date of this report for forwarding to Miss A.

    b. Clarify what measures have been taken to ensure that all women who remain with a diagnosis of PUL after initial scans and blood tests are reviewed by a registrar or SMO and provide HDC with evidence that this has occurred within 3 months of the date of this report.

    c. Provide HDC with an update on its review of the safety netting advice provided in its discharge documentation for women discharged with a PUL and provide a copy of the updated electronic discharge documentation as evidence within 6 months of the date of this report.

    d. Use this case as a basis for developing education and/or training on managing ectopic pregnancies for staff. Evidence confirming the content of the education

and/or training (eg, training material) and delivery (eg, attendance records) is to be provided to HDC within 3 months of the date of this report.

e. Provide an updated copy of the SHO handbook with the red flags for ectopic pregnancies highlighted and confirm that ectopic pregnancies are covered in SHO teaching to HDC within 3 months of the date of this report.

f. Perform an audit of the last 10 consumers who presented to the ED with PUL or a suspected ectopic pregnancy to check whether the care provided was compliant with its internal guidelines. As part of this audit, the auditor should evaluate whether an appropriate clinical review occurred and whether adequate safety netting advice was provided to the consumer. Results of this audit, including any corrective actions, are to be provided to HDC within 3 months of the date of this report.

43. I recommend Health NZ – Te Toka Tumai Auckland:

a. Provide a written apology to Miss A for the deficiencies identified in this report. This apology is to be sent to HDC within 3 weeks of the date of this report for forwarding to Miss A.

b. Use this case as a basis for developing education and/or training on managing ectopic pregnancies for staff. Evidence confirming the content of the education and/or training (eg, training material) and delivery (eg, attendance records) is to be provided to HDC within 3 months of the date of this report.

Follow-up actions

44. A copy of this report with details identifying the parties removed, except Health NZ Waitematā, will be sent to the Royal Australian and New Zealand College of Obstetricians and Gynaecologists and will be placed on the HDC website, www.hdc.org.nz, for educational purposes.

Rose Wall
Deputy Health and Disability Commissioner

Appendix A: Independent clinical advice to the Commissioner

The following independent clinical advice was obtained from Dr John Short, obstetrician and gynaecologist:

Dear […]

Complaint: Te Whatu Ora – Waitematā & Te Whatu Ora – Te Toka Tumai (Auckland)

Your ref: C21HDC01744

I have been asked to provide advice in this case (21HDC01744), regarding the care provided to [Miss A] from 7 to 11 July 2021. I have read and agree to follow the Commissioner's guidelines for independent advisors. I can confirm there is no conflict of interest.

I am a specialist Obstetrician and Gynaecologist, vocationally registered in New Zealand since 2007. I have worked as a senior medical officer in Obstetrics and Gynaecology at Christchurch Women's Hospital since 2006.

I have been asked to advise whether I consider the care provided to [Miss A] was reasonable in the circumstances, and why. I have been provided with relevant documents, including the consumer complaint, hospital records, clinician reports and documents (including clinical guidelines) from the hospitals involved. I have been asked these specific questions:

1. The appropriateness of [Miss A]'s overall management by Te Whatu Ora – Waitematā. Please comment on the timeliness of the investigations undertaken, diagnosis, and treatment. Please comment on the 'wait and see' approach and whether surgical intervention should have occurred earlier.

2. The appropriateness of the assessment undertaken by the North Shore Hospital Obstetrics & Gynaecology team between 7 July 2021 and 8 July 2021.

3. The appropriateness of the decision to discharge [Miss A] on 8 July 2021.

4. The adequacy of the safety netting advice provided to [Miss A] by the North Shore Hospital Obstetrics & Gynaecology team.

5. The appropriateness of Te Whatu Ora – Waitematā policies on the management of ectopic pregnancy and pregnancy of unknown location, and whether they were followed adequately in this case.

6. Any other matters relating to [Miss A]'s care from Te Whatu Ora – Waitematā that you consider warrant comment.

7. The appropriateness of [Miss A]'s overall management by Te Whatu Ora – Te Toka Tumai Auckland. Please comment on the timeliness of the investigations undertaken, diagnosis, and treatment.

8. The appropriateness of [Miss A]'s assessment at the Auckland District Health Board Early Pregnancy Unit on 10 July 2021.

9. The appropriateness of Te Whatu Ora – Te Toka Tumai Auckland's policies on ectopic pregnancy and EPAU, and whether they were followed adequately in this case.

10. Any other matters relating to [Miss A]'s care from Te Whatu Ora – Te Toka Tumai Auckland that you consider warrant comment.

Background

[Miss A] attended North Shore Hospital on 7 July 2021, following referral from [a private radiology service]. An ultrasound scan had been performed to investigate pelvic pain and abnormal vaginal bleeding in the context of a positive pregnancy test. An intrauterine device had been removed on 30 June (it was likely that she fell pregnant with this in situ – a risk factor for ectopic pregnancy). The scan had been strongly suggestive of an ectopic pregnancy, demonstrating a right adnexal mass, separate to the ovary, measuring 5.1 x 4.2 x 5.7cm. The Radiology staff, concerned regarding the possible consequences of an ectopic pregnancy, directed [Miss A] to the nearest hospital (North Shore) rather than her 'local' hospital (Auckland City, based on her address).

[Miss A] was reviewed by the gynaecology team at North Shore Hospital. She was found to be stable. The junior doctors felt that ectopic pregnancy was unlikely and miscarriage a better explanation for her bleeding. The scan images were reviewed by two SMOs, who felt that it was likely a failing pregnancy. She remained in hospital overnight and was discharged on 8/7 with a plan for further follow-up at Auckland City Hospital (a referral to the early pregnancy clinic was made). HCG levels had been measured, with levels of 1050 on 6 July, 1151 on 7 July, and 984 on 8 July. It is unclear whether these were performed at the same or different laboratories, but the pattern of results is referred to as 'plateauing' and is typical of ectopic pregnancy.

Nursing staff from Auckland City Hospital contacted [Miss A] on 9 July to arrange follow-up. She described pain and was therefore advised to attend the emergency department. Apparently, her pain settled so she did not attend. A back-up plan was made to attend the Women's Assessment Unit the following morning (10 July) for a review and further HCG, but this was not communicated to [Miss A], and she did not answer her phone despite several calls.

[Miss A] was reviewed at Auckland City Hospital on 10 July and further blood for HCG level taken (result was 700). She was seen by a senior house officer and was considered stable. There were no registrars or more senior doctors available to see her. A plan was made to review her in another two days with advice to return sooner if she had pain and/or bleeding.

She returned with increased pain on 11 July. Surgery was arranged that day due to concern regarding ectopic pregnancy. This was confirmed and treated at laparoscopy.

Comment

With regard to the specific questions

1. **The appropriateness of [Miss A]'s overall management by Te Whatu Ora – Waitematā. Please comment on the timeliness of the investigations undertaken, diagnosis, and treatment. Please comment on the 'wait and see' approach and whether surgical intervention should have occurred earlier.**

The care provided at Te Whatu Ora – Waitematā was substandard. The diagnosis of ectopic pregnancy was quite obvious based on symptoms, risk factors, ultrasound findings, and HCG pattern. The Waitematā guideline, on the page 6 algorithm, clearly states that she should have had surgical management due to the presence of a mass >5cm. In my opinion, she was unsuitable for the 'wait and see' approach, and surgery should have been arranged on 8 July.

2. **The appropriateness of the assessment undertaken by the North Shore Hospital Obstetrics & Gynaecology team between 7 July 2021 and 8 July 2021.**

The assessment by the junior doctors was appropriate. On [h] July, the ultrasound images were reviewed by two senior medical officers, who concluded that ectopic pregnancy was unlikely. They do not appear to have reviewed the patient or taken into account other info such as the plateauing HCG and risk factors for ectopic pregnancy. In my opinion, the assessment was inadequate and the SMOs preferred to rely on their incorrect interpretation of the ultrasound images.

3. **The appropriateness of the decision to discharge [Miss A] on 8 July 2021.**

This was inappropriate (see 1 and 2 above).

4. **The adequacy of the safety netting advice provided to [Miss A] by the North Shore Hospital Obstetrics & Gynaecology team.**

In my opinion, this was inadequate. Due to the incorrect diagnosis, the potential seriousness of her condition was not emphasised to [Miss A]. The problem was merely passed on to another healthcare provider. In doing so, they did not emphasise the potential seriousness of her condition. For example, had this been done, she may have been more likely to attend the emergency department as suggested on 9 July.

5. **The appropriateness of Te Whatu Ora – Waitematā policies on the management of ectopic pregnancy and pregnancy of unknown location, and whether they were followed adequately in this case.**

These are appropriate but were clearly not followed (see above).

6. **Any other matters relating to [Miss A]'s care from Te Whatu Ora – Waitematā that you consider warrant comment.**

I am left with the sense that Te Whatu Ora – Waitematā were prioritising transferring the responsibility for [Miss A]'s care back to her 'local' hospital rather than fully executing the duty of care they owed after admitting her. This is referenced several times in the documentation provided.

7. **The appropriateness of [Miss A]'s overall management by Te Whatu Ora – Te Toka Tumai Auckland. Please comment on the timeliness of the investigations undertaken, diagnosis, and treatment.**

There are some areas of concern, assuming that all relevant information was included in the referral from Waitematā (which I haven't seen). Proper triage and a more critical analysis of this information should have alerted the Auckland team to the fact that Waitematā had made the incorrect diagnosis and led to modification of the management plan and immediate review.

8. **The appropriateness of [Miss A]'s assessment at the Auckland District Health Board Early Pregnancy Unit on 10 July 2021.**

Ideally, she would have been seen by someone more senior than the senior house officer. However, this review occurred on Saturday, with on-call staffing only, and the registrars were busy. Again, review by a more senior practitioner would have prompted a more critical analysis of the available information and an earlier diagnosis.

9. **The appropriateness of Te Whatu Ora – Te Toka Tumai Auckland's policies on ectopic pregnancy and EPAU, and whether they were followed adequately in this case.**

The policy is appropriate. However, it was not followed appropriately in my opinion. Box A on page 8 states that she was unsuitable for expectant management (aka 'wait and see') due the presence of an extrauterine mass suspicious for ectopic pregnancy.

10. **Any other matters relating to [Miss A]'s care from Te Whatu Ora – Te Toka Tumai Auckland that you consider warrant comment.**

The team at **Te Whatu Ora – Te Toka Tumai Auckland** were placed in a difficult position due to the misdiagnosis and mismanagement by **Te Whatu Ora – Waitematā.** The findings therefore need to be interpreted in this context. Unfortunately, the Auckland team appear to have been too willing to trust the advice and plan from Waitematā, rather than critically appraise the available information and adjust the plan accordingly.

<u>Conclusion</u>

Ectopic pregnancy is a potentially serious condition that can lead to significant morbidity and even mortality, if not diagnosed promptly. Despite ample information to support this diagnosis, the gynaecology team at **Te Whatu Ora – Waitematā** failed to make the correct diagnosis, instituted an incorrect management plan and passed the problem to another healthcare provider. In doing so, they failed to impress upon [Miss A] the potential seriousness of her condition. The gynaecology team at **Te Whatu Ora – Te Toka Tumai**

Auckland appear to have blindly accepted the incorrect judgement of Waitematā, continuing the incorrect management and not following their own guidelines.

In my opinion, with regard to the care provided by **Te Whatu Ora – Waitematā**, there was a severe departure from accepted standards of care. The diagnosis of ectopic pregnancy was quite obvious, and surgery should have been performed on 8 July. This is consistent with Waitematā guidelines. Instead of doing this, they discharged her with limited information, leaving responsibility for follow-up to another healthcare provider. This put [Miss A] at significant risk.

In my opinion, with regard to the care provided by **Te Whatu Ora – Te Toka Tumai Auckland**, there was a mild departure from accepted standards of care. I am very sympathetic to the predicament they were placed in by **Te Whatu Ora – Waitematā.**

I hope you find this report helpful, and please contact me if require further information.

Yours Sincerely,

John Short

5 May 2025

Addendum to report

I have been asked to provide further comment on this case, following the responses of Auckland and Waitematā Districts (dated May 2024, forwarded to me April 2025).

Both organisations dispute aspects of my initial report. In providing further information I have reviewed both responses, my initial report, and the records provided to me by HDC.

In each case, my opinion is unchanged. Neither organisation provided care consistent with accepted standards. In the case of Auckland, I remain of the opinion that there was a mild departure from accepted standards of care. In the case of Waitematā, my opinion is that there was a severe departure from accepted standards of care.

[Miss A] presented to Waitematā hospital with an obvious diagnosis of ectopic pregnancy, supported by clinical history, blood results, and ultrasound findings. They appear to have disregarded this diagnosis, opting to defer treatment in favour of continued monitoring. The responsibility for this was then transferred to another organisation. Further delays in diagnosis and treatment occurred at Auckland hospital, not all of which were outside their control, leading to the need for emergency surgery some days after the diagnosis should have been confirmed. Whilst there was no lasting physical harm to the consumer, there was certainly emotional distress, and this certainly rates as a 'near miss'.

The Waitematā response seeks to suggest that the diagnosis of ectopic pregnancy was considered by their team. This appears to be based on recollections of staff after the event. This is certainly not supported by the contemporaneous records available to me, including medical notes (which state 'Images reviewed by [Dr B] and [Dr C] prior to handover and thought to be failing pregnancy too') and discharge summary (which states 'Diagnosis- PUL-likely miscarriage' and under 'clinical management' 'USS reviewed by SMO x2: not in keeping with ectopic pregnancy, most likely failing pregnancy'). These clearly state that, following review of the scan pictures by SMOs, the working diagnosis was of a failed pregnancy, and a continued monitoring plan was made accordingly. This conclusion appears to [have] been reached by review of the pictures alone without full review of the actual patient by an experienced clinician. It is also clear that the potential for a diagnosis of ectopic pregnancy, and the consequences of this, were discussed with the consumer prior to her discharge from Waitematā (see Dr […] letter page 2, points 5&6). Had the diagnosis of ectopic pregnancy been properly considered and communicated, there should have been a discussion with the consumer regarding the management options. These include surgery, expectant management (with 'safety netting') or medical management. There is no evidence this discussion took place. Also, if it had, the final decision should have been reached in a manner that met the standards for informed consent. I remain of the opinion that the preferred treatment was surgery as per the Waitematā guidelines, despite their assertions to the contrary.

The Waitematā response (refer to page 3, paragraph 7, and page 4, paragraphs 2, 3, and 4) makes reference to miscommunication, between both the medical staff and the consumer, as a factor. This is certainly true but is far from the only factor in this case.

The Auckland team were undoubtedly placed in a difficult situation by their colleagues. However, they continued to disregard the diagnosis of ectopic pregnancy in favour of ongoing monitoring. I also refer the commission to the 'Women's Health GRAMP' notes (page 2, no 3), which highlight a series of concerning points about the care provided.

Overall, a substandard assessment of the consumer led to misdiagnosis, miscommunication, and mismanagement of a potentially serious condition. This placed a consumer at significant risk of harm and constitutes an avoidable 'near miss'. The bulk of the responsibility lies with the Waitematā team, although the actions of the Auckland [team] did also contribute. I am unconvinced by any of the arguments presented in the organisations' responses, and my opinion is therefore unchanged.

I hope you find this report helpful. Please contact me if you need further information.

Yours Truly,

John Short