Decision 20HDC01991
23 June 2025

HEALTH & DISABILITY COMMISSIONER
TE TOIHAU HAUORA, HAUĀTANGA

Failure to diagnose placenta accreta spectrum

1. The Health and Disability Commissioner (HDC) received a complaint from Mrs A about the care provided to her by Nelson Marlborough District Health Board (NMDHB) (now Health New Zealand|Te Whatu Ora (Health NZ) Nelson Marlborough). This report concerns the management of Mrs A's antenatal and postnatal care, including the adequacy of communication and a failure to diagnose placenta accreta spectrum (PAS).[1]

Summary of events

Background

2. Mrs A's obstetric history included an elective Caesarean section (C-section); a miscarriage followed by a dilation and curettage (D&C) procedure;[2] and subsequently, another pregnancy complicated by placenta previa[3] and episodes of antepartum haemorrhage,[4] for which she underwent a planned C-section the following year. Postnatally, Mrs A experienced ongoing bleeding and pain and required a D&C to remove retained products of conception (RPOC)[5] four weeks postpartum. Following the D&C, Mrs A developed infection and bleeding, which resolved at five weeks postpartum.

Antenatal care

3. In 2019 Mrs A became pregnant. Between Month1 2019 and Month4 2020, Mrs A presented to Nelson Hospital multiple times with severe abdominal pain and bleeding. Mrs A's symptoms were investigated and diagnosed as a ruptured ovarian cyst,[6] constipation, non-specific abdominal pain and bacterial vaginosis[7] respectively. Health NZ Nelson Marlborough told HDC that over the course of Mrs A's antenatal care, regular ultrasound scans (USS) were undertaken. No signs of PAS were reported.

4. Mrs A was booked for an elective C-section on 24 Month5 (at approximately 38 weeks' gestation) because of her previous complicated pregnancy and postnatal period. Consultant obstetrician & gynaecologist (O&G) Dr B was booked to perform the procedure.

Emergency C-section

[1] A serious condition in pregnancy that occurs when blood vessels and other parts of the placenta grow too deeply into the uterine wall.
[2] A procedure in which the cervix is made larger, and the inner lining is scraped to remove uterine tissue and contents.
[3] A condition in which the placenta is positioned in the lower part of the uterus and partially or completely covers the cervical opening.
[4] Bleeding from or into the genital tract during pregnancy, occurring from 24+0 weeks of pregnancy and prior to the birth of the baby.
[5] Tissue that remains in the uterus after a pregnancy ends.
[6] A fluid-filled sac on an ovary that breaks open.
[7] A common condition caused by an imbalance of natural bacteria in the vagina.

Names (except Health NZ Nelson Marlborough, Nelson Hospital, and the clinical advisors on this case) have been removed to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

5. On 29 Month4 Mrs A attended Nelson Hospital after she experienced further bleeding and uterine tightening/discomfort. Mrs A's baby was found to be in a breech position, and on 1 Month5 an emergency C-section was performed, some three weeks earlier than had been planned.

6. Dr C, a locum obstetrician, performed the procedure. Following the delivery of Mrs A's baby girl, there was rapid blood loss from Mrs A's uterus. A large (five centimetre) fundal (uterine) rupture was noted, with 'placenta protruding through' and 'minor omental adhesions[8]'. Assistance was sought from a second obstetrician. Dr C removed the placenta (piecemeal) and repaired the rupture by oversewing the area. However, Mrs A developed disseminated intravascular coagulation (DIC)[9] during the procedure and required a blood transfusion. Before closing the C-section incision, Dr C checked the uterine cavity and noted that it 'certainly appeared clear'.

7. Mrs A was admitted to the Intensive Care Unit (ICU) and her baby was transferred to the Special Care Baby Unit.

Postnatal care

8. On 2 Month5 Mrs A was seen in the ICU by Dr C, who discussed with her what had happened in the operating theatre. Dr C said that he told Mrs A that he had performed the surgery to the best of his ability, but he was suspicious that there might still be some small amounts of placental tissue remaining. He told HDC that at this point, he became aware of Mrs A's problems with excessively adherent placenta following her previous delivery.

9. Dr C recorded in the clinical notes: '[T]hinks all placenta removed, but was slightly adherent, have sent for histology … [E]xplained will monitor closely [for] signs of retained placenta.' However, there is no record that the placenta was sent to the laboratory, and the theatre notes do not record that a placenta specimen was sent for histology. The laboratory checked its records and found no indication that it had received a sample.

10. Dr B told HDC that Mrs A's care was then handed over to her, as Dr C's locum tenure was only for a few days. No handover notes were provided, although Dr B told HDC that she was present during Dr C's review of Mrs A in the ICU, and the operation note was available to her at that time.[10] There is no mention of PAS in the operation note or in the clinical notes from Dr C's review.

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[8] The placental tissue was sticking to the omentum (the layer of tissue around the stomach and intestines).

[9] Abnormal blood clotting throughout the body's blood vessels.

[10] In response to the provisional opinion, Health NZ Nelson Marlborough told HDC that clinical records are available in hard-copy format on a patient's medical file held in the ward for the duration of their inpatient stay. In addition, it stated that on discharge, clinical records are scanned and uploaded to the electronic patient information, where they are available to be viewed by clinical staff during subsequent inpatient and outpatient appointments.

11. Dr B reviewed Mrs A on 3 Month5. Mrs A reported that her bleeding had settled but she was '[c]oncerned [about the] risk of retained placenta'. Dr B assured her that she would be followed up closely.

12. On 5 Month5 Mrs A's case was discussed at the Nelson Hospital monthly Gynaecology/Radiology multi-disciplinary meeting (MDM) and the possibility of PAS was queried. The antenatal scans were reviewed, and notes from the MDM record: '[N]o evidence of increta[11] or percreta[12] … Past history suggests could be risk of myometrial defect[13] from [RPOC] but not evident on scans.' In response to the provisional opinion, Health NZ Nelson Marlborough suggested that the MDM review 'was the appropriate and adequate degree of review of the complications which developed after delivery of [Mrs A's] baby'.

13. Dr B said that her postoperative plan was influenced by the above MDM findings. She told HDC:

> 'When using scans to guide my decisions I almost always look at the report/comments. I do not review images in these types of cases. I am an obstetrician and gynaecologist, not a radiologist. I made my decisions based on the information that was available to me at the time.'

14. Furthermore, Dr B said that on the day after Mrs A's delivery, she saw the photographs taken at the time of Mrs A's surgery,[14] and these showed a defect in the myometrium with the placenta coming through. However, Dr B said that she was not able to diagnose PAS from those photographs and nor was it suggested to her by her colleagues. Dr B told HDC that she was concerned about a risk of retained placental tissue with an increased risk of secondary postpartum haemorrhage (PPH), infection, and protracted bleeding; however, 'a decision for surgery to remove retained placental tissue (if that became evident) would not be made lightly due to a high risk of perforation'. Mrs A was discharged on 9 Month5.

15. Dr B reviewed Mrs A 10 days postpartum. Dr B said that Mrs A asked why she had had a uterine rupture, and it was explained to her that '[they] did not currently have any information that would enable [them] to give her a definitive reason why'.

16. Mrs A underwent a follow-up USS on 23 Month5 (three weeks postpartum), the results of which were 'strongly suspicious for retained placental tissue'. Dr B discussed the results with Mrs A on 27 Month5 and noted that she was 'clinically well with minimal pain and very light bleeding', and they agreed to 'watch and wait' for another month. Mrs A told HDC that at

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[11] A condition in which the placenta grows too deeply into the wall of the uterus.
[12] The placenta attaches itself and grows through the uterus and potentially the nearby organs (such as the bladder).
[13] An abnormality in the outer layer of the uterus.
[14] It is noted that the intraoperative photographs taken by Dr C at the time of Mrs A's surgery were never uploaded to her clinical file.

this appointment, she asked questions regarding her delivery, and Dr B 'said that she knew nothing and that [they] would never know'. However, Dr B disputed saying that.

17. Another USS was performed on 22 Month6, which found material in the uterine cavity 'suggestive of blood and clot, however additional retained products cannot be excluded'. Dr B explained the findings to Mrs A on 23 Month6 and documented: '[She] has ongoing light bleeding but is clinically well. She understands our desire to NOT instrument her uterus unless absolutely necessary.' The plan was to 'induce some withdrawal bleeds' using a hormonal medication.

18. A USS of Mrs A's pelvis was performed on 10 Month8, which showed '[m]arked non-specific endometrial thickening at 30 mm'. Dr B rang Mrs A to discuss the results and noted that she had had no further bleeding for two weeks. Dr B wrote: 'At this point I do not think anything further needs to be done. We have agreed we will adopt a watch and wait approach.' Dr B told HDC that she arranged an appointment with Mrs A in three months' time to 'debrief and plan the way forward'.

19. Mrs A said that Dr B did not disclose to her appropriately that the USS 'showed a mass still in [her] uterus and that [her] uterus was enlarged'. However, Health NZ Nelson Marlborough stated that '[t]here were no findings in regard to indication of a mass being present'.

20. Mrs A told HDC that she felt 'literally left in the dark' by Dr B regarding what happened during her delivery. Mrs A said that on every occasion on which she asked for information, Dr B 'led [her] to believe she knew nothing'. Mrs A stated that she asked for a meeting with Dr B for an explanation for her traumatic delivery, and Dr B booked her in to answer her questions in three months' time. Mrs A also said that Dr B led her to believe that Dr C had left Nelson Hospital without leaving any information regarding the delivery, but on contacting Dr C herself in Month8 2020, he told her that 'he had left surgery notes, he handed over to [Dr B] the day after [Mrs A's] delivery and he made sure the right people knew what had happened'. Dr B stated that this is incorrect, and Dr C left notes in Mrs A's clinical record and an operation note, although nothing indicated a diagnosis of PAS.

21. Dr B saw Mrs A on 21 Month9, and Mrs A reported ongoing minimal bleeding and pain. Dr B told HDC: 'The tone of the consultation then rapidly became confrontational.' She said that Mrs A asked why she had had a uterine rupture, and Dr B responded that she did not know. Dr B told HDC that Mrs A then asked her about the histology analysis from her placenta. Dr B said that she checked and could not find a record of it in the hospital system, and she told Mrs A that the request may never have been sent.

22. Dr B said that Mrs A recounted a conversation she had had with Dr C, who apparently told her that her uterus had ruptured because she had PAS, and Mrs A accused her of missing the diagnosis and then covering it up. Mrs A told HDC that at this meeting, she asked Dr B to read and explain her surgery notes, but Dr B 'refused saying they don't mean anything as

anyone can write in your medical records. That what [Dr C] has said means nothing.' Dr B disputed refusing to go through Dr C's operation note with Mrs A.

23. Dr B documented in a letter to Mrs A's general practitioner (GP), dated 26 Month9:

> '[Mrs A] had lots of questions as to why she had a uterine rupture and whether she had a placenta accreta or not. These are questions that I do not have answers to as I was not present at the delivery and there is no objective evidence of this.'

24. Dr B said that she felt 'ambushed and upset' during this consultation and subsequently advised her service manager of the need for an urgent meeting with Mrs A together with an independent party to review her notes to address her concerns about Dr B's care and her claim of a misdiagnosis and cover-up. However, Dr B said that there was significant delay in organising this despite numerous phone calls and emails to her service manager. She also stated that given Mrs A's pain and her concerns that she had PAS, she organised an MRI to investigate her symptoms further.[15] On 13 Month10 Mrs A's care was transferred to O&G Dr D.

25. On 21 Month10 Mrs A had an MRI at Nelson Hospital, which revealed a mass in her uterus. The MRI concluded that the findings were most likely to be retained placental tissue that extended beyond the myometrium, consistent with PAS. Health NZ Nelson Marlborough said that this was the first imaging with a finding to support a diagnosis of PAS.

26. Mrs A told HDC that she had 'lost a great deal of trust in [Dr B] and Nelson Hospital' and therefore decided to see Dr C, as she 'felt safer being treated by him'.

27. On 3 Month11 Mrs A was reviewed by Dr C. Dr C had requested a review of Mrs A's antenatal and postnatal scans at the Gynaecology/Oncology MDM. The review found that the antenatal scans showed an area that was suspicious for PAS and an unusual-appearing cystic area. The review found that a cystic area (referred to as a mass at one point) was present on all postnatal scans. The MDM report also noted that at the time of surgery, a 'mass could be seen at the fundus separate from the rupture', which was not recorded on the operation note.

28. Dr C noted in his letter to Mrs A's GP, dated 7 Month11:

> 'It now appears that [Mrs A] had a placenta percreta that, with the power of hindsight, could have been diagnosed antenatally. It is extremely likely that the pain [Mrs A] was experiencing during the pregnancy was related to this fundal percreta.'

[15] In response to the provisional opinion, Mrs A told HDC that the MRI 'only occurred at [her] demand … to [Dr B] that it be undertaken'.

29. On 23 Month11 Mrs A met with Dr D to discuss her ongoing care in view of the MRI findings, and a hysterectomy was recommended.

30. On 25 Month11 a meeting was held between Mrs A, Dr B, the clinical director of O&G, and the service manager to address Mrs A's concerns. Dr B told HDC that she apologised for 'the torrid experience' that Mrs A had gone through, and for not organising a formal debrief sooner to allow Mrs A to address her concerns. Dr B said that she also apologised for Mrs A's impression of her lack of empathy. Following the meeting, Mrs A reported to her GP that she still felt that answers were not given.

Subsequent events

31. Dr C carried out a laparoscopic hysterectomy on Mrs A on 19 Month12, the histology of which revealed placenta increta.

32. The histology report, dated 22 Month12, noted that '[p]lacenta frozen from delivery [1st Month5]' was also examined and demonstrated 'normal histology'.

Further information

Dr B

33. Dr B told HDC that she had a low index of suspicion for PAS given that:

- Mrs A's antenatal presentation was not typical of PAS;
- Mrs A's antenatal scans showed no evidence of PAS when reviewed at the Nelson Hospital MDM; and
- Dr C did not report PAS following Mrs A's C-section.

34. Dr B told HDC that ongoing bleeding postnatally 'is in keeping with retained placenta and does not necessarily raise suspicion for PAS'. Furthermore, she stated that the intraoperative finding of placenta protruding through fundal rupture does not allude to PAS and said that 'if there was a rupture with placenta over it, placental tissue would protrude through'. Dr B wondered whether Mrs A had sustained a uterine perforation at her previous D&C, which then contributed to the rupture in this pregnancy, but did not consider PAS at any point until Mrs A had her MRI.

35. Dr B stated that while she is disappointed that the placenta sample was not reported by Nelson Hospital, the findings suggested that 'the histology of the placenta was unlikely to have resulted in earlier diagnosis'.

36. Dr B told HDC that she was not evasive or dishonest with Mrs A. Her impression was that Mrs A felt traumatised by her delivery, and this anxiety led to her wanting certainty about why she had suffered a uterine rupture. Dr B stated that she did not have any definitive answers for Mrs A, and it is her practice to be honest where she does not know the answer rather than to speculate, which would not have been helpful given Mrs A's anxiety.

However, Dr B said that if Mrs A 'had pushed for an explanation of the various potential reasons for uterine rupture, [she] would have been happy to go through that with her'.

37. Dr B sought an opinion from Dr E (O&G) regarding this matter. Overall, Dr E considered that there is no definitive evidence of PAS in this case. Dr E's report, dated 29 June 2023, included the following:

- There was no evidence of any placental adhesion disorder in Mrs A's pregnancy. The usual symptoms of PAS do not typically include pain during pregnancy.
- The MRI that suggested PAS did not take into account the fact that the uterine fundus had been oversewn, and so inevitably some placental tissue would have been included in the scar and portions of the placenta retained in the muscle.
- The hysterectomy specimen report did not consider the possibility that the fundus could be a result of placental tissue retained with the oversewing performed at the time the rupture was discovered.
- The frozen placenta, which was submitted to pathology, showed no evidence of PAS.

Health NZ Nelson Marlborough

38. Health NZ Nelson Marlborough told HDC that Dr B was 'diligent in her efforts to provide [Mrs A] with answers to her questions in the context of a progressively unfolding diagnosis post-partum of accreta spectrum disease'. Furthermore, Dr B's knowledge of the C-section and uterine repair procedure was gained from reviewing the clinical records made by Dr C, and it was on this basis that she responded to Mrs A's questions and concerns.

39. Health NZ acknowledged the importance of ensuring that specimens for histological evaluation are handled with due care. Health NZ stated that processes within the hospital (and those of its laboratory provider partner) are aimed at ensuring that all specimens are collected and processed appropriately, and there is a specific section for recording details of specimens on the 'Operating Theatre Record'. Health NZ said that it has 'been unable to determine a satisfactory explanation' for the discrepancy between the clinical notes and its theatre and laboratory records.

40. Health NZ acknowledged that 'a more comprehensive review of [Mrs A's] care may have been beneficial in maintaining an on-going therapeutic relationship', but stated that at the time, the O&G team were reassured by the findings from the MDM review on 5 Month5.

Scope of investigation

41. The following issue arising from the complaint was investigated:

- Whether Health New Zealand|Te Whatu Ora Nelson Marlborough provided Mrs A with an appropriate standard of care between Month1 2019 and Month11 2020 (inclusive).

ACC treatment injury claim

42. Mrs A's GP submitted a treatment injury claim for her, which originally was declined. However, in 2021 ACC reversed its decision and accepted Mrs A's claim. As part of its review, ACC obtained advice from O&G Dr F. In summary, Dr F advised:

Antenatal care

- The ultrasound scans and investigations that were carried out were appropriate in the circumstances and no additional investigations were indicated.

Postnatal care

- Ultrasound appearances that were described would be consistent with either uterine rupture or PAS, but given the rarity of PAS, it was reasonable to interpret these as '?secondary of uterine rupture and repair'.
- When Mrs A's condition did not improve, it was appropriate to have requested the MRI.
- Following Mrs A's previous C-section, she had a uterine curettage four weeks postpartum, which caused damage to the endometrial-myometrial interface, leading to the development of PAS in her subsequent pregnancy. Earlier diagnosis would not have altered the outcome (hysterectomy).

Responses to provisional opinion

Mrs A

43. Mrs A was given the opportunity to respond to the provisional opinion. In her feedback, Mrs A refers to the significant impact this experience has had on both her life and her perspective on the healthcare system. During the pregnancy and thereafter, she states that she often felt unheard and isolated and says that she felt as though she was perceived as someone who was exaggerating their health issues. Mrs A believes this was a life-altering experience that continues to affect her.

Dr B

44. Dr B was given the opportunity to respond to the provisional opinion and her comments have been incorporated into this report where relevant and appropriate.

Health NZ Nelson Marlborough

45. Health NZ Nelson Marlborough was given the opportunity to respond to the provisional opinion. Health NZ Nelson Marlborough told HDC that the uterine rupture and complications Mrs A experienced 'reflected a rapidly evolving clinical picture, appropriately responded to and managed by the clinical team'. Further comments have been incorporated into this report where relevant and appropriate.

Independent clinical advice

46. Independent clinical advice was obtained from O&G specialist Dr Sornalatha Vasan (Appendix A). In summary, Dr Vasan advised:

Antenatal care = accepted standard of care

- Mrs A was assessed, investigated, and managed appropriately.
- All of the USS she had during pregnancy reported normal placentation (no evidence of PAS).
- PAS has not been found to cause abdominal pain. The risk of PAS was recognised and plans made to monitor closely for retained products after delivery.
- Mrs A was at high risk of PAS, but USS did not report any abnormality until after delivery. Under these circumstances, PAS could not be considered as a likely diagnosis.

Postnatal care

- When Mrs A presented with abdominal pain and bleeding postnatally, expressing concerns of retained placenta as well as USS reporting retained products around fundus, attempts should have been made to rule out PAS due to:
    - History of retained placenta requiring return to theatre for D&C with prolonged recovery;
    - Significant blood loss in recent delivery by C-section associated with fundal uterine rupture (NOT C-section scar rupture, which is more common and expected);
    - Placenta removed piecemeal (unsure if removed completely); and
    - Development of DIC requiring massive blood transfusion and ICU admission.
- A fundal rupture in a patient who had had previous C-sections should allude to previous myometrial injury. A previous myometrial injury that was significant enough to cause rupture is high risk for PAS in future pregnancies, more so as Mrs A had adherent placenta in her previous pregnancy and in the current Caesarean delivery. When the patient presents repeatedly with signs of retained products, it is imperative to rule out PAS. At this stage, referral and review with tertiary centre or prompt MRI could have been considered. Not doing so until Mrs A raised concerns of PAS = **moderate departure**.
- Mrs A's placenta should have been sent for histological evaluation = **moderate departure**.
- Uterine rupture resulting in a DIC requiring massive blood transfusion and ICU care needs systematic case review beyond the departmental level. Not undertaking a serious adverse event review (SAER) = **severe departure**.

47. Dr David Milne, radiologist, was asked to perform a blind review of Mrs A's antenatal USS (Appendix B). Dr Milne advised that overall, there were no adverse findings.

Relevant policies

48. Health NZ's 'Histology Specimens Labelling and Checking' policy, dated 9 April 2018, provides the following:

'**Background**

At Nelson Marlborough Health (NMH) within the perioperative services, endoscopy units, cardio-intervention suite and Surgical Outpatients department's specimens of human tissue are removed, from patients, for histology/microbiological reasons to assist in confirming a medical diagnosis or disease.

…

Process

- Surgeon/physician clearly communicates the source and type of tissue sample at the time the specimen is removed from the patient and whether it is to be a fixed or non-fixed specimen.
- The circulating nurse confirms verbally the source, type of each specimen with the surgeon/physician.
- Each individual specimen is labelled accordingly to its removal from the patient …
- The circulating nurse will place a patient identification label onto the specimen container, including the lid on larger specimen containers, date and write the tissue type and position should it be required e.g. left or right.
- The circulating nurse will ensure the laboratory form has a patient identification label and then writes down the individual specimens with a corresponding number.
- If a patient specimen has to be prioritised and forwarded to the laboratory during the operation then the container is checked by surgeon and scrub nurse before leaving the operating theatre to ensure details are correct.
- At the end of the operation the operating surgeon/physician will check each specimen, sign the laboratory form before any specimen leaves the operating theatre, it is not the nursing staff responsibility to complete the laboratory requisition form.

…

- The specimen record book in the theatre is to be updated with — patient name, NHI, date of specimen, type of specimen and where sent to.
- The perioperative form is updated with type and number of specimen and where sent to.'

49. Health NZ's 'Adverse Event Management' policy, dated 11 January 2019, provides the following:

'**Overview**

…

The use of the term "adverse event" represents incidents, "near misses" and "PTCH" (potential to cause harm) events in this policy.

…

Policy statement

[Health NZ] undertakes to continuously improve the care delivered by its services, to reduce risk and ensure the safety of everybody using its premises and facilities, by promptly identifying, reviewing and documenting all adverse events in its reportable event system — Safety1st.

Incidents, "near misses" or PTCH events will be documented, investigated and reviewed in a thorough, objective manner commensurate with their seriousness.

…

Definitions

Adverse events are those events that:

…

- could have caused harm, serious harm, damage or loss if:
  - the situation had not been ameliorated in time to prevent harm occurring

…

Harm may be physical, psychological, or cultural in nature.

A **Serious Adverse Event** is a type of incident that signals the need for immediate investigation and response — that is, any unexpected occurrence involving death or serious physical or psychological injury, and including near-misses or process variations for which a recurrence would carry a significant chance of a serious adverse outcome.

Examples of Serious Adverse Events include:

…

- unanticipated clinical outcomes
- clinical events leading to prolongation of hospitalization.'

My decision

50. I have reviewed all the information in this case, including the independent clinical advice.

51. Overall, I consider that the care provided to Mrs A antenatally was appropriate. I am unable to reconcile the differences in the reporting of the antenatal scans between the first Gynaecology/Radiology MDM and the second Gynaecology/Oncology MDM and therefore, I defer to the advice of Dr Milne, who did not report any findings consistent with PAS during his blind reading. I am therefore not critical that PAS was not diagnosed during Mrs A's pregnancy. Furthermore, I accept the advice of Dr Vasan that Mrs A was assessed, investigated, and managed appropriately antenatally, and I acknowledge that Dr E's ACC advice supports this.

52. However, I have identified deficiencies in care provided postnatally, which are outlined below.

Health NZ Nelson Marlborough — breach

53. I accept Dr Vasan's advice that Mrs A's placenta should have been sent to histology. While I note that subsequently the histological findings of the placenta were reported as 'normal', which may not have resulted in an earlier diagnosis of PAS, as acknowledged by Health NZ Nelson Marlborough, histology specimens should be handled with due care. I am therefore critical that Mrs A's placenta was not processed properly as per the 'Histology Specimens Labelling and Checking' policy, which resulted in a disconnect between Dr C's request that the placenta be sent for histology and it being sent to the laboratory — the findings of which may have provided Mrs A with further insight as to her condition.

54. In response to the provisional opinion, Health NZ Nelson Marlborough stated that the 'definitive guidance for adverse events' is the Health Quality & Safety Commission|Te Tāhū Hauora (HQSC) 'National Adverse Event Reporting' policy (the policy) dated 2017[16] (which documents a Severity Assessment Criteria (SAC) to determine which events require an SAER[17]), and guidance surrounding events in the maternity setting was further outlined in 2019;[18] in particular:

- SAC 2 = 'Permanent major or temporary severe loss of function';[19] and
- SAC 3 = 'Permanent moderate or temporary major loss of function'.[20]

55. In response to the provisional opinion, Health NZ Nelson Marlborough submitted that based on the above guidance, Mrs A's situation would have been assessed as an SAC 3 (which does not require a mandatory SAER), as although her postpartum haemorrhage required a blood

[16] National_Adverse_Events_Policy_2017_WEB_FINAL.pdf (accessed 13 June 2025).
[17] This policy mandates that a 'formal review of all SAC 1 and 2 rated adverse events' is undertaken.
[18] Severity assessment criteria (SAC) examples (accessed 13 June 2025).
[19] Including: 'Delayed recognition of patient deterioration resulting in unplanned transfer to intensive care …'
[20] Including: 'Unplanned transfer to higher level of care, including hospitalisation (e.g., from community setting)' or 'Increased length of stay (greater than one day)' or 'Surgical or other significant intervention required'.

transfusion, there was no delayed recognition of her condition; in particular, the clinical situation was identified and responded to promptly (Mrs A was transferred to the ICU).

56. While I acknowledge Health NZ Nelson Marlborough's submission that the standard regarding an adverse event review should be dictated by HQSC's policy, I am of the view that Health NZ's 'Adverse Event Management' policy (2019) holds more weight in respect of this case, given its specificity to Health NZ Nelson Marlborough.

57. I therefore accept Dr Vasan's advice that not undertaking an SAER was a severe departure from the accepted stand of care. As per the 'Adverse Event Management' policy, a serious adverse event includes an unanticipated clinical outcome and clinical events leading to prolongation of hospitalisation. Mrs A required an emergency C-section on 1 Month5, and she suffered a uterine rupture, resulting in DIC, a blood transfusion, and ICU care, and she remained in hospital for nine days following delivery. In my view, this meets the requirements for an SAER under the Adverse Event Management policy. Furthermore, Health NZ acknowledged that 'a more comprehensive review of [Mrs A's] care may have been beneficial in maintaining an on-going therapeutic relationship'. I agree and consider that had an SAER been undertaken, Mrs A may have had more information on what happened during her traumatic delivery, and may have provided her with the answers she was seeking.

58. For failing to send Mrs A's placenta for histological evaluation and failing to undertake an SAER, I find Health NZ Nelson Marlborough in breach of Right 4(2)[21] of the Code.

Dr B

Standard of care — adverse comment

59. I acknowledge that antenatally, Mrs A's presentation was not typical of PAS and there was no report of possible PAS following her C-section; however, I accept Dr Vasan's advice that when Mrs A presented with abdominal pain and bleeding postnatally, expressing concerns about retained placenta, as well as USS reporting retained products around the fundus, greater effort should have been made to rule out PAS.

60. I accept Dr Vasan's advice that when a patient with a previous myometrial injury significant enough to cause uterine rupture in a current pregnancy repeatedly presents (postnatally) with signs of retained products, it is important to rule out PAS; however, I also note Dr F's advice that given the rarity of PAS, it was reasonable to interpret the postnatal USS as 'secondary of uterine rupture and repair'.

61. Dr B stated that she considered the possibility that Mrs A had sustained a uterine perforation during her previous D&C, which may have contributed to the rupture on 1 Month5. Furthermore, the Nelson Hospital Gynaecology/Radiology MDM noted that Mrs A could be at risk of a myometrial defect. While I acknowledge that Dr B was taking a cautious approach

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

towards Mrs A's care, given the risk of undertaking a D&C in the setting of a uterine rupture, I am concerned that she did not escalate Mrs A's care to a tertiary centre or undertake an MRI earlier, when the postnatal USS all alluded to RPOC, and given Mrs A's history of RPOC requiring further D&C, and the uterine rupture in her current pregnancy.

Communication — educational comment

62. At the outset, it is important to acknowledge that there are many differences between the information provided by Dr B and that provided by Mrs A regarding what was discussed during the postnatal reviews. Mrs A contends that Dr B did not communicate with her effectively regarding her health, treatment and care, and did not disclose all information. Alternatively, Dr B submits that she was not evasive or dishonest with Mrs A, but rather she did not have any definitive answers for Mrs A as to why she had had a uterine rupture.

63. Mrs A understandably wanted answers regarding her traumatic delivery. Under the Code of Health and Disability Services Consumers' Rights (the Code), every consumer has the right to an explanation of their condition.[22]

64. The question is whether Dr B should have been more definitive with Mrs A sooner about PAS being the probable reason for her uterine rupture. I accept that Dr B was not present during the C-section and uterine rupture procedure, and therefore her knowledge of the events and the condition of Mrs A's uterus at the time was limited to what was written in the operation note and what was discussed during Dr C's review of Mrs A on 2 Month5, when Dr B was in attendance. I also recognise that neither the operation record nor the clinical notes documented from Dr C's review mention any possible cause for Mrs A's uterine rupture or PAS. It is unclear why, if Dr C considered PAS as a possible explanation for Mrs A's uterine rupture, this was not documented on the operation note or relayed to Dr B at handover. I accept that as Dr B is not a radiologist, she based her postoperative treatment plan on the findings of the report rather than reviewing the scans herself. In addition, I note Dr B's comments that she was not able to diagnose PAS from the intraoperative photographs taken by Dr C, which she viewed only once. It is also relevant to note that the Nelson Hospital Gynaecology/Radiology MDM did not find any evidence of PAS on review of Mrs A's antenatal scans. Taking all these factors into account, I accept that it was reasonable for Dr B not to refer to PAS in her discussions with Mrs A over the postnatal care period spanning Month5 to Month11.

65. However, while I appreciate Dr B's concern regarding Mrs A's anxiety, which is why she did not consider giving a speculative answer, it is clear that having no possible explanation for her uterine rupture was causing Mrs A further distress. Dr B told HDC that had Mrs A 'pushed for an explanation' of the various potential reasons, she would have gone through those

[22] Right 6(1)(a) of the Code states: 'Every consumer has the right to the information that a reasonable consumer, in that consumer's circumstances, would expect to receive, including an explanation of his or her condition.'

with her. In my view, Dr B should have been forthcoming with this information, which may have alleviated some of Mrs A's distress and helped to maintain trust.

66. Furthermore, as acknowledged by Dr B herself, I consider that she should have organised a formal debrief sooner to allow Mrs A to address her concerns, which may have prevented the subsequent provider–consumer relationship breakdown. However, in making these comments, I note the efforts made by Dr B to organise a formal debrief with her service manager following the consultation with Mrs A on 21 Month9, and that due to delays outside Dr B's control, this meeting did not occur for a further two months, which I suggest only exacerbated Mrs A's frustrations.

Changes made since events

Health NZ Nelson Marlborough

67. In response to the provisional opinion, Health NZ Nelson Marlborough told HDC that it has made the following changes:

- 3 FTE positions have been established (including x2 'Event Review Facilitators' (ERF)[23]) with specific focus on training, supporting and mentoring clinical staff and managers to identify, report and review adverse events and develop appropriate recommendations to improve delivery of care and services to consumers. In addition, ERFs are focused on enabling improvement and education as a result of adverse events and have recently launched a 'learning wall' (an anonymised copy of which was provided to HDC), 'which offer reflections and insights into events where harm has occurred as a result of gaps in provision of health care'.
- All new senior clinical and managerial staff have one-to-one coaching to ensure that they understand their responsibilities to support the adverse event reporting and review process.
- Health NZ Nelson Marlborough has (in partnership with Victoria University of Wellington Te Ngāpara Centre for Restorative Practice) developed the practice and advocating for the principles to be incorporated into the 2023 National Adverse Events Reporting Policy and has made significant progress towards embedding restorative practice into its SAERs.

Dr B

68. In response to my recommendation made in the provisional opinion, Dr B provided HDC with a written apology to Mrs A for the deficiencies in care identified in the report. This apology has been forwarded to Mrs A in conjunction with a copy of the final report.

[23] Health NZ Nelson Marlborough told HDC that facilitators 'support review teams around processes, engage with consumers and whānau to ensure their voice is heard in reviews and complete all administrative reporting to HQSC'.

69. In response to my recommendation made in the provisional opinion, Dr B reviewed her practice in light of the deficiencies identified in the provisional report and reported back to HDC on her learnings from this. In particular:

- Dr B acknowledged that '[c]ognitive biases and human factors' had an impact on her decision-making process and may have contributed to the possible diagnosis of PAS postnatally not being fully considered. Furthermore, Dr B acknowledged that the failure to convey information effectively (including a possible alternative explanation for the cause of Mrs A's uterine rupture) and to address Mrs A's concerns contributed to Mrs A's feelings of frustration and distrust, and the lack of timely briefing added to her anxiety and worsened her overall experience.
- Dr B reflected on how acknowledging and managing personality differences is crucial in ensuring professional and empathetic interactions with patients. She told HDC that she is planning to undertake the Medical Protection Society's online courses 'Open Disclosure Principles and Conversation' and 'Introduction to Human Factors' to assist with this. Furthermore, Dr B told HDC that she has reflected on how a 'prompt and compassionate debrief is essential in helping patients process their healthcare experiences' and recognises that delays in providing such support can exacerbate distress, prolong emotional recovery, and have a negative impact on patient–doctor relationships.

Recommendations and follow-up actions

70. I recommend that Health NZ Nelson Marlborough:

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

b) Review its policies and processes regarding histology specimens in light of these events and report back to HDC on any recommended changes or amendments, within three months of the date of this report.

71. I recommend that Dr B report back to HDC upon completion of the Medical Protection Society's online courses 'Open Disclosure Principles and Conversation' and 'Introduction to Human Factors'.

72. A copy of this report with details identifying the parties removed, except Health NZ Nelson Marlborough, Nelson Hospital, and the clinical advisors on this case, will be sent to the Royal Australasian College of Obstetricians and Gynaecologists, the Ministry of Health|Manatū Hauora, and the Health Quality & Safety Commission|Te Tāhū Hauora, and will be published on the HDC website.

Rose Wall
Deputy Health and Disability Commissioner

Appendix A: Independent clinical advice to Commissioner

The following independent clinical advice was obtained from O&G specialist Dr Sornalatha Vasan on 5 April 2022:

'Complaint: Nelson Marlborough District Health Board ref: C20HDC01991

Thank you for asking me to provide advice on this case.

I am a Fellow of the Australian and New Zealand College of Obstetricians and Gynaecologists and am on their Expert Witness Register.

I work as a general O&G Specialist and I am an examiner for RANZCOG and in assessment panel for international medical graduates in New Zealand.

I have no personal or professional conflict in this case.

I have read the following documents you provided

1. Letter of complaint dated [28th Month12] and Further information dated …
2. [Health NZ's] response dated …
3. Clinical records from [Health NZ] covering the period from [Month1] 2019 to … 2021 including all multidisciplinary reviews
4. [Dr B's] response dated … 2021
5. Images of Surgery
6. Email communications between consumer and [Health NZ]

Background:
I have not summarised the events of this case as they have been detailed previously. I will detail events surrounding [Mrs A's] care antenatally, delivery and subsequent events leading to further surgery where required to explain my opinions on the questions asked.

The overall care provided to [Mrs A] by [Health NZ] was reasonable in the circumstances.

1. Overall standard of care provided to [Mrs A] with regards to investigations and management of [Mrs A's] abdominal and vaginal bleeding during pregnancy and postnatally.

[Mrs A] first presented to [Health NZ] on 19 [Month1] at 21 weeks to ED complaining of sudden onset of severe right sided abdominal pain and shoulder tip pain at 1720 hours that day. The pain came on while she was driving. There was no history of trauma, and she had never experienced similar pain before. She had no significant past medical

history. Her obstetric history included an elective Caesarean Section in her first pregnancy … years before; a miscarriage at … weeks followed by a D&C; and [another] pregnancy … years before complicated by placenta previa and episodes of antepartum haemorrhage for which she underwent a planned caesarean section. Following last pregnancy she had an evacuation of retained products of conception at 5 weeks post-natal followed by episodes of bleeding and infection which resolved 5 months post-partum.

[Mrs A] was assessed by on call [senior doctor] at 2015 hours and undertook a bedside ultrasound scan (USS). This showed a live pregnancy but no indication of the cause for the pain. Referral was made to General Surgery team (to exclude the possibility of appendicitis), observation overnight and a USS in the morning. On 20 [Month1] [Mrs A] was reviewed by [O&G] on call (twice) and [a specialist in surgery] who reported that appendicitis was unlikely. The report of her USS that day … included "Mild/moderate intra-abdominal and pelvic fluid" and "No placental abnormality seen"; normal gestation, did not reveal a cause for [Mrs A's] pain. The clinical impression was either a possible ovarian cyst rupture or a small bleed from the corpus luteum.

On 21 [Month1] Mrs A was assessed by [O&G] as well as [a specialist in surgery] and USS findings were explained to her. She reported that her pain was slowly improving. Mrs A was discharged home that day with most likely diagnosis/cause of her pain as per previous clinical impressions was a ruptured cyst with bleeding into the abdomen.

On 26th [Month1] [Mrs A] was reviewed by her lead maternity carer (LMC) as she still had right sided abdominal pain and had noticed uterine tightenings. There was no vaginal bleeding and she had not had a bowel motion for 3 days. On examination her general observations were normal and her cervix was noted to be closed. The findings were discussed with [O&G] who recommended an enema. She reported some relief following a bowel motion and was discharged home.

On 30th [Month1] [Mrs A] presented to ED reporting decreased fetal movements and a history of sudden onset of similar pain to her first admission that came on soon after she woke up while lying in bed. Her bowels were still troublesome, but she reported no bleeding from bowel or vagina. On examination her general observations were normal, but she was tender in both the right upper and lower abdominal regions. There was no guarding or rebound tenderness. Her blood tests were normal except for a slight rise in inflammatory markers (C-reactive protein/CRP). The clinical impression was that she had non-specific abdominal pain and constipation. She was admitted for further analgesia and observation and treatment of her constipation. She was more comfortable the following day after passing two bowel motions and was discharged home.

On 16th [Month2] [Mrs A] was seen by … [O&G] … noted the significant history from her [previous] pregnancy in … of retained placental tissue 5 weeks post elective

Caesarean Section, as well as the post-natal course complicated by bleeding and endometritis. He booked an elective Caesarean Section at 38+5 and assured her that increased attention would be paid to her post-natal course.

On 7th [Month3] [Mrs A] presented at 27+ weeks for assessment following the passage of mucous bloody discharge, followed by fresh vaginal (PV) bleeding and uterine tightening. She was understandably anxious about this given her experiences in her [previous] pregnancy. On examination, her abdomen and uterus were soft and non-tender. Speculum examination showed old brown blood and on vaginal examination her cervix was closed. Cardiotocograph (CTG) was normal. [Mrs A] was reviewed by [a senior doctor], who recommended observation and US.

US reported:

Placenta: Anterior fundal, not low lying. Posterior to the cervix is a 26 mm length well-circumscribed mildly lobulated echogenic focus, the inferior edge of which lies 41 mm from the internal cervical os. No associated internal vascularity or feeding vessels, query focus of clot. No periplacental fluid collection. No succenturiate lobe identified.

IMPRESSION:

1. Fetal measurements are normal for gestation.

2. Normal amniotic fluid.

3. The placenta is not low lying.

4. 26 mm echogenic focus posterior to the cervix, query adherent clot.

No placental abnormality was reported.

Vaginal swab showed bacterial vaginosis and she was treated with metronidazole. She was discharged home with recommendation to her LMC for follow-up USS in 2 weeks to review the echogenic focus.

On 10th [Month3] [Mrs A] presented with severe left sided abdominal pain with nausea since midnight. There was no vaginal bleeding, she was not constipated and fetal movements were normal.

On examination she had some tenderness in the left lower quadrant and her uterus was not tender. The CTG was normal with no sign of uterine activity and her bloods were normal. She was seen on the morning ward round by [O&G]. There were no signs of premature labour or abruption. She was discharged home with a plan for 2 weekly growth scans and follow up in the Clinic.

On 21 [Month3] [Mrs A] had Scan for growth.

Findings:

EFW 1767grams, +/- 15%. EFW lies on the 91st centile. Presentation: Breech, Amniotic fluid: Normal, AFI 12cm, DVP 4.6cm. Placenta: Anterior and not low lying.

Conclusion:

1. Normal growth. EFW 91st centile.

2. Normal amniotic fluid.

3. Clot not seen trans abdominally.

Baby on 98th centile. Gestational age by earliest ultrasound: 29 weeks 5 days.

On 17th [Month4] [Mrs A] was reviewed by her LMC at the Maternity Unit. She reported decreased fetal movements that day. Her CTG was reassuring. Recent results had shown mildly elevated bile salts at 26 (normal <15). On consultation with [the senior doctor] she was booked for review in ANC.

On 20th [Month4] at 34 weeks' gestation [Mrs A] presented to the Maternity Unit for review on the day of her planned Obstetric Clinic appointment with discomfort in her vagina and pelvis, brown PV discharge and a history of itching feet and hands the previous week.

[Mrs A] was assessed by [a senior doctor] that morning. It was noted that growth on USS at 29 and 33 weeks were normal. Recent blood tests were normal with mildly raised bile salts. On examination there was no vaginal bleeding evident on speculum with brown PV discharge suggestive of vaginosis. Vaginal swab was sent to Laboratory. [Mrs A] raised her concerns about any possible increased risk of intrauterine fetal death (IUFD) with cholestasis. She was reassured that risk of IUFD is related to peak level and hers was currently low. Possible role for ursodeoxycholic acid was discussed. Recommended weekly liver function tests (LFT), bile salts and obstetric review; booked Clinic follow up for 9 [Month5]. Following discharge [Mrs A] called the Maternity Unit at 1325 hours to report passage of bright red mucus PV. This was discussed with same [doctor] and it was considered as most likely related to her recent speculum examination. She was advised to observe for further discharge and to contact her LMC if she had any concerns.

On 20th [Month4] [Mrs A] came back to the Maternity Unit at 13.40 hrs reporting that her abdomen had become rock hard and she had a pink PV loss and on examination her routine observations were normal with a soft abdomen and uterus. There was brown discharge on her pad but no bleeding or pooling of liquor on speculum exam. Her Amnisure test came back positive, suggesting the presence of amniotic fluid in the vagina. She was admitted for observation and oral erythromycin for 10 days for preterm premature rupture of membranes (PPROM). As she was 34 weeks pregnant a decision was made not to administer steroids as per local practice.

On 22 [Month4] [Mrs A] was feeling irregular tightening with no bleeding and no liquor seen on her pads. After Consultant assessment it was agreed she could be discharged home that day with advice on when to return and a plan for twice weekly reviews and Clinic follow up as previously planned.

On 24th [Month4] [Mrs A] presented for her planned review and was seen by [the senior doctor]. Her bedside USS showed normal liquor volume and she was clinically well. [The doctor] agreed with continuing the current management plan.

[Mrs A] returned to the Maternity Unit after her formal USS at 1630 hours same day. The US also showed normal liquor volume. She was concerned about PV bleeding and was assessed by [the doctor] again. Speculum examination showed brown PV discharge with no blood seen. There were no signs of labour, and the senior doctor suspected the discharge might have been a "show", and she was discharged home.

On 27th [Month4] [Mrs A] presented for a routine review. She reported feeling "crap". She had no abdominal pain or fever. There was some ongoing stringy brown discharge and normal fetal movements. Otherwise her bloods and CTG were normal. These findings were discussed with [the senior doctor] and she was discharged home.

On the evening of 29 [Month4] (1910 hours) [Mrs A's] LMC called the Maternity Unit to advise they were coming in and [Mrs A] might be in labour. History taken on arrival was that she had tripped over that morning, landing on her hands and knees. She had experienced increased tightenings and discomfort since the fall, with more and redder PV discharge noticed. Her observations and CTG were normal, with tightenings on CTG of 1:8. This presentation was discussed with the locum [O&G] and a decision was made to admit her.

[Mrs A] was seen by [Dr C] at 0830 hours on 1 [Month5] during his Consultant ward round. [Dr C's] plan included a repeat USS the next day; and that she could be discharged home if there was no further PV loss by lunchtime.

[Mrs A] did go home, but the Maternity Unit was contacted at 1435 hours with a report of spontaneous rupture of membranes (SROM). She was reviewed by [Dr C] at 1500 hours. He noted increasing uterine activity, clear liquor and a normal CTG and made the decision to proceed with a category 2 Caesarean Section in view of Breech presentation with … previous CS.

Hand written Operation note by [Dr C]:

Straight forward entry; live female infant was delivered at 16.59 hours. Extensive haemorrhage noted from uterus and 5 cm uterine fundal rupture with placenta protruding through rupture. Filmy omental adhesions were released from this site of rupture. [Senior doctor] assistance was requested and massive transfusion protocol activated. Bleeding was arrested by deep sutures around rupture. With a [senior staff

member] scrubbed and assisting and [another senior staff member] was made to over sew the ruptured area. Bleeding was controlled. CS incision was closed after checking uterine cavity was clear. Estimated blood loss was 3000 mis. Patient was transferred to ICU with blood transfusion and a diagnosis of Caesarean section with oversewing of uterine rupture; severe PPH and DIC.

On 2 [Month4] [Mrs A] was reviewed by [Dr C] who had performed CS and debriefed the procedure and subsequent events. Summarised as:

Scarring of uterus consistent with two previous CS. Large blood vessels (sinus) in lower segment, therefore the incision made slightly higher than usual.

Severe uterine bleeding removal of placenta — followed by hypotension; identified rupture at fundus which was closed temporarily and returned to fundus rupture — developed DIC. Thinks all placenta removed but slightly adherent and placenta sent for histology. Explained that will watch close for signs of retained placenta.

On 5 [Month5], [Mrs A's] case was discussed at the scheduled monthly lunchtime Gynaecology Radiology Multi-Disciplinary Meeting (MDM).

a. G4P3 2 previous caesarean sections. Previous ERPOC postpartum. Multiple admissions for pain and APH. Presented with SROM breech @ 35+/40

Postero-fundal rupture found (unexpected) ?increta/percreta no other organ involvement evident at surgery.

b. Antenatal scans reviewed — no evidence of increta or percreta — MRI & USS Low specificity and sensitivity.

Past history suggests could be risk of myometrial defect from ERPOC but not evident on scans.

c. Plan: Intraoperative photos to be reviewed. Plan for managing clinically.

[Mrs A] recovered steadily postoperatively with good mobility and minimal lochia. She was supported by multidisciplinary team of Physiotherapy, Social worker and regular review by Medical staff. She was discharged home after a week feeling well with normal lochia.

She was reviewed 2 weeks later where she reported mental agony over complications during her delivery and fear of abnormal vaginal bleeding or infection requiring hysterectomy. She did not have abnormal vaginal bleeding. A pelvic USS was requested which reported ? retained products. She had telephone consult to discuss US report. She was reassured since she was feeling well with no abnormal bleeding wait and watch approach was recommended.

A repeat USS was arranged in four weeks and she was reviewed. US reported retained products of conception. A telephone consult was conducted. [Mrs A] was reassured that since she was asymptomatic oral progesterone was prescribed and planned further review. She had regular reviews and she was assessed to be stable. On 26th Month9 when reviewed [Mrs A] had considerable concerns regarding her delivery and further US report. She queried if she had Placenta accreta syndrome.

She was referred for debrief/mediation meeting via service manager in the next few weeks so that [Mrs A's] concerns can be addressed.

Subsequently she was reviewed by another [senior doctor] with MRI report which reported possible Placenta accreta spectrum. A hysterectomy was recommended and arranged for the same but [Mrs A] chose to have it done in [another region].

Antenatally [Mrs A] presented frequently with abdominal pain and at times with minimal vaginal bleeding which resolved after admission. She was appropriately assessed, investigated and managed. All the ultrasounds she had during pregnancy reported normal placentation.

Postnatally although there was high risk of retained placenta with infection and bleeding she recovered gradually without significant sequelae over time.

Placenta percreta involves invasion to the uterine serosa or surrounding structures. Antenatal diagnosis optimizes delivery planning, reducing maternal morbidity and mortality secondary to hemorrhage.

The most important factor affecting outcome is prenatal diagnosis of this condition.

Ultrasound detects PAS (placenta accreta spectrum) prenatally in approximately 50% of cases in population-based studies, but may detect PAS with up to 90% accuracy in expert centers.

The diagnosis is often easier when placenta is previa than fundal although PAS can occur from previous intrauterine procedures like evacuation, D&C, myomectomy.

The incidence of placenta accreta spectrum in the upper uterine segment consists of a small proportion of patients compared with the lower segment localization. Placenta percreta is the rarest form, representing only 5–7% of PAS.

Diagnosing placenta accreta spectrum without previa is less likely to be done antepartum, and a high rate of severe maternal morbidity ensues.

The best management of abnormally invasive placenta remains unclear, a primary hysterectomy at the time of cesarean delivery or following failed removal of a retained placenta has been the mainstay of therapy. If there is not an excessive hemorrhage and

the patient is hemodynamically stable, we can leave the placenta tissue in situ to preserve the uterus to maintain future fertility. Compression sutures; uterine packing; selective arterial embolization and/or balloon occlusion; and uterine and/or hypogastric artery ligation can be used to minimize blood loss. Methotrexate can be used as an adjuvant therapy though its controversial effectiveness.

[Mrs A] was managed appropriately antenatally.

During delivery Placenta percreta was not diagnosed. Was managed as uterine fundal rupture which is unusual with previous CS. Rupture is almost always along the CS scar. In this patient previous uterine curettage had left scar in uterine fundus. Uterine perforation could have occurred during that procedure which wasn't diagnosed or placenta accreta in previous pregnancy. Although ultrasound evaluation is important, the absence of ultrasound findings does not preclude a diagnosis of placenta accreta spectrum; thus, clinical risk factors remain equally important as predictors of placenta accreta spectrum.

There was no clear documentation of state of placenta at delivery and removal. "Think all placenta removed" in operation note. Seeing placenta protruding through fundal defect should have alerted possible Placenta percreta.

Intra operative management controlled uterine haemorrhage effectively and patient was stabilised with blood products in ICU. With appropriate and adequate management [Mrs A] recovered post operatively without infection or ongoing severe vaginal bleeding requiring emergency hysterectomy.

Post-natally when she presented with recurrent abdominal pain and vaginal bleeding although not severe, PAS was not considered as a possibility and MRI was not requested earlier until [Mrs A] raised concerns of PAS.

Mild deviation from standard of care.

2. With regard to her prenatal care:

Whether appropriate consideration was given to [Mrs A's] history of previous retained placenta requiring instrumental removal following her second delivery.

With regard to above history [Mrs A] was at high risk of Placenta accreta spectrum, diagnosis of which is mostly Ultrasound which did not report any such abnormality until after delivery. MRI post natally reported PAS. Under these circumstances PAS could not be considered as likely diagnosis. The above risk was recognised and plans were made to monitor closely for retained placental products after delivery.

Accepted standard of care.

Whether it [would] be expected that [Mrs A's] history of previous retained placenta and subsequent removal will alter the management decisions prior to proceeding with Caesarean section on 1st [Month5].

Since there was no antenatal diagnosis of PAS which can be diagnosed with Ultrasound proceeding with emergency CS for rupture of membranes in breech position and labouring with previous two CS was appropriate management under the circumstances.

Accepted standard of care.

Whether it could be reasonably expected that a diagnosis of PAS would be made and or considered as a cause of [Mrs A's] recurrent abdominal pain during her pregnancy

PAS has not been found causing abdominal pain. Preterm labour and significant haemorrhage have been the usual presentation. Quite often these symptoms are associated with placenta previa.

Accepted standard of care.

3. With regards to her post-natal care:

Whether [Dr B's] post-natal management of [Mrs A's] care was consistent with accepted practice on the basis of clinical information available to her.

[Dr B] was not involved in the delivery of [Mrs A]. Antenatally there was no evidence of PAS. In the operation note it was documented as uterine fundal rupture which was oversewn. PAS was not mentioned as a possibility.

In the Radiology review following delivery of [Mrs A] Dr … had queried PAS. Review of antenatal US were concluded as not PAS. Recommendation was to review intra operative picture and clinical correlation.

When [Mrs A] had presented with abdominal pain and bleeding postnatally expressing concerns of retained placenta as well as US reporting retained products around fundus attempts should have been made to rule out PAS.

At this stage referral and review with tertiary centre or prompt MRI could have been considered (hindsight needs to be taken into account).

Mild deviation from standard of care.

Whether a diagnosis of PAS should have been suspected over this period and if it was would such a diagnosis be expected to have significantly altered the management strategy.

When [Mrs A] presented repeatedly postnatally with Ultrasound reporting possible retained products [Dr B] should have considered PAS as a possibility with background history of previous retained placenta requiring instrumental removal and significant

blood loss; DIC and massive transfusion during recent CS. Intraoperative finding of placenta protruding through fundal rupture should have alluded to PAS. Earlier MRI could have reduced much of [Mrs A's] anxiety, pain and fear as well as risk of infection and severe haemorrhage with potential need for emergency hysterectomy which did not occur.

If PAS had been diagnosed earlier and acted upon as surgical or expectant management [Mrs A] would have felt cared for and supported without losing trust.

[Dr B] could have been reassured with [Mrs A's] recovery with minimal symptoms.

Moderate deviation from standard of care.

The standard of care with regards to obtaining histology of [Mrs A's] placenta.

From the available information it is unclear how histology was not reported in Nelson … Laboratory but later was made available. Often specimens don't reach laboratory even after being requested by operating Surgeon due to various technical errors. Placental histology per se may not be useful in diagnosis of PAS unless it was incomplete or sent along with uterus in situ.

Following a serious event as this specimen for histological evaluation should have been sent with due care.

Moderate deviation from standard of care.

Standard of Documentation held by [Health NZ] with particular reference to any expectation that a diagnosis of possible PAS would be documented in Operation record or post op notes completed by [Dr C] based on his observation during surgery.

In reference to operation notes hand written notes w[ere] the only operation record available. Every clinical event either consultation or procedure should be documented as a typed letter. In an event with significant complications as severe PPH; DIC; uterine rupture and subsequent ICU management clear explicit and thorough documentation was mandatory.

With additional senior [staff members'] input in theatre PAS should have been considered and documented. Post operative review of the incident/care should have been carried out which could have highlighted PAS as a possible diagnosis.

General documentation of clinical notes was according to standard expected.

Moderate to severe deviation from standard of care.

References:

Conservative management of placenta percreta. Shinya Matsuzaki,Kiyoshi Yoshino,Masayuki Endo,Aiko Kakigano,Tsuyoshi Takiuchi,Tadashi Kimura. First published: 30 November 2017 **https://doi.org/10.1002/ijgo.12411** Gynaecology & Obstetrics

International Journal of Obstetrics & Gynaecology Volume140, Issue3. Themed Issue: Placenta accreta spectrum disorders.'

The following further advice was obtained from Dr Vasan during January–April 2023:

'Date: 03/04/2023 01:59 p.m.

Subject: Re: *Confidential: Re: 20HDC01991 Private and Confidential Correspondence from the Health and Disability Commissioner

…

If this was available in the clinical notes at the time of further follow up this is sufficient and meets standard of care. I recollect this was not available during subsequent reviews.

Nga mihi

Vasan'

'…

Date: 03/04/2023 01:05 p.m.

Subject: *Confidential: Re 20HDC01991 Private and Confidential Correspondence from the Health and Disability Commissioner

Kia ora Dr Vasan

Thanks for your helpful response. One last brief question if you don't mind.

[Dr C] did provide a handwritten note of the operation (which I have attached — the password is the same as previously). Is that note insufficient, or does it meet the standard?'

'Date: 03/04/2023 12:48 p.m.

Subject: Re: *Confidential: Re: 20HDC01991 Private and Confidential Correspondence from the Health and Disability Commissioner

…

Regarding the ambiguity in the report:

1. If [Dr C] had documented operation report either as detailed written document or dictated to that effect but was not made available in the clinical records is a systemic error (Hospital record system) — moderate breach of standard of care.

If [Dr C] did not provide either hand written (detailed) or dictated operation report following this event it is individual error — lack of documentation will equal to moderate breach of standard of care.

2. Uterine rupture away from Caesarean scar and eventual post partum hemorrhage requiring second Consultant involvement in the care of the patient requires systematic case review with proper analysis of the event and recommendations. There was no evidence of such a review other than departmental discussion in a multidisciplinary meeting. This is a moderate breach of standard of care.

Please let me know if there is further clarification required.

Nga mihi

S Vasan'

'Date: 29/03/2023 10:09 a.m.

Subject: *Confidential: Re: 20HDC01991 Private and Confidential Correspondence from the Health and Disability Commissioner

Kia ora Dr Vasan

Thanks for getting in touch again. It might be easier just to ask my questions by email, if that is ok with you:

1. You are critical in your report that there is no typed letter recording the 1 [Month5] Caesarean operation, and you question whether it is an individual error or a systemic error, depending on whether [Dr C] dictated a note or not. Could you advise, for each of the two possibilities (i.e. if [Dr C] did dictate the note, and if he did not), whether you consider it a breach of the standard of care and, if so, what the severity is (i.e. mild, moderate, severe)?

2. Regarding the issue I highlighted in green in the copy of your advice I attached to my … email, I am still unsure about exactly what the departure from the standard of care was — is it the failure to carry out a systemic review following the traumatic birth? If it was, what are the features of the event (e.g. the uterine rupture) that creates the requirement for a systemic review?

Thanks in advance for your further advice.'

'Date: 06/03/2023 04:28 p.m.

Subject: *Confidential: RE: 20HDC01991 Private and Confidential Correspondence from the Health and Disability Commissioner

Kia ora Dr Vasan

As we are having some trouble arranging a discussion, I would be grateful if you would clarify:

1. Where you write, "*Clear typed documentation of surgical event is mandatory especially in a serious event as this. Difficult to comment if it was [a staff member's] error or system error. [A staff member] could have dictated but was not typed or recorded in the system or missed dictation*", could you comment on whether this is a departure from the standard of care? Whether it is a systems error or an individual error, could you quantify that error (in terms of mild, moderate, or severe)? If the severity differs depending on whether it is a systems or individual error, could you give an answer for both possibilities?

2. You also identify the failure to carry out a serious adverse event review following the birth. Is that failure a separate moderate to severe departure from the standard of care?

Thanks and I look forward to hearing from you.'

'Date: 22/01/2023 06:04 p.m.

Subject: RE: 20HDC01991 Private and Confidential Correspondence from the Health and Disability Commissioner

…

Regarding three yellow highlights: all three refer to same concerns, mild to moderate deviation according to different aspects of the same concern.

Regarding Blue and green highlights:

Clear typed documentation of surgical event is mandatory especially in a serious event as this. Difficult to comment if it was [a staff member's] error or system error. [A staff member] could have dictated but was not typed or recorded in the system or missed dictation.

A serious event warrants systemic review with all relevant [staff members] involved in the care to assess the event and make recommendations for better management if deficiencies were recognised.

On 5 [Month5], [Mrs A's] case was discussed at the scheduled monthly lunchtime Gynaecology Radiology Multi-Disciplinary Meeting (MDM) and PAS was queried, discussed but not confirmed. Recommendation was made to review operation report and assess with clinical condition.

This reflects moderate deviation from standard of care from Clinicians involved and [Health NZ].

I hope this clarifies your concerns. Please let me know if you need further clarifications.

Nga mihi nui

S Vasan'

'Date: 10/01/2023 04:39 p.m.

Subject: 20HDC01991 Private and Confidential Correspondence from the Health and Disability Commissioner

Kia ora Dr Vasan

You kindly provided advice to the Commissioner on this matter in April last year. I have been asked to look at this case and in particular into whether the Commissioner should commence a formal investigation. I have reviewed your advice and I have a couple of questions about it if you have a few minutes.

I realise it has been some time since you provided your advice, so perhaps we could schedule a time later in the week to talk once you have reviewed your advice? Please let me know when would be convenient.

To give you some idea of my questions, I have attached a copy of your advice with some highlighting. The password is the same as the one previously advised to you. Let me know if you need me to re-send it.

I am particularly interested in:

1. I have highlighted three sections in yellow. In the first two, you identify mild deviations from the standard of care. In the third, a moderate deviation. All three appear to be a criticism that, given the intraoperative findings and [Mrs A's] history, PAS should have been considered as a strong possibility and further investigations undertaken to rule it out. Where you have made three separate criticisms in your report, do you regard the three as discrete deviations from the standard, or are they all the same deviation? If they are separate, what is the difference between the three?

2. I have also highlighted two sections in blue and green. The final deviation from the standard of care that you identify is a moderate to severe one. You advise that there

should have been a typed letter clearly documenting the operation. You also advise in the same section that PAS should have been considered and documented, and post operative review of the incident should have been carried out which could have highlighted PAS as a possible diagnosis. Could you clarify what the deviation from the standard of care is here? Is it the failure to clearly record and document the operation (i.e. [Dr C's] failure), or is it the failure to carry out a post-operative review of the incident (i.e. [Health NZ's] failure)? If it is both, how do you regard the severity of the two departures?'

The following further advice was obtained from Dr Vasan on 14 March 2025:

'**Complaint: Health New Zealand|Te Whatu Ora Nelson Marlborough (previously Nelson Marlborough District Health Board (NMDHB)) Our ref: 20HDC01991**

1. In response to your request to provide further advice on this case in light of the further information provided from your office I have perused further information.

• Letter from [Dr B] on 26 July 2023 and Opinion from [Dr E]

"Whether any of the further information causes you to amend the conclusions drawn in your initial report about the care provided by [Dr B]; in particular:

- Whether [Dr B's] post-natal management of [Mrs A's] care was consistent with accepted practice on the basis of clinical information available to her; and
- Whether a diagnosis of placenta accreta spectrum (PAS) should have been suspected over this period and
- if it was, would such a diagnosis be expected to have significantly altered the management strategy."

I would like to revert to relevant details in my initial advice in this regard.

On [2 Month4 2020] [Mrs A] was reviewed by [Dr C] who had performed Caesarean section and debriefed the procedure and subsequent events. Summarised as:

Scarring of uterus consistent with two previous CS. Large blood vessels (sinus) in lower segment, therefore the incision made slightly higher than usual.

Severe uterine bleeding removal of placenta — followed by hypotension; identified rupture at fundus which was closed temporarily and returned to fundus rupture — developed DIC. Thinks all placenta removed but slightly adherent and placenta sent for histology. Explained that will watch close for signs of retained placenta. — This information was available to [Dr B] before post-natal review of [Mrs A].

[Dr B] was not involved in the delivery of [Mrs A]. Antenatally there was no evidence of PAS. In the operation note it was documented as uterine fundal rupture which was oversewn. PAS was not mentioned as a possibility.

In the Radiology review following delivery of [Mrs A], Dr … had queried PAS. Review of antenatal US were concluded as not PAS.

Recommendation was to review intra operative picture and clinical correlation.

When [Mrs A] had presented with abdominal pain and bleeding post-natally expressing concerns of retained placenta as well as US reporting retained products around fundus attempts should have been made to rule out PAS due to the past history of retained placenta requiring return to theatre for instrumental removal of placenta with prolonged recovery as well as significant blood loss in recent delivery by caesarean section associated with fundal uterine rupture (NOT Caesarean section scar rupture which is more common and expected), placenta removed in piecemeal, unsure if removed completely; developing DIC requiring massive blood transfusion, ICU admission.

I want to comment and elaborate on [Dr B's] statements in her letters:

5. "I disagree. Intraoperative finding of placenta protruding through fundal rupture does not allude to PAS — if there was a rupture with placenta over it, placental tissue would protrude through. I had wondered if [Mrs A] had sustained a uterine perforation at her last dilatation and curettage (D&C) which then contributed to the rupture, but I did not consider PAS at any point until [Mrs A] had her MRI."

In her initial letter [Dr B] wrote:

77. "I understand [Mrs A] went forward for hysterectomy on 19 [Month12]. I have seen a histology report which found features in the uterus consistent with placenta accreta."

87. [Dr C] did not report placenta accreta following [Mrs A's] Caesarean Section. I would have expected one of the doctors involved in [Mrs A's] Caesarean Section to have recorded the presence of placenta accreta had this been observed or suspected.

88. "Given this background, I had a low index of suspicion for placenta accreta. My clinical judgment — discussed and agreed with [Mrs A] — was that post-delivery we would take a cautious watch and wait approach to monitor her progress, together with monitoring by USS where indicated. After [Mrs A] told me of her concerns that she had placenta accreta I referred her for an MRI, which confirmed that as a likely diagnosis."

A fundal rupture in a patient who had had previous CS should allude to previous myometrial injury. Previous myometrial injury which was significant enough to cause rupture is high risk for PAS in future pregnancies more so when she had adherent placenta in previous pregnancy and in the current caesarean delivery. When the patient

presents repeatedly with signs of retained products it is imperative to rule out PAS which is a more morbid condition requiring more intensive management even if retained products was a possibility.

Assuming it is definitely retained products and rupture at fundus was due to previous injury, placenta protruded through the dehiscence could only be considered after ruling out PAS which is higher possibility after such repeated episodes of adherent placenta and post-partum haemorrhage.

The placenta accreta spectrum has become an important contributor to severe maternal morbidity. Because placenta accreta spectrum is potentially life threatening, hysterectomy is the typical treatment unlike retained placenta which also needed to be evacuated timely to avoid infection and secondary postpartum haemorrhage, rarely sepsis leading to severe morbidity.

Conservative management carries risk of infection and severe haemorrhage with potential need for emergency hysterectomy.

At this stage referral and review with tertiary centre or prompt MRI could have been considered. Not doing so until [Mrs A] raised concerns of PAS is not consistent with standard accepted practice.

This is a ***moderate departure from standard of care***.

(The care provided did not meet a particular standard or accepted practice but there were relevant mitigating factors present and considered.)

2. "Please clarify your advice regarding the reviews of [Mrs A's] care undertaken by [Health NZ]; in particular:

- In your initial advice, you identified that [Mrs A's] case was discussed at the [Health NZ] MDM on 5 [Month5], where PAS was queried, but not confirmed and the recommendation was to review intra-operative pictures and clinical correlation. You further advised (in an email dated 3 April 2023) that failing to undertake a systematic case review was a moderate departure from the standard of care.
- Can you please clarify whether this criticism is about the failure to undertake a serious adverse event review and/or regarding the appropriateness of the [Health NZ] MDM and its findings."

MDM review was a multidisciplinary discussion of the event reviewing investigations and management of the event. The recommendations were appropriate. This was ***accepted standard care***.

Uterine rupture (unconventional fundal not scar rupture) resulting in DIC requiring massive transfusion, ICU care is a central event and needs systematic case review

beyond the departmental level. [Health NZ] is expected to undertake these reviews as per standard of care provided to patients. [Health NZ] not undertaking serious adverse event review is a ***severe departure from expected standard of care.***

I have amended my opinion on the above after further assessment of all documents.'

Appendix B: Independent clinical advice to Commissioner

The following independent clinical advice was obtained from radiologist Dr David Milne on 2 August 2023:

'RE: [Mrs A] NHI: … Ref: 20HDC0991

I have been requested by HDC to perform a blind review of ultrasound examinations performed on [Mrs A] during her pregnancy of 2019–2020.

I have been given a list of imaging to be reviewed and have sourced this imaging from [… Radiology] and [Health NZ], Nelson.

The imaging includes:

1. … 2019 [radiology report], visit [number]. First trimester ultrasound. Clinical indications: routine nuchal translucency
2. 11 [Month1] 2019 [radiology report], visit [number]. Second trimester ultrasound. Clinical indications: routine anatomy scan
3. 20 [Month1] 2019 [Health NZ], Nelson Hospital. Pelvic, renal and gallbladder ultrasound. Indications: abdominal pain, pregnant.
4. 7 [Month3] 2020 [Health NZ], Nelson Hospital. Pregnancy ultrasound. Indication: antepartum haemorrhage. Placenta documented as fundal and not low lying at anatomy scan.
5. 21 [Month3] 2020 [radiology report], visit [number]. Second trimester ultrasound. Clinical indications: scan for growth. Baby on the 98%. Previous APH with evidence of clot (26mm) close to cervix.
6. 13 [Month4] 2020 [radiology report], visit [number]. Third trimester ultrasound. Clinical indications: repeat growth
7. 24 [Month4] 2020 [Health NZ], Nelson Hospital. Obstetric liquor ultrasound. Indication: obstetric cholestasis. Prolonged rupture of membranes? Amniotic fluid volume.

I am informed that [Mrs A's] EDD by earliest ultrasound was …

I requested further information regarding [Mrs A's] obstetric history which would have been disclosed routinely at the time of ultrasound scanning and this was her prior obstetric history including prior caesarean sections. I received a reply that [Mrs A] was …, via … caesarean sections and that this, her [next] pregnancy, was planned caesarean.

Review of imaging

I have reviewed the imaging but not the formal reporting of the imaging made at the time. My observations will be focused on the adequacy of the imaging and any atypical findings rather than a replication of reporting.

18 [Month1 2019]. Adequate imaging. No fetal anatomical abnormality. Size equivalent to gestation at 12 weeks.

11 [Month1 2019]. Adequate imaging. No fetal anatomical abnormality. Placenta towards the fundus of the uterus. Normal liquor. Biometry appropriate.

20 [Month1 2019]. The right kidney demonstrates mild hydronephrosis with a transverse diameter of the renal pelvis on this side of 13mm. The left kidney is unremarkable. The Uterus has received a limited examination focussing on the placenta looking for a periplacental bleed but none is identified.

7 [Month3 2020]. This scan was performed at the time of an antepartum bleed. The imaging includes trans abdominal and trans vaginal scanning. No fetal abnormality is seen. The fetal biometry is appropriate. Normal liquor. The placenta is fundal and anterior, well clear of the internal os. The placenta does contain some prominent lacunae but no peri-placental bleed is shown.

On trans vaginal scanning a small echogenic area is shown posterior to the cervix. I am uncertain what this is but it could be retained sub-membranous clot in the context of a recent bleed.

21 [Month3 2020]. Fetal biometry indicates size on the 90% for 29 weeks 5 days. No fetal anatomical abnormality. Placenta well clear of the internal os. No peri-placental bleed. Transvaginal scanning has not been repeated to revisualise the small presumed residual clot seen on the prior scan. This is not an omission in scan protocol however.

13 [Month4 2020]. Fetal biometry continues to demonstrate a large fetus, now on the 98% for 33 weeks. No anatomical abnormality. Fetal position is breech or oblique. Placenta is fundal and anterior, well clear of the internal os. For the first time a succenturiate lobe to the placenta has been identified at the right lateral aspect of the uterus. Again, clear of the internal os.

24 [Month4 2020]. Limited scan not including fetal biometry. Adequate liquor. Flexed leg breech position. No placental issues. Succenturiate lobe not labelled as identified. No peri-placental bleed.

Comment on imaging
Imaging is of high quality throughout. I have not identified any significant fetal abnormality. The fetus is large in the third trimester scans. The placenta is antero fundal and clear. No placenta is seen in the region of the prior caesarean section scans which

would have been lower segment rather than fundal. A succenturiate (accessory placental) lobe was identified on one imaging episode but not prior or following that.

The scan of 20 [Month1 2019] demonstrated hydronephrosis of the maternal kidney on the right but this has not been imaged subsequently so I presume this was not of ongoing clinical concern.

I would make the comment however that the images reviewed are a representation of the ultrasound examination performed at the time and not the complete study.

Summary of findings
No adverse findings. Large fetus.

I would be happy to provide further advice on this case if required.

Yours sincerely,

Dr David Milne
Radiologist.'