Consultant obstetrician and gynaecologist breaches Code for not providing an appropriate standard of care to a pregnant woman

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The Deputy Health and Disability Commissioner has found an obstetrician and gynaecologist breached the Code of Health and Disability Services Consumers' Rights (the Code) in his care of a pregnant woman who he discharged home, despite her showing 'red flag' symptoms for infection and experiencing abdominal pain.

The woman had earlier presented to a public hospital when she was 33 weeks pregnant because of a continuous clear vaginal discharge and abdominal pain. Ongoing antibiotics, pain relief and steroids were administered. At that stage, her discharge did not indicate infection.

Four days later, at a pre-scheduled scan, it was found that the woman had decreased amniotic fluid and her vaginal discharge had started to change colour. Her abdominal pain remained. She was discharged, with an induction of labour booked for two weeks from then, and advised to return to hospital if she had concerns.

The next day the woman returned to the maternity unit, as contractions had started. A foetal heartbeat could not be heard during a scan and, sadly, the death of her baby in utero was confirmed. The woman then delivered her baby vaginally and had the placenta removed surgically.

Rose Wall said, "Given the presence of green discharge and Ms A's ongoing abdominal pain, I am critical that Ms A was discharged home without any further assessment…chorioamnionitis[1] can present subtly and develop rapidly. This would have placed the wellbeing of her foetus at risk. For this reason, I would have expected Dr C to arrange for Ms A to be admitted to the maternity unit for full investigations to be undertaken. This did not occur."

Ms Wall said the consultant had failed to provide services to the woman with reasonable care and skill - Right 4 (1) - for not investigating the concerning green vaginal discharge appropriately. Ms Wall agreed with expert advice which said the decision to discharge the woman was a severe departure from accepted practice.

The consultant accepted the woman should have been admitted to the maternity unit for further assessment. Since the incident, Health New Zealand|Te Whatu Ora has developed a pamphlet on self-monitoring for women at home who have confirmed pre-term rupture of membranes.

[1] Bacterial infection resulting in acute inflammation of membranes of placenta

Ms Wall has recommended Health New Zealand update its obstetric orientation to stress the importance of assessing patients who show symptoms of infection and provide HDC with updates that came out of its serious events analysis.

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Editor’s notes

Please only use the photo provided with this media release. For any questions about the photo, please contact the communications team.

The full report of this case can be viewed on HDC’s website - see HDC's 'Latest Decisions'.

Names have been removed from the report to protect privacy of the individuals involved in this case.

The Commissioner will usually name providers and public hospitals found in breach of the Code unless it would not be in the public interest or would unfairly compromise the privacy interests of an individual provider or a consumer. More information for the media, including HDC’s naming policy and why we don't comment on complaints, can be found on our website here.

HDC promotes and protects the rights of people using health and disability services as set out in the Code of Health and Disability Services Consumers' Rights (the Code).

In 2022/23 HDC made 592 quality improvement recommendations to individual complaints and we have a high compliance rate of around 96%.

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