Registered Midwife, RM B

Birthcare Auckland Limited

A Report by the

Deputy Health and Disability Commissioner

(Case 20HDC00715)

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

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Complaint and investigation

1. The Health and Disability Commissioner (HDC) received a complaint from Mr and Mrs A about the services provided to their son, Baby A, by Birthcare Auckland Limited and Registered Midwife (RM) B. The following issues were identified for investigation:

- *Whether Birthcare Auckland Limited provided Baby A with an appropriate standard of care in 2019 and 2020, including Birthcare's adverse event and complaint management.*
- *Whether RM B provided Baby A with an appropriate standard of care in 2019.*

2. This report is the opinion of Deputy Health and Disability Commissioner Rose Wall, and is made in accordance with the power delegated to her by the Commissioner.

3. The parties directly involved in the investigation were:

Mrs A	Complainant/mother
Mr A	Complainant/father
Birthcare Auckland Limited	Group provider
RM B	Individual provider/registered midwife

4. Further information was received from:

RM C	Lead maternity carer/registered midwife
RM D	Birthcare senior staff member
RM E	Birthcare senior staff member
RM F	Birthcare registered midwife
RM G	Birthcare registered midwife
RM H	Birthcare registered midwife
RM I	Birthcare registered midwife
RN J	Birthcare registered nurse
RM K	Birthcare registered midwife
Dr L	Paediatrician
Ambulance service	
District Health Board (DHB)[1]	
Accident Compensation Corporation (ACC)	

5. Student midwife Ms M is also mentioned in this report.

6. Independent clinical advice was obtained from paramedic Mr Mark Bailey, registered midwife Ms Mary Wood, and paediatrician Dr John Doran. Their advice is included as Appendices A, B and C, respectively.

[1] On 1 July 2022, the Pae Ora (Healthy Futures) Act 2022 came into force, which disestablished all district health boards. Their functions and liabilities were merged into Te Whatu Ora|Health New Zealand. All references to the DHB in this report now refer to Te Whatu Ora.

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Background

7. In the late hours of 23 Month1[2] 2019, Baby A was born at Birthcare Auckland. Baby A's mother had a normal pregnancy and labour, and Baby A was delivered uneventfully and healthy. However, in the 24–48 hours that followed, Baby A's initially healthy presentation slowly declined. Baby A was suffering from hypoglycaemia (low levels of sugar in the blood) but there was a delay in identifying this.

8. Baby A's hypoglycaemia and corresponding deterioration culminated in him collapsing during an ambulance transfer to the neonatal intensive care unit (NICU) at the public hospital on 25 Month1. During the ambulance ride, Baby A had a seizure and his heart stopped, and he required resuscitation.

9. In hospital, scans showed that Baby A had extensive brain damage, and he was not expected to survive. However, Baby A's condition stabilised and, at time of writing, is reported to be well, although he has cerebral palsy with significant developmental delays. The family faces ongoing uncertainty around the extent of the impact of Baby A's brain damage on his future development.

10. Following these events, Baby A's parents made a formal complaint to Birthcare. Unfortunately, the matter was unable to be resolved, and their concerns were escalated to this Office.

11. Baby A's parents told HDC:

> "What makes this incident an even more difficult pill to swallow is the way Birthcare has dealt with the situation … Birthcare's repeated failure for open disclosure and engagement with us has caused a large rippling effect in the way [Baby A's] case has transpired … This has caused us significant harm and additional level of distress as a family."

12. This report has two components:

- Part 1 discusses the care provided to Baby A from 23 to 25 Month1 2019.
- Part 2 discusses Birthcare's subsequent management of the adverse event and Baby A's parents' complaint.

[2] Relevant months are referred to as Months 1–11 to protect privacy.

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PART 1: BABY A'S CARE FROM 23 TO 25 MONTH1

Baby A's family, Birthcare, RM B, Dr L, RM C, and the ambulance service — opening comment

13. At the outset, I express my sincere condolences to Baby A, Mrs A, and Mr A for the devastating events that occurred on 25 Month1. I appreciate that their lives were altered permanently from that day forward. I also acknowledge that these events have had a profound effect on the health professionals involved.

14. I begin by making the following observations. First, I have been struck by the numerous detailed but also conflicting recollections provided to this Office by the parties involved. This report does not purport to traverse each and every discrepancy in information. I will discuss these only where they are relevant and material to my decision-making.

15. Secondly, I note the comment of my midwifery advisor, RM Mary Wood, that "[w]hen reviewing an event such as this, one is looking at the whole picture at once and the outcome is known, but in reality the situations unfold gradually". I agree, and note that the opinions formed are based on the information known at the time of the events, rather than with the benefit of hindsight.

Baby A's birth

16. Baby A was born at 11.22pm on 23 Month1 at 37 weeks and 1 day's gestation. He weighed 2.79kg, being on the 19.6th centile. At 11.45pm, Baby A's first breastfeed was achieved and a "deep latch" and audible sucking were noted. At 1.30am on 24 Month1, Baby A was transferred to a postnatal room.

Opinion: Birthcare, RM B, and RM C — other comment

Baby A's gestational age and decision to birth at Birthcare

17. There has been considerable disagreement around whether it was appropriate to birth Baby A at Birthcare, and whether Baby A's gestational age was accurate. I will discuss these issues briefly, as, for the reasons I outline below, I am satisfied that Baby A's gestational age was accurate and that it was appropriate to birth him at Birthcare.

18. Birthcare and RM B contend that Baby A's gestational age may be under question. In RM B's retrospective note of 2 Month2, she wrote:

> "[Mrs A] reported during the day that she feared baby was less than 37 weeks as she discovered she was pregnant at 18 weeks and she had been told that it was then inaccurate."

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19. Based on this, Birthcare and RM B believe it was inappropriate for Mrs A to have delivered at Birthcare.

20. On the other hand, Baby A's parents told HDC that they have never speculated that their scans were inaccurate, nor had they been told of any inaccuracies. Mrs A's Lead Maternity Carer (LMC), RM C, told HDC: "[T]here is no other documentation by [the] GP, myself or [any] other health practitioner that there is a different [estimated delivery date (EDD)]."

My opinion

21. My midwifery advisor, RM Wood, noted that Mrs A had a scan to determine her dates. This scan indicated fetal measurements that gave a gestational age of 18 weeks and 1 day. This EDD was confirmed two weeks later when the anatomy scan found that Baby A was an appropriate size for the gestational age of 20 weeks and 2 days. This was consistent with the initial scan.

22. RM Wood acknowledged that without an earlier scan to determine precise dates, the EDD that was used may not have been exact. However, in her opinion, the majority of midwives would have relied on the EDD that was indicated in both of the above scans. They would have used this EDD, together with Mrs A's clinical growth during her pregnancy, to determine the appropriateness of Mrs A birthing at Birthcare. In this instance, most midwives would have been happy to deliver at Birthcare.

23. My assessment of whether or not it was appropriate to deliver at Birthcare is made based on the information known at the time that decision was made. It is with the benefit of hindsight and from conversations that occurred after the birth that Birthcare and RM B are now raising concerns about Baby A's gestational age. I agree with RM Wood that in the absence of any other evidence to the contrary, at the time of decision-making, it was reasonable for RM C to rely on information from Mrs A's scans to determine gestational age. This, along with Mrs A's normal pregnancy, supported a decision to deliver Baby A at Birthcare.

Overview of Mrs A and Baby A's Birthcare clinical notes

24. At 1.40am on 24 Month1, care was handed over from RM C to Birthcare core midwives. A summary of Baby A's progress from 2am, 24 Month1 through to 4pm, 25 Month1 is outlined in the table below.

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Time	Clinical notes/Feeding chart	BA-L[3]	BA-R[4]
RM F			
2am	Baby A attempted at left breast but not interested		
6am	Mrs A reports breast fed Baby A this morning but not interested		
RM G			
6am	Baby A latched but short feed at breast, sleepy++		
9am	Feeding chart commenced, 0.5ml EBM[5]	3[6]	3
12.15pm	0.6ml EBM	-	6[7]
2pm	LMC visit, Mrs A finding one breast challenging		
2.15pm	Attempting to latch baby, passed urine, had not passed meconium, baby sleepy++		
RM I			
3pm	To do skin to skin and feed, alert, pink, vigorous		
3.15pm	0.7ml EBM	3	5[8]
4.40pm	Been on breast, skin to skin, some good sucking, nappy dry but wet nappy earlier, alert, vigorous		
7pm	Breastfeeding	4[9]	5
9.35pm	Fed at both sides at 7pm, wet nappy, had 0.9mls to give at next feed, due very soon		
10.40pm	0.9ml EBM	1[10]	1
11.20pm	+/- 1ml EBM	1	1
RN J			
2am	Very unsettled, crying continuously, has not been able to breast feed, giving EBM top ups, has passed urine, has passed meconium, pink and warm		
3.30am	0.4ml EBM	1	1
5.45am	Asleep, well settled. Mrs A reports that Baby A is unsettled and not wanting to breast feed. Small amounts of EBM top ups given		
RM B			
8am	Called as feed due and baby asleep, breastfeed attempted — not interested, passed urine, passed meconium.	1	1
9am	0.5ml expressed but family document only took 0.1ml, sleepy	-	-
9.40pm	LMC visit — 3 way conversation about feeding plan		
11.50am	Not interested in feeding, Baby A cold to touch and put skin to skin, temperature 36.2°C — checked twice		

[3] Breastfeeding assessment (left breast).
[4] Breastfeeding assessment (right breast).
[5] Expressed breast milk.
[6] A breastfeeding assessment score of 3 means, "Latches but slips on and off".
[7] A breastfeeding assessment score of 6 means, "Slow rhythmical sucking, swallowing >10 minutes".
[8] A breastfeeding assessment score of 5 means, "Slow rhythmical sucking, swallowing <10 minutes".
[9] A breastfeeding assessment score of 4 means, "Latches but sucking not coordinated".
[10] A breastfeeding assessment score of 1 means, "Offered but baby not interested".

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12.13–12.30pm	0.8ml EBM, temp 36.8°C, still not interested in feeding, sleepy+++	1	1
1.50pm	Eyes checked as Mrs A worried that he could have rolled his eyes — eyes clear and normal, temperature 36.7°C		
3pm	Breastfeed attempted	1	1
3.30pm	0.5ml EBM	1	1
3–4pm	Very sleepy, face a bit bluish, temperature 36.4°C, paediatrician called, BSL "low" twice, infant formula attempted but unsuccessful, lethargic, ambulance transfer to NICU arranged		

Opinion: RM C — educational comment

Serial blood glucose (SBG) and random blood glucose screening (RBG)

25. It is important to note the distinction between SBG and RBG.

26. SBG screening is sequential and is generally carried out over the first 10 to 12 hours after birth, with the first recording taken 1–2 hours post birth and then repeated 3 hourly with subsequent feeds as a screening tool until there have been three consecutive normal blood glucose recordings.

27. RBG screening is carried out to check a baby's blood glucose level when there has been a specific event that may have affected a baby's blood glucose level, or when a baby is showing signs that may be indicative of low blood sugar.

SBG screening at birth

28. RM C told HDC that Baby A did not require SBG screening at birth. She acknowledged that he was perhaps "borderline", but maintains that he did not meet the criteria for SBG at 2 hours postpartum.

29. Birthcare's Neonatal Hypoglycaemia Policy (August 2018) states:

> **"Babies who require glucose screening**
> - All babies <10th centile or >95th centile
>
> …
> - If standard centile charts are not available, all term babies with a birth weight <2.8kg or >4.5kg."

30. Baby A's birthweight was 2,790g. RM C told HDC that Baby A's centile was calculated the following day, and therefore was not known at 1–2 hours of age.

31. RM C told HDC:

> "I have read the Neonatal Hypoglycaemia Policy, that now is easily accessible. During the event it was not. In fact, I asked administration to kindly email me the guidelines about a week after the event."

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32. Birthcare disputes that the policy was not easily accessible.

My opinion

33. My midwifery advisor, RM Wood, advised that Baby A did not show signs that there was a problem until he was over 24 hours old. She advised that given the clinical picture at the time, not carrying out SBG screening at birth would have been a decision many midwives would have made. RM Wood commented that Baby A was a good birthweight for 37 weeks, and had behaved normally after birth and was vigorous, had breastfed well, and was warm. RM Wood noted the invasive nature of blood sampling, and concluded: "I do not consider this a significant departure from an acceptable standard."

34. ACC's midwifery advisor advised that Baby A did not meet the criteria for SBG screening at birth, but he had a number of attributes that would have put him at a low threshold for testing. She noted that Baby A was just over 37 weeks' gestation, Mrs A had had two raised polycose tests in pregnancy, and, although not less than the 10th centile, his birthweight was less than 2,800g. RM Wood noted that polycose testing is not diagnostic, whereas a glucose tolerance test (GTT) is, and Mrs A's GTT was normal.

35. RM Wood also noted that different facilities have differing protocols for glucose screening. She referenced a number of other birthing unit protocols that require glucose screening after birth if babies are under 2,500g, rather than 2,800g.

36. At the time Baby A was 1–2 hours old, RM C was unaware of Baby A's healthy centile. In the absence of this information, Birthcare's policy would support commencement of SBG screening for Baby A, owing to his birthweight being less than 2,800g. However, RM Wood's advice that there are differences in facility protocols suggests to me that there is some variation around the standard of care. This, as well as RM Wood's and RM B's advice noted above, suggests to me that it was open to RM C to apply clinical judgement and omit SBG monitoring after birth, particularly considering that Baby A's weight was only 10g less than 2,800g. I note RM C's reflection that this experience has taught her the necessity of increased vigilance around hypoglycaemia in newborns. This heightened awareness is appropriate.

Handover at 1.40am, 24 Month1

37. RM C and RM F agree that there was a discussion about whether Baby A should have glucose screening at handover; however, they have differing recollections about what was said.

38. RM F told HDC that RM C "declined" glucose screening, stating that Baby A had had a great first feed and was to be treated as "normal". Other statements provided by subsequent midwives on shift support RM F's recollection.

- RM G told HDC: "The LMC had handed over to the previous (night shift) midwife that [Baby A] was to have routine postnatal care."
- RM I said: "[RM G] said the LMC said no to having serial blood sugars done."
- RN J said: "Handover was that LMC had advised that she did not want [SBG] done."

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39. On the other hand, RM C stated: "I never said no [SBG] was to be done." She told HDC that she advised RM F to use her clinical judgement. This conversation took place in the presence of a student midwife, Ms M. Ms M confirmed that RM C replied that it was up to RM F to use her clinical judgement.

40. The above handover discussions were not documented.

41. After handover, Baby A's centile was generated when RM C lodged documentation into MMPO.[11] Baby A's centile was 19.6. RM C told HDC that as the centile was normal, she did not remember to document it in the Birthcare notes. Birthcare confirmed that at the time of the events, documenting centiles in Birthcare clinical notes was not a requirement.

My opinion

42. I note the considerable dispute between Birthcare midwives and RM C as to what was discussed at handover. I do not consider it necessary to make a factual finding about the precise nature of the handover discussion given that I have concluded above that it was open to RM C to apply clinical judgement and omit SBG monitoring after birth. Accordingly, if I favoured Birthcare staff's recollection, I would not be critical of the advice at handover not to commence SBG screening.

43. If I were to favour RM C's and Ms M's recollections, I note RM Wood's advice that this would be a typical conversation between midwives when a woman and her baby are transferred from the birthing suite to the maternity suite and ongoing midwifery care is handed over to the core midwives. Such a conversation promotes the following New Zealand College of Midwives (NZCOM) consensus statement on the roles and responsibilities of midwives in a hospital setting: "[NZCOM] expects that self-employed and employed midwives respect each other's right to autonomous practice and their accountability for that practice." I agree. I would expect each individual to take responsibility and act as an autonomous health professional, and this would include applying their own clinical judgement to decision-making as and when the situation arises.

44. However, I do note that the handover conversation was not documented, and neither was Baby A's centile after RM C generated it in the early morning of 24 Month1.

45. Standard four of a midwife's Standards of Practice states: "The midwife maintains purposeful, on-going, updated records and makes them available to the woman and other relevant persons." I consider that documentation of key handover discussions and Baby A's centiles would have supported continuity of care and more effective communication between the LMC and core midwives. I trust that RM C will reflect on this in her current and future practice.

Postnatal visit at 9.40am, 25 Month1

46. RM C visited Mrs A and Baby A on the morning of 25 Month1. RM C documented that Baby A was "fussy at the breast then gets worked up and falls asleep". She noted that Baby A had passed urine and meconium. At this time, Mrs A was asking to go home. RM C documented:

[11] The Midwifery and Maternity Providers Organisation practice management system.

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"[I]f baby latches and feeds well then I'm happy for them to be discharged by 6pm." RM C recorded the following plan:

> "Make sure baby has at least some colostrum every 2–3 hours …
>
> If baby does not latch, express and feed with spoon or syringe …
>
> Plan made with core [midwife] to sleep for 2 hours, both, then stimulate and help with breast and expressing."

47. RM C noted that she would be on site birthing another client and would see Mrs A and Baby A after this. In RM C's retrospective note dated 26 Month1, she documented that at this visit Baby A was noted to be "warm, pink, active and vigorous when awake, great tone and feisty". RM C queried whether Baby A may have been "overtired".

48. RM C acknowledged that this visit would have been an opportunity to offer an RBG test. She told HDC:

> "I wish I took this test but I did not. I did not have the whole clinical picture from staff and concern was not raised on the clinical notes. I was just there briefly to prevent discharge of [Mrs A] and [Baby A]."

My opinion

49. RM Wood commented that it is very common for healthy babies to be very alert in the two to three hours after their birth and then sleepy during the next 24 hours. Baby A's initial sleepiness was in keeping with normal behaviour of a term infant.

50. RM Wood advised that "with the benefit of hindsight this would have been a good time to consider a RBG given that breast feeding efforts since the previous night had been inadequate and because of his ongoing sleepiness". However, RM Wood noted that Baby A had passed urine at 8am, which was reassuring, and he was described as pink, warm and vigorous when awake. RM Wood concluded: "Although I do feel a RBG would have been wise at this time, not doing so would not constitute a departure from acceptable standards given the circumstances at the time."

51. The DHB's review noted that Baby A's poor feeding patterns started on Day 2 (24 Month1), when he was documented not to be interested in feeding, and he scored 1 on the breastfeeding assessment. The review noted that these were risk factors for hypoglycaemia. ACC's advisor noted that this would have been an opportune time to undertake a full clinical assessment of Baby A, including temperature and blood glucose screening.

52. I agree that RM C's postnatal visit was a missed opportunity to explore the reasons behind Baby A's poor feeding patterns and sleepiness. However, I accept RM Wood's advice that Baby A's presentation at this time would still be considered normal behaviour, and, whilst it would have been prudent for RM C to initiate further assessments by way of temperature and RBG, this did not constitute a departure from accepted practice.

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Opinion: RM B — breach

Introduction

53. RM B qualified and registered as a midwife overseas in 2010 and was employed by Birthcare in 2019. She told HDC that she is an experienced midwife. RM B stated that at this level, she is also able to carry out the additional duties and responsibilities of a shift coordinator.

54. My midwifery advisor, RM Wood, commented that given the circumstances, the care Baby A received met the accepted standard of care up until the morning of 25 Month1, after which she identified a number of departures from accepted practice. I concur with RM Wood. In particular, I am critical of RM B's failure to:

- Carry out an RBG test when Baby A's temperature was recorded as 36.2°C;
- Undertake a more critical assessment of Baby A's possible seizure activity;
- Commence pulse oximetry when Baby A was noted to be bluish;
- Immediately administer oral dextrose gel when Baby A's RBG test returned a "LOW" result;
- Take baseline vital signs for Baby A prior to the ambulance transfer;
- Respond to Baby A's deteriorating condition by administering oxygen when vital signs were abnormal in the ambulance; and
- Follow the correct basic life support protocols required in an emergency situation, including prioritising chest compressions.

55. I will discuss each issue in turn.

Sleepiness and hypothermia

56. At 8am on 25 Month1, RM B documented that Baby A was woken up for a feed but was "not interested at all". His previous feed had been at 3.30am. In Mrs A's notes, RM B documented that Baby A was "sleepy and not latching".

57. At some point during the morning of 25 Month1,[12] Baby A was noted to be "cold to touch". This is first documented in Baby A's clinical notes at 11.50am; however, Baby A's parents told HDC that they had concerns about his cool body temperature much earlier than this. RM B documented: "I found baby cold to touch … put baby [skin to skin] as cold (36.2°C checked twice). Also baby not interested at all in feeding. To check the temperature again in 30 minutes." At 12.30pm, RM B documented: "[T]ried to latch baby on with assistance but still very sleepy +++ … put [skin to skin] with dad." Baby A's temperature was 36.8°C. In response to the provisional opinion, RM B submitted that this temperature was reassuring.

58. RM B told HDC that she has looked after many babies who have had a low temperature within 24 hours of birth, and this has been rectified by placing them skin to skin with their

[12] The precise time at which Baby A's low body temperature was identified, and by whom, is disputed. This factual discrepancy has not been elaborated on as it is not considered relevant to the opinions formed.

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parents. She noted that this is what she did, and that Baby A did warm up. RM B stated: "Even though I did not mention it in my notes, I remember at that stage Baby A was pink, not jittery, having intake and good urine out, and looked hydrated and well perfused." RM B said that therefore she was not too concerned when his temperature was low for the first time. She told HDC that at this time, her only concern was with Baby A's low temperature and his sleepiness, which could be explained by the fact that he was cold.

59. RM B said that she did not carry out an RBG test or escalate the matter further because Baby A's intake and output had been good and he had no abnormal movements that would have alerted her to the potential for hypoglycaemia.

60. RM B also told HDC:

> "Between 11.50am and 3.30pm, I think I mentioned [Baby A's] low temperature and difficulty warming up baby to the Shift Coordinator, [RM K]. I cannot be certain of the time, as I did not record this in the clinical notes. But my Shift Coordinator remembers this."

61. RM K told HDC that she took over the coordinating role from the Clinical Charge Manager at 3pm, and her first involvement with Mrs A and Baby A was at 3.45pm when there was difficulty giving Baby A infant formula.

62. RM C told HDC that at 1.30pm, RM B came to see her while she was attending to another client's birth to inform her that Baby A was cold and not keen on breastfeeding, and that she was going to call the paediatrician. However, RM B said that this did not occur, and later said that she "probably did not" discuss this with RM C at this time, as RM B understood that RM C was going to visit around 12–1pm. RM B stated: "I might have intended to update the situation to her during her visit."

My opinion

63. RM Wood commented that by 11.50am, Baby A was noted to continue to be sleepy, and was found to be cold. She advised: "No consideration was given to performing a random blood glucose." This also applies to the care provided at 12.30pm. In RM Wood's opinion, not performing an RBG at these times was a moderate departure from accepted standards.

64. Similarly, Birthcare's own review noted that in line with policy, blood glucose screening should have been commenced once Baby A was feeding poorly and had a low temperature. ACC's advisor commented that when Baby A's temperature was recorded as 36.2°C, an RBG test should have occurred. She advised: "This was a clear clinical indication to do further assessment and make a referral … By following the policy, the care pathway was clear."

65. RM Wood advised that a telephone consultation between RM B and RM C should have taken place at this time. In her opinion, by not consulting RM C, RM B was solely responsible for the decisions she made in the provision of care to Baby A.

66. I have considered RM B's submissions in relation to the care she provided at this time, including those she made in response to the provisional opinion. However, the

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overwhelming advice and conclusions above support the view that an RBG test ought to have occurred, and anything less than this would not be considered adequate. I agree. RM B should heed the advice of RM Wood and RM B, as well as Birthcare's internal review.

67. I have also considered RM B's submissions about whether or not she escalated Baby A's care at this point in time. I have found it difficult to reconcile the various submissions. I question whether they are an accurate reflection of the events as they transpired or whether conversations earlier in the day have merged with those later in the day. I am therefore not able to comment on the adequacy of RM B's escalation.

68. However, I note that if RM B did escalate Baby A's care to RM K or RM C, this was not recorded. Standard four of a midwife's Standards of Practice states: "The midwife maintains purposeful, on-going, updated records and makes them available to the woman and other relevant persons." I remind RM B of the importance of maintaining complete clinical records, and suggest that she reflect on this and ensure that it informs her current and future practice.

Possible seizure activity

69. Sometime between 12.30pm and 1.50pm,[13] Mrs A observed Baby A's eyes roll to the back of his head with only the whites showing. Mrs A told HDC that she immediately rang RM B. Mrs A said that within no more than 5 to 10 minutes after this call, Baby A let out a short loud cry followed by a very brief stiffening or arching of his body before turning blue in his face and hands. Mrs A rang RM B again and informed her that Baby A had turned blue and that she was worried that Baby A had suffered a seizure.

70. At 1.50pm, RM B documented: "Called as worried because she saw baby rolling his eyes … [E]yes checked … Baby awake when I popped in, eye clear and normal." RM B noted that she had "no concern regarding eyes", but also noted "to keep an eye on it". Baby A's temperature was documented as 36.7°C, and, in response to the provisional opinion, RM B said that this was reassuring.

71. In RM B's retrospective note dated 26 Month1, she added: "[B]aby opened eyes, was looking at me. I found no abnormal elements regarding his eyes, or no abnormal movements (arms, legs …)."

72. RM B told HDC that she is aware of what to look for and what a seizure looks like. She said: "If I had witnessed any jittery movements, I would have performed a random blood glucose level. I could not see any worrying symptoms at the time." RM B also stated: "I am certain [Mrs A] did not use the word 'seizure' when she called me or when I was in the room, as this would have alerted me to be very concerned." She said she therefore did not have any concerns to escalate the situation to anyone.

[13] The precise time of Baby A's possible seizure activity is disputed. This factual discrepancy has not been elaborated on as it is not considered relevant to the opinions formed.

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My opinion

73. I am open to the possibility that Baby A did in fact exhibit signs of seizure activity. It is not necessary for me to make a factual finding as to whether the term "seizure" was specifically noted by Mrs A. As the clinician in the room, it was RM B's responsibility to consider the underlying causes of Baby A's presentation.

74. RM Wood advised that eye rolling and fixed staring are signs of seizure activity, and she would have expected some escalation of Baby A's monitoring, especially an RBG test. Similarly, RM B advised that a full assessment should have been carried out and a referral made to a paediatrician. In RM B's view, at the very least, there needed to be communication with the LMC and whoever was in charge of the shift. She viewed this as a failure to recognise the severity of the situation.

75. I acknowledge that RM B did respond to Mrs A's concerns by examining Baby A, and found no abnormalities, but documented that she would remain vigilant about this. However, in the context of a sleepy baby who had not been feeding well, and who had had a low temperature earlier in the day, a more critical assessment of the situation may well have prompted RM B to take more action at this time — including taking an RBG and escalating Baby A's care to the shift coordinator and/or RM C.

3pm, 25 Month1: cyanosis

76. Between 3pm and 4pm, RM B documented: "[B]aby very sleepy, face a bit blueish." Baby A's temperature was 36.4°C (checked twice). RM B told HDC: "[I]n hindsight, I should have checked [Baby A's] oxygen levels when his temperature dropped, and he was noted to be blueish."

77. RM B documented that given that "baby was getting more sleepy throughout the day, [and] struggling with maintaining his temperature", she informed Mrs A that she would call paediatrician Dr L.

My opinion

78. RM Wood advised that cyanosis (bluish colour of the skin) is a serious concern and an indication of low oxygen levels. In her opinion, this should have demanded immediate action, and pulse oximetry should have been used to check Baby A's oxygen levels. RM Wood noted that this was especially the case given that Baby A was also lethargic, and had had a temperature drop and poor feeding during the course of the day. RM Wood regarded this omission as a significant departure from accepted practice.

79. The ACC advice also notes that a full assessment and escalation pathway needed to have occurred at this time.

80. I accept RM Wood's advice. I note that RM B believes that it is only with hindsight that she can see that she should have checked Baby A's oxygen levels. That may have been the case if Baby A had not, up until that point, shown any other concerning clinical signs. However, by this time, he continued to feed poorly, had been unable to maintain his temperature, and was also sleepy. Mrs A had also reported that she had seen Baby A's eyes rolling. In my view,

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critical consideration of all of Baby A's symptoms should have alerted RM B to the seriousness of the situation and led her to investigate further by way of a full assessment, including measuring Baby A's oxygen levels. Instead, RM B demonstrated inadequate independent clinical decision-making and relied on the advice of an off-site paediatrician. I note that in response to the provisional opinion RM B submitted that she did not fail to respond to the symptom (bluish colour), because she immediately sought advice from Dr L. I maintain that taking an oxygen level was an assessment that should have occurred, the results of which could have been conveyed to Dr L to guide treatment.

Hypoglycaemia

81. RM B and Dr L had three short telephone calls. There is substantial dispute about what was discussed between RM B and Dr L (discussed below). What is not disputed is that following RM B's first call with Dr L, she carried out an RBG test, which returned a "LOW" result (this was checked twice).

82. Mrs A recollected that when she asked RM B what this meant, RM B told her that Baby A's blood sugar was so low that she could not get a reading. When Mrs A asked RM B what should be done, she did not answer but left the room to make the second call to Dr L.

83. Following the second call, RM B attempted to give Baby A infant formula via a bottle and teat, but this was unsuccessful. She requested the assistance of RM K. The documentation noted Baby A to be "sleepy and lethargic" at this point. RM K was also unsuccessful in feeding Baby A infant formula.

Administration of oral dextrose

84. Birthcare's Neonatal Hypoglycaemia Policy (August 2018) states:

> "**Babies who require glucose screening —**
>
> - Babies who are stressed and exhibiting abnormal clinical signs:
>   - poor feeding patterns
>   - …
>   - hypothermia, etc.,"
>
> **Testing blood glucose levels**
>
> …
>
> 2. If glucose level is 1.2–2.5nM/kg on first test (1–2hrs), rub 0.5ml/kg of 40% dextrose gel into buccal mucosa then feed or offer EMB immediately and recheck blood glucose within 30 minutes …
>
> …
>
> 5. If glucose below 1.2nM/Kg at any stage … or if feeds not tolerated, the advice is baby needs admission to NICU. Inform/update LMC of all blood glucose results prior to any subsequent referral to paediatric service."

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85. RM B told HDC that she was aware of Birthcare's policies and procedures, including the Neonatal Hypoglycaemia Policy. When she commenced working at Birthcare, she was inducted to information and questionnaires about breastfeeding, vulnerable babies, and hypoglycaemia.

86. RM B acknowledged that oral dextrose should have been offered after Baby A's blood glucose test returned a "low" reading, but told HDC: "At this this stage, I was seeking advice from [Dr L] and acting under his instruction."[14]

My opinion

87. ACC's advisor advised that a "low" reading meant that the blood sugar level would have been lower than 1.2mmol. RM Wood stated that a blood sugar level this low would constitute an emergency situation, and oral dextrose gel should have been administered immediately. She said that this would have improved Baby A's low blood sugar level, and did not require Dr L's advice to initiate. Birthcare's own review noted that once Baby A had been identified as hypoglycaemic, dextrose gel should have been administered.

88. RM Wood considered that omitting to administer oral dextrose gel once Baby A had returned a low blood sugar level was a significant departure from accepted practice. RM B considered this to be evidence of a failure by staff to recognise the severity of the situation.

89. I agree. I do not accept RM B's submission that she did not administer oral dextrose gel to Baby A because she was acting under the instruction of Dr L. RM B is a registered health professional and an experienced midwife. She was the midwife in attendance with Baby A at the time, and therefore, above all else, she is accountable to Baby A, Mrs A, and to her own practice. RM B should have recognised and responded appropriately to the clearly disturbing clinical picture that was rapidly emerging at this point. Treatment of hypoglycaemia was well within RM B's scope of practice.

90. In making this comment, I acknowledge RM B's submission in response to the provisional opinion that she did follow the Birthcare policy, which states that when glucose is below 1.2nM/Kg the advice is baby needs admission to NICU, by arranging transfer to NICU. I remain of the view that in this emergency situation, oral dextrose should have been administered by RM B immediately, prior to the transfer, and that it is inexcusable that she failed to do so.

Ambulance transfer

Vital signs

91. On RM B's third and final call to Dr L, he advised her to transfer Baby A to NICU. RM B documented: "NICU called … aware of all the details. Ambulance called."

92. Baby A's vital signs are not documented in the clinical notes. Birthcare's Transfer of a Critically Ill Neonate (August 2018) provides:

[14] Whether Dr L advised RM B to administer oral dextrose gel is disputed. This factual discrepancy has not been elaborated on as it is not considered relevant to the opinions formed.

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> "**Essential Information —**
>
> … Current status including vital signs (temp, heart rate, respirations, oxygen saturations level, feeding, elimination, colour, behaviour)
>
> **Procedures**
>
> …
>
> 4. LMC/Birthcare staff midwife … escort if ambulance required
>
> …
>
> 7. Time of departure documented and baseline observations of the baby to be taken prior to transfer."

93. RM B told HDC that although not documented, after the final call to Dr L, she attempted to talk to RM C to inform her of Baby A's transfer to NICU. However, RM C told HDC that at that time she was with another client who was giving birth and pushing and required her full attention.

94. The ambulance departed at 4.23pm. Mrs A, RM B, a student midwife, and two the ambulance service staff accompanied Baby A in the ambulance. The Ambulance Care Summary documented that at departure, Baby A's heart rate was 180 beats per minute and his oxygen saturation level was 87%. In RM B's retrospective note made the following day, she recorded that Baby A's heart rate was 170 beats per minute and his oxygen level was 87–88%. She also documented retrospectively: "I suspected something wasn't right as baby had been sleepy."

95. At around 4.26pm, during the transfer, Baby A was noted to begin grunting and he changed colour. The Ambulance Care Summary reported that shortly after this, Baby A was "noted to begin seizure like activity lasting approximately 20 seconds", although RM B disputes that this occurred.[15] Baby A is reported to have collapsed (he stopped breathing and then his heart stopped beating) as he was being moved from the stretcher for treatment and airway management.

96. Baby A arrived at the public hospital at 4.29pm and, among other interventions, he received his first dose of dextrose gel at 5.26pm.

My opinion

97. RM Wood noted the essential information required under the above policy, and advised that she cannot find any record of vital signs having been recorded prior to Baby A's ambulance transfer. She considered this to be a significant departure from accepted practice.

98. RM Wood further advised that oxygen saturation levels at Baby A's age should have been above 95%, and his heart rate should have been below 160 beats per minute. She

[15] This factual discrepancy has not been elaborated on as it is not considered relevant to the opinions formed.

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commented that the recordings for Baby A during the transfer were not normal and should have alerted RM B that Baby A was requiring further help, such as oxygen administration and monitoring of his respiratory rate. RM Wood concluded that RM B did not respond as would have been expected, and considered this to be a serious departure from accepted practice.

99. In response to the provisional opinion, RM B submitted that there is no evidence that the omission to record Baby A's vital signs prior to the ambulance transfer, and then to administer oxygen after they were found to be abnormal, had any measurable impact on his outcome. RM B highlighted the short time period of care this relates to, and the unfamiliar and extremely stressful environment in which she was working.

100. I acknowledge the challenging circumstances of an ambulance transfer of an unwell baby. I also note that despite this window of care being a crucial time for Baby A, the trip to the hospital took only six minutes. That said, and notwithstanding any speculation as to the impact it would have had on Baby A's outcome, I consider that even in such a difficult situation, the taking of baseline observations and responding to deterioration in a timely manner is of the utmost priority. It was beholden on RM B, as the health professional ultimately responsible, to take control and intervene.

101. Despite RM B's submission, I maintain my view that the absence of baseline observations impeded the effective monitoring of Baby A's condition during his transfer. When his vital signs were obtained, they were clearly abnormal. Whilst I leave open the possibility that RM B was concerned by these observations, she failed to act on her concerns by way of oxygen administration or further assessment until Baby A's collapse.

Resuscitation

102. When Baby A collapsed (went into respiratory and cardiac arrest), resuscitation efforts were commenced. There is some dispute over how the resuscitation events unfolded.

103. In RM B's retrospective notes made the following day, she wrote:

> "[O]n our way, more than half way, baby just collapsed. The lady in the ambulance removed baby's heart rate and [oxygen saturation] monitoring. Once I saw baby was not moving anymore, I started stimulating him to make him come back but he did not respond. He became blue. I checked his breathing but I saw no breathing movements. The ambulance lady gave me material to oxygenate baby, so I started to assemble everything and asked her to start insufflation. I checked baby's heart rate … I could not find a heart sound so I started to do [cardiopulmonary resuscitation (CPR)] and checked that baby's chest was moving as we helped him breathing."

104. RM B told HDC that stimulating Baby A involved "rubbing his back vigorously".

105. RM B told HDC: "I tried to stimulate [Baby A] initially by rubbing on his back strongly to try to elicit breath … I then went on to do chest compressions." She said that this is how she was trained to carry out CPR in her home country.

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106. The ambulance service told HDC:

> "When [the attending paramedic] identified [Baby A] was displaying seizures, she immediately intervened and provided ventilator support with the equipment carried on the ambulance … [S]he recalls directing the midwife to commence resuscitation by starting CPR. The attending paramedic further recalls handing the midwife the resuscitator bag that required connection of the facemask to it while she made contact via radio with the emergency department before then assisting with resuscitation."

107. The ambulance service said that the attending personnel administered oxygen and airway support while instructing RM B to commence chest compressions. However, it is reported that RM B did not understand the instructions and provided back slaps and attempts to stimulate Baby A to breathe.

108. Mrs A recollected that the paramedic jumped into "fast-mode action", unstrapping Baby A from the stretcher and handing him to RM B. Mrs A said that RM B then placed Baby A face down in her hand and began tapping his back. Mrs A told HDC that she may have observed Baby A being given oxygen, but she did not see RM B or the paramedic doing chest compressions.

109. RM B told HDC that she felt unsupported during the resuscitation. She said that she had to do everything herself and at the same time — checking Baby A's heart rate, assembling the ventilation equipment, and starting CPR compressions.

110. During the resuscitation, the pulse oximeter that was monitoring Baby A's heart rate and oxygen saturations was removed.[16] RM B told HDC that this meant that during the resuscitation she had no indicator for Baby A's heart rate.

My opinion

111. RM Wood referred to the following New Zealand Resuscitation Newborn Life Support (NLS) Algorithm:

> "Open airway (positioning)
> Stimulate
> Assess respiration and heart rate
> Commence positive pressure ventilation
> Commence chest compressions"

112. RM Wood advised that normally these steps would be undertaken almost simultaneously to ensure effective resuscitation as soon as possible, and would have needed both the midwife and paramedic working together.

113. RM Wood said that applying back rubs to an unresponsive baby who appears to be in cardiac and respiratory arrest is inadequate. Rather, the baby should be positioned so as to open

[16] RM B maintains that ECG leads were also applied and removed. This factual discrepancy has not been elaborated on as it is not considered relevant to the opinions formed.

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his airway, ventilation should be commenced immediately (with oxygen depending on the heart rate) and, if a pulse is absent or low, immediate chest compressions should be commenced. RM Wood concluded that RM B's resuscitation techniques were inadequate in this situation and a moderate departure from accepted practice. However, she acknowledged the difficult and extreme stress of managing a situation such as this in the back of a moving ambulance. RM Wood noted that the journey from Birthcare to the public hospital was very short, and these events occurred over only a few minutes.

114. It is not disputed that back rubs were carried out on Baby A to stimulate breathing. However, the evidence is far less clear on whether chest compressions were commenced after this. RM B's clinical note written the following day indicates that she commenced CPR, and in her statements to HDC she has said consistently that she carried out chest compressions. On the other hand, Mrs A told HDC that she did not see anyone doing chest compressions on Baby A, and the ambulance service's evidence is silent on whether chest compressions occurred after stimulation. Given the conflicting accounts, I am unable to conclude one way or another.

115. However, I conclude that irrespective of RM B's efforts to carry out chest compressions, she did not follow the correct basic life support protocols required in an emergency situation such as this. The evidence supports the picture that chest compressions did not feature as predominantly as back rubs, and this is concerning. Given that Baby A was in respiratory and cardiac arrest, chest compressions should have been initiated promptly. RM B should have made chest compressions a priority, and they should have begun immediately after the paramedic commenced ventilation (airway support and oxygen).

116. In response to the provisional opinion, Mr and Mrs A also highlighted the statement from the Australian and New Zealand Resuscitation Council's Guideline 13.3, Assessment of the Newborn Infant,[17] that "[s]lapping, shaking, spanking or holding the newborn upside down are potentially dangerous and should not be used".

Conclusion

117. I acknowledge RM B's submissions in response to the provisional opinion, including that there were multiple missed opportunities for other providers to intervene in Baby A's care, that she made efforts to escalate her concerns about feeding on the morning of 25 Month1, and that her clinical involvement with Baby A was affected by her competing obligations to other women and their babies.

118. I have carefully considered the context in which RM B was providing Baby A with care. I maintain my view that for the reasons outlined above, RM B did not provide services to Baby A with reasonable care and skill by failing to:

- Carry out an RBG test when Baby A's temperature was recorded as 36.2°C;
- Undertake a more critical assessment of Baby A's possible seizure activity;

[17] January 2016.

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- Commence pulse oximetry when Baby A was noted to be bluish;
- Immediately administer oral dextrose gel when Baby A's RBG test returned a "LOW" result;
- Take baseline vital signs for Baby A prior to the ambulance transfer;
- Respond to Baby A's deteriorating condition by administering oxygen when vital signs were abnormal in the ambulance; and
- Follow the correct basic life support protocols required in an emergency situation, including prioritising chest compressions.

119. Accordingly, I find that RM B breached Right 4(1) of the Code of Health and Disability Services Consumers' Rights (the Code).[18] Furthermore, I consider that, particularly when viewed together, RM B's failures in her care of Baby A demonstrate care that fell seriously below the appropriate standard. Therefore, it is in the public interest to refer her to the Director of Proceedings for a decision as to whether proceedings should be taken.

Responsibility during ambulance transfer — educational comment

120. RM B told HDC that she had transferred babies to the public hospital previously. She stated that Birthcare's Transfer of a Critically Ill Neonate does not specify who should be responsible during an ambulance transfer, and she expected there to be joint responsibility between herself and the paramedics in the ambulance.

121. Birthcare told HDC:

> "[I]t is normal practice for a midwife to retain responsibility for a mother or baby during an ambulance transfer to the hospital. This has been [the ambulance service's] rules for several years. The midwife should request support and assistance if needed."

122. The Ambulance Care Summary stated: "[N]il handover received, [midwife] wanting to retain care of patient en route to ED … nil intervention required baby [ambulance] crew when asked." The ambulance service confirmed with HDC that the care of Baby A was retained by RM B.

My opinion

123. RM Wood advised that it has been her experience that a midwife will always accompany a woman or baby during a transfer between hospitals and facilities. The midwife is there as an escort and to oversee the wellbeing of the woman/baby, as the midwife would be most likely to recognise any deviation from normal quickly, as this is the midwife's area of expertise. However, in an emergency, especially a full resuscitation, this would be managed jointly by the paramedic and the midwife.

124. Similarly, my paramedic advisor, Mr Mark Bailey, commented that in the absence of a clinical handover, the clinician responsible for Baby A is the registered professional, ie, the midwife. He noted that at the time of events, paramedics were yet to become registered

[18] Right 4(1) provides: "Every consumer has the right to have services provided with reasonable care and skill."

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health professionals. However, he said that in his experience, transitioning from a supporting role into a lead role and beginning to direct treatment is considered appropriate when a patient's condition has deteriorated unexpectedly. Paramedics are more accustomed to the challenge of working in a moving vehicle, and are familiar with the equipment and layout.

125. Although previously I have commented on a lack of clarity in the lines of responsibility between midwives and ambulance personnel,[19] in this case it appears that Birthcare and the ambulance service mutually understood their responsibilities, and this is supported by advice from my independent advisors. However, it appears that RM B was not aware of this mutual understanding, and I suggest that she reflect on how she can ensure that she has clarity of her role and responsibilities prior to and during an ambulance transfer.

Opinion: Ambulance service — educational comment

Baby A's vital signs at departure

126. I have discussed Baby A's vital signs at paragraphs 91–101.

127. Mr Bailey did not identify any departures from accepted standards in the care the ambulance service provided to Baby A. I accept this advice. However, I note that my midwifery advisor, RM Wood, commented that Baby A's observations on departure were documented as a heart rate of 180 beats per minute and an oxygen saturation level of 87%. RM Wood advised that oxygen saturation levels at Baby A's age should have been above 95%, and his heart rate should have been below 160 beats per minute. Therefore, the recordings for Baby A from the beginning of the transfer were abnormal, and oxygen administration or further assessment could have occurred earlier.

My opinion

128. I acknowledge that Baby A's transfer was six minutes in duration and that there was also a midwife in the ambulance. Nonetheless, I share RM Wood's advice with the ambulance service as an opportunity for further reflection on the care provided to Baby A, and also for future care provided to other unwell neonates. I trust that the ambulance service will share this learning with its staff appropriately.

Resuscitation

129. Baby A's resuscitation is discussed at paragraphs 102–116.

130. Both Mr Bailey and RM Wood advised that resuscitation should have involved ventilation and chest compressions, and acknowledged that this would require joint effort from both the paramedic and midwife.

[19] HDC decision number 20HDC00487.

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131. Mr Bailey advised that the actions of the paramedic in directing RM B to provide chest compressions while the paramedic provided airway support and oxygen are completely consistent with the expected actions and standard of care of ambulance personnel in this situation. However, RM Wood queried why the pulse oximeter was not placed back onto Baby A immediately, as this would have been part of the expected action during a resuscitation such as this.

My opinion

132. I accept that resuscitation was a joint effort between RM B and the paramedic. I also agree that reapplication of Baby A's pulse oximeter would have aided the resuscitation. Events such as these provide an important opportunity to reflect on improvements to current and future practice. I trust that the ambulance service has done so.

Opinion: Dr L — educational comment

Telephone calls with RM B between 3pm and 4pm on 25 Month1

133. As mentioned previously, RM B and Dr L had three short telephone calls. There is substantial dispute about what was discussed between RM B and Dr L. Where the discrepancies in fact are relevant, these will be discussed. I have obtained independent paediatric advice from Dr John Doran.

134. Dr L told HDC that on the day RM B telephoned him, it was his afternoon off. He received the call when he was outdoors and, due to the windy conditions, phone reception was poor. In a retrospective note made the following day, he wrote:

> "3 calls in quick succession:
> 1. Sleepy infant — poor feeding [therefore] do [blood] sugar
> 2. Sugar low — usual protocol gel [and] also formula by bottle
> 3. Can't feed [and] [blood sugar] still [very] low [therefore] transfer"

135. Dr L told HDC that the above was a memo he made for his records only, and it was never intended to be an add-on or part of the clinical record.

136. Dr Doran advised that the above note does not appear to be a part of Baby A's or Mrs A's clinical notes, and therefore he concluded that it was a brief personal note or reminder for Dr L. Dr Doran said that in this case, it cannot be seen as a clinical document but a memo. Dr Doran advised that if it did represent clinical documentation, it would be below the expected standard and a moderate departure from accepted practice. Dr Doran noted that the note was not timed or signed, and the information is minimal and lacked key clinical information such as gestation, birth weight and age, as well as feeding history and other basic clinical information such as temperature and heart and respiratory rate.

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Phone call 1

137. RM B told HDC that when she telephoned Dr L, she told him about Baby A's sleepiness and bluish colour, and the difficulty Baby A was having in latching and maintaining his temperature at a normal level. In contrast, Dr L recalled that Baby A was described as a small infant who was sleepy and not feeding well. Dr L does not recall RM B mentioning any colour issues. Both RM B and Dr L agree that the advice at the end of the first call was to perform an RBG test.

138. Dr Doran commented that from the clinical documentation — both the maternity documentation and Dr L's retrospective note — it is not possible to advise on the appropriateness of the clinical information sought or offered.

Phone call 2

139. RM B informed Dr L of Baby A's "low" blood sugar reading. Dr L told HDC that he advised RM B to give Baby A some dextrose gel and some infant formula. In contrast, RM B recalls and documented that Dr L's advice was to give the infant formula but not the dextrose gel.

140. Dr Doran advised that if HDC favoured RM B's recollection, Dr L's advice would be incomplete, as all current protocols would recommend oral dextrose gel as the first line of treatment, followed by milk (breast or infant formula).

141. Dr Doran noted that an additional part of advice should be to repeat an RBG test 30 minutes after dextrose gel and milk to ensure that the expected response has occurred. Dr Doran did not see this advice documented, nor any evidence that a follow-up RBG occurred while Baby A was at Birthcare. Dr L told HDC that his documented "usual protocol" was intended to reflect this.

142. Dr Doran advised that this would be a minor departure from accepted practice. He noted that management of hypoglycaemia should be well protocolled so that anyone should know how to treat hypoglycaemia.

Phone call 3

143. RM B made a third call to Dr L advising that the infant formula had been unsuccessful. Dr L told HDC that faced with a situation of a hypoglycaemic infant who was too lethargic to feed, he requested a Priority 1 transfer to NICU at the DHB.

144. Dr Doran advised that the advice to arrange transfer to NICU was appropriate. He commented that neither of the clinical documents indicate the priority of the transfer, and it does not appear that Dr L gave additional advice or checked whether dextrose gel had been given. Dr Doran also observed that Dr L documented "[blood sugar] still very low" in his retrospective notes, but from the clinical documents, it appears that no repeat RBG test was done.

145. Dr Doran concluded that although the advice provided was appropriate, it was very minimal in content as judged from the documentation. He considered this a minor departure from accepted practice as it was clear that the desired action was a referral to NICU.

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My opinion

146. I am unable to resolve the factual disputes around the precise description RM B gave to Dr L during phone call 1, and whether Dr L advised RM B to administer dextrose gel in phone call 2. However, it is clear from RM B's documentation and subsequent actions that if this advice was given, it was not acted on. I do not consider the disputed facts to be material to the conclusions I reach below.

147. Having considered the above in its entirety, I accept Dr Doran's advice that Dr L's care was largely acceptable, albeit with some minor deviations from accepted practice. However, Dr Doran also advised that by accepting telephone calls and continuing to give advice, Dr L accepted responsibility for the advice provided, even though he was off duty. Dr Doran commented that Dr L could have recommended that RM B communicate with another available paediatrician or NICU instead.

148. I agree. Whilst I appreciate Dr L's sincere attempts to assist, even when clearly off duty, Baby A's case highlights the importance of effective communication between clinicians, and of ensuring an appropriate setting to achieve this.

149. For completion, the above also highlights the importance of clearly establishing the roles and responsibilities of on-call paediatricians in this context. I am particularly thoughtful about Dr L's responsibility to document the advice he provided, and to include this in Baby A's clinical notes. I consider that in a situation where medical advice was provided and acted upon, Dr L ought to have made an entry in the clinical records as soon as practicable in addition to recording a personal memo. I will also discuss this with Birthcare, but I invite Dr L to consider this for future calls of a similar nature.

Opinion: Birthcare Auckland Limited — breach

Escalation and documentation

150. A number of handover discussions between Birthcare staff are summarised at paragraphs 37–39. These conversations were not documented in Baby A's or Mrs A's clinical notes. Although it is disputed whether RM C gave advice that SBG testing should not occur, it is not disputed that this was what was understood by Birthcare staff.

151. Birthcare's review noted: "[W]hen Birthcare staff felt [Baby A] should have blood glucose monitoring they did not document this in the clinical notes" and "Birthcare staff concerns and the divergence of opinion over the blood glucose monitoring was not escalated to senior staff." The review recommended that the roles and responsibilities of the shift coordinator be reviewed and documented formally, to strengthen the escalation of any Birthcare staff concerns.

152. Similarly, the DHB's review recommended improved facilitation of contemporaneous documentation of cumulative risk, which could include a summary of events documented in

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the clinical notes each shift if concerns are identified. It also recommended a clear escalation pathway to senior staff when concerns are identified.

My opinion

153. Standard four of a midwife's Standards of Practice states: "The midwife maintains purposeful, on-going, updated records and makes them available to the woman and other relevant persons."

154. I have outlined my views on whether Baby A should have been commenced on SBG testing in another part of this report. Of concern to me here is that numerous Birthcare staff appear to have believed that Baby A should have received SBG testing and that RM C was not adhering to Birthcare policies and procedures. However, consistently, staff failed to escalate the issue appropriately and to document important handover discussions. Given that a number of Birthcare staff appear to have failed in this respect, ultimately I hold Birthcare responsible for the deficiencies.

155. I note that at the time of the events, Birthcare did not have a formalised policy for the Role and Responsibilities of a Shift Coordinator, and one was established following these events. This is appropriate.

Management of hypoglycaemia

156. Below is a summary of what the Birthcare staff involved in Baby A's care said about their training and orientation to Birthcare's Neonatal Hypoglycaemia Policy:

- RM F said: "Prior to 25 [Month1], I was not trained by Birthcare on neonatal hypoglycaemia … [T]here is no official training that I was provided with. However during my orientation … I was shown where the policies and procedures are kept and had drawn on the Neonatal Hypoglycaemia Policy in the past."
- RM G said: "I am aware that we have a manual with clinical procedures … I have read through them however I do not recall having any specific training in hypoglycaemia."
- RM I told HDC: "I did not have any orientation when I started at Birthcare or prior to 25 [Month1]. Therefore, I have not received any formal training on Birthcare's policies and procedures on neonatal hypoglycaemia."
- RN J said: "I am fully aware of Birthcare's policies and procedures on Neonatal Hypoglycaemia … I have been oriented to it and have received training on it when I started working at Birthcare."
- RM B told HDC that she was aware of Birthcare's policies and procedures, including the Neonatal Hypoglycaemia Policy. She said that when she commenced working at Birthcare, she was inducted to information and questionnaires about breastfeeding, vulnerable babies, and hypoglycaemia.

157. Below is a summary of what the Birthcare staff involved in Baby A's care said about their understanding of their responsibilities for managing hypoglycaemia in a newborn:

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- RM F stated: "[At the time of events, I understood that] [a]s core midwifes, we have to ask the LMC's consent to do procedures/interventions on 'their' women and babies. This has allowed me to believe that we could not override their decisions."
- RM I said: "[T]here was no clinical need to do a random blood sugar on my shift. If there had been, I would have had no hesitation of doing one."
- RN J said: "If I had concerns of hypoglycaemia, there is absolutely no question that I would have straight away considered a random blood glucose sugar test and treated or referred accordingly."
- RM B told HDC that she did not give Baby A dextrose gel because "at this stage, [she] was seeking advice from [Dr L] and acting under his instruction".
- RM K told HDC that she did not consider giving dextrose gel to Baby A given that this did not feature in Dr L's previous advice.

158. The DHB's review noted: "[T]he neonatal hypoglycaemia policy may not be consistently understood by all staff. It also suggests that the midwife/nurse scope of practice in relation to the policy may not be consistently well understood." The review recommended that the neonatal hypoglycaemia policy be incorporated into mandatory training for midwives and nurses.

159. In response to the provisional opinion, Birthcare submitted that it would not be appropriate to find that there were inconsistencies around Birthcare staff's understanding of hypoglycaemia and its management, which is within a midwife's scope of practice. It noted that this would be the critical issue rather than formal training on a Birthcare policy.

My opinion

160. I agree with the DHB's review findings that the Birthcare policy on neonatal hypoglycaemia is not consistently well understood and I maintain that this is reflected in the staff statements provided above. However, I also acknowledge that hypoglycaemia and its management are within a midwife's scope of practice. Notwithstanding the knowledge midwives should have through their own training, it is incumbent on providers to ensure its staff are aware of the particular requirements of its own policies to maintain a consistent standard of care.

161. NZCOM's consensus statement on the roles and responsibilities in a hospital setting states: "[NZCOM] expects that self-employed and employed midwives respect each other's right to autonomous practice and their accountability for that practice."

162. NZCOM's Standards of Practice 6 and 7 state: "Midwifery actions are prioritised and implemented appropriately with no midwifery action or omission placing the woman (or baby) at risk" and "The midwife is accountable to the woman, to herself, to the midwifery profession and to the wider community".

163. My advisor, RM Wood, noted that the Standards of Practice involve taking responsibility for the woman and baby in whatever setting for practice. She also commented that an LMC's

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care plan for a baby is not prescriptive and relies on the autonomy of midwives in decision-making, and decisions are made depending upon the ongoing needs of the mother or baby.

164. In the context of treating hypoglycaemia, all Birthcare staff who were in the room caring for Baby A were responsible for ensuring that he received appropriate care. This included carrying out the appropriate tests and interventions when they believed this was warranted, guided by Birthcare's policies and procedures. I am alarmed that some staff at Birthcare appear to have had a poor understanding of this, and did not appreciate they were individually accountable for the decisions they took. I strongly suggest that Birthcare evaluate the beliefs and values held by its staff to ensure that these align with NZCOM's consensus statement and standards of practice.

165. In response to the provisional opinion, Birthcare submitted that only one staff member (RM F) made a statement suggesting they had a poor understanding of autonomous and accountable midwifery practice and that this was related to their training overseas. I disagree with Birthcare's view that only one midwife made such a statement. I consider that RM B's and RM K's statements (at paragraph 157) are also demonstrative of a poor understanding of autonomous and accountable midwifery practice.

Arrangement with Dr L

166. Dr L told HDC that he works in close proximity to Birthcare and regularly provides advice and care for individual infants at the request of their LMC. However, Dr L and Birthcare told HDC that there is no formal or contractual arrangement between the two parties.

167. Birthcare explained that "the way in which maternity structures exist in New Zealand is that [Dr L], as a paediatrician, is able to be requested by an LMC or a parent to review a baby. He then claims directly for his service under the section 88 notice. In doing so, he acts completely independent to Birthcare, similar to an LMC." Dr L told HDC: "I did not make a claim to the Ministry of Health for services provided to [Baby A]. I did not regard myself as having provided them in the usual sense of actual involvement with this infant."

168. After the events, Dr L made a retrospective note for his own records, which was never intended to be a part of Baby A's clinical notes. Dr L was not involved in any of the subsequent reviews commissioned or carried out by Birthcare.

169. In response to the provisional opinion, Birthcare stated that there was never an expectation that Dr L was on call 24/7 nor that he would be the first port of call, rather in emergency situations the call was always to the public hospital's NICU.

My opinion

170. My independent paediatric advisor, Dr John Doran, noted the "ad hoc" arrangement between private paediatricians (including Dr L) and Birthcare, and suggested that Birthcare have a very clear "roster" or similar so that communication lines are clear.

171. I agree. In my view, the arrangement between Dr L and Birthcare is not satisfactory. For Baby A, it became a patient safety issue. In my view, Dr L should not have been contacted

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or expected to respond and manage a situation such as this when he was clearly not in a position to do so. The informal and ad hoc involvement of Dr L added a further complicating layer to Baby A's care because it meant that at a very critical time, instead of following the Neonatal Hypoglycaemia Policy, an impaired conversation took place between the midwife and paediatrician.

172. In the provisional opinion I stated that a robust arrangement should be introduced to ensure specialist expertise is reliably to hand as and when required and there should be no reliance on loose arrangements such as this one.

173. I note that in response to the provisional opinion, Birthcare said that Dr L is no longer called upon, and a newborn early warning chart (NEWS) is in place that directs escalation to the NICU at the public hospital.

Conclusion

174. To summarise, I have concerns that at the time Baby A received services from Birthcare:

- There were inconsistencies around Birthcare staff's orientation and training on the Neonatal Hypoglycaemia Policy;
- Some Birthcare staff demonstrated an alarmingly poor understanding of autonomous and accountable midwifery practice, and this led to Baby A receiving inadequate care; and
- The arrangement between Dr L and Birthcare was not satisfactory and became a patient safety issue for Baby A.

175. Moreover, Birthcare's responsibility for ensuring that consumers receive safe services of an appropriate standard is outlined in the Health and Disability Services Standards (2008), which must be followed by all health and disability service providers under the Health and Disability Services (Safety) Act 2001. Standard 1.8 states that consumers receive services of an appropriate standard.

176. Birthcare's own policy identifies that hypoglycaemia is the most common metabolic problem in newborn infants. This is supported by the ACC review. My paediatric advisor, Dr Doran, commented that as it is a common condition for newborns, the expectation should be that all staff who care for newborns are familiar with how to manage hypoglycaemia, including the early use of dextrose gel.

177. I agree that the management of hypoglycaemia should be a basic skill for all Birthcare staff. Yet, for Baby A, no one at Birthcare administered him dextrose gel even after two RBG tests showed that he was hypoglycaemic. This is a fundamental failure to deliver services to a vulnerable infant with care and skill. Accordingly, I find Birthcare in breach of Right 4(1) of the Code.

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Resuscitation training — other comment

178. During Baby A's transfer to hospital, RM B was required to initiate CPR on Baby A. Understandably, she found this challenging. I note that at the time of events, RM B had yet to complete her midwifery emergency skills training. She completed this after the time of these events.

179. I understand that the Midwifery Council of New Zealand requires internationally trained midwives to complete this training within 12 months of being granted an annual practising certificate.

180. I consider that it would have been prudent for Birthcare to ensure that its newly employed staff undertook essential training such as midwifery emergency skills as part of their induction into Birthcare. For RM B, this would more than likely have assisted her with Baby A's deterioration during the transfer to hospital. I recommend that as part of its induction process, Birthcare ascertain when a newly employed midwife last undertook emergency skills training, and, if this did not occur recently, support the midwife to complete this as soon as practicable. In addition, Birthcare may wish to confirm with its staff that they are aware of their roles and responsibilities during an ambulance transfer.

PART 2: ADVERSE EVENT AND COMPLAINT MANAGEMENT

Opinion: Birthcare Auckland Limited — breach

Introduction

181. Mr and Mrs A, as Baby A's guardians and representatives, are considered to be health and disability services consumers for the purpose of this part of the report.[20]

182. Again, I begin by acknowledging the significant number of issues raised by Baby A's parents and Birthcare in relation to the management of both the adverse event and the complaint made by Baby A's parents. This report discusses the issues that are relevant to the opinions formed.

Complaint management

183. Below is the summary of events and communications that took place after Baby A's transfer to NICU on 25 Month1.

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[20] The definition of "consumer" in clause 4 of the Code includes, for the purpose of Right 10, a person entitled to give consent on behalf of that consumer.

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Date/time	Event description
18 Month4	RM D emails the DHB (now Te Whatu Ora) requesting a review of Baby A's care.
13 Month7, 10.02am	The DHB emails its review to RM E and RM D.
11.45am	RM E acknowledges receipt and advises: "I will read it more thoroughly over the weekend."
22 Month7	Baby A's parents email RM E a formal letter of complaint.
24 Month7	RM E acknowledges receipt of the complaint and advises: "I forwarded your and [Baby A's] clinical notes to [the DHB] for an independent review. I am expecting [the] report within the coming week. I will come back to you when I have received the report."
31 Month7	RM D emails RM E requesting "my [Baby A] file" be dropped off to her house over the next couple of days. She writes: "[O]ver the next couple of days I can incorporate [the DHB review] into our report."
2 Month8	RM D emails RM E: "Oh my Lord, I just read [Mrs A's] complaint three times. Her perspective and events vary from the staff reports. I'm going to incorporate [the DHB review] into our draft report today ..."
20 Month8	Mrs A emails RM E to follow up on a response to the formal complaint and submits a complaint with this Office.
21 Month8, 12.25pm	RM D replies to Mrs A's follow-up email and advises that she will be responsible for responding to the formal complaint and that she will require until 5 Month9 to do so.
2.35pm	Mrs A replies raising concerns about a lack of transparency in the complaint process and seeking clarity on a number of issues, including the date on which Birthcare received the DHB's review and what Birthcare's complaint process involves. Mrs A also queries why the DHB review has been withheld from her.
22 Month8, 2.25pm	RM D replies to Mrs A: • Advising: "I received [the DHB] review on my return from self-isolation on Monday 13 Month8"; • Enclosing Birthcare's Comments and Complaints Policy; and • Declining to provide the DHB's review because permission had not been obtained from the DHB to do so.
23 Month8, 5.36pm	The DHB emails a copy of its review to Mrs A. The DHB wrote: "[RM D] has agreed that [we] will release our report to you as you have requested."
1 Month9	Birthcare responds to Mr and Mrs A's complaint and apologises.

184. Mrs A told HDC that after receiving RM E's email of 24 Month7, she assumed that Birthcare had proceeded to ask the DHB to conduct a review of Baby A's case only in response to having received a formal complaint from them.

185. Mr and Mrs A also raise considerable concern that RM E and RM D provided false information to them about when they received the DHB's review. Mr and Mrs A submitted:

> "[I]f this was not a deliberate cover-up, then we now beg the question as to the reasons why [RM E] and [RM D], both in senior management positions at Birthcare ... would feel

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the need to provide us with false information about the timing of their receipt of the DHB report."

186. Birthcare told HDC that the email sent by RM E on 24 Month7 was "unacceptable" and was not known by others at Birthcare at the time. Birthcare asserted that had it been known, it could have prevented the incorrect message being conveyed. Birthcare stated that RM E is deeply apologetic that her response, in a situation where she was not sure how to respond, was incorrect.

187. Birthcare stated that RM D's emails on 31 Month7 and 2 Month8 occurred during a period when RM D had been overseas and was then in isolation because of the COVID-19 situation, and she was not able to attend to matters directly, as would normally have been the case.

188. Birthcare later acknowledged that the view taken by RM D on 22 Month8 in declining to provide the DHB's review was incorrect, and Birthcare apologises for having taken that position.

My opinion

189. Right 10 of the Code provides that every consumer has the right to complain about a provider in any form appropriate to the consumer, and the provider must facilitate a fair, simple, speedy and efficient resolution of complaints. As part of this, the provider must have a complaints procedure that ensures that (among other things) the consumer is informed of any relevant internal complaints procedures, and the consumer receives all information held by the provider that is or may be relevant to the complaint.

190. Right 10 also states that within 10 working days of giving written acknowledgement of a complaint, the provider must decide whether it accepts that the complaint is justified and, if it decides that more time is needed and that additional time is more than 20 working days, it informs the consumer of that and the reasons for it.

191. Right 5(2) provides that every consumer has the right to an environment that enables both consumer and provider to communicate openly, honestly, and effectively.

192. It is clear that on 24 Month7, RM E acknowledged and accepted Mr and Mrs A's complaint on behalf of Birthcare. Birthcare then had 10 working days to determine how much time it required to investigate the complaint. In RM D's email to Mrs A dated 21 Month8, she advised that she would need until 5 Month9, but she failed to communicate this to Mrs A within 10 working days of RM E's acknowledgement. The above timeline suggests that RM D was available on email either to respond to Mrs A herself, or arrange for someone else to do this, much earlier than 21 Month8. The delay in this response led Mrs A to escalate the complaint to this Office.

193. Both RM E and RM D communicated with Mrs A about her complaint, but did not provide her with any information about Birthcare's internal complaints procedure until it was requested.

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194. Both RM E and RM D referred to the DHB's review without explaining that the review had been commissioned for another purpose prior to the receipt of Mr and Mrs A's complaint. Initially, this led Mrs A to believe that the DHB's review was a part of the complaint handling process, but when she requested it, disclosure of the review was declined by RM D. Because of this, Mrs A approached the DHB directly and received the report. Notably, the DHB released the report after agreement from RM D.

195. The complicated nature of this information release would seem unnecessary and, not unreasonably, appears to have contributed to Mr and Mrs A's mistrust of Birthcare. RM D may need to upskill her knowledge of complaint management, including the disclosure of information.

196. It is clear that the DHB sent its review to RM E and RM D on 13 Month7. RM E acknowledged receipt of the review on the same day, and RM D had access to her emails and was aware of the review as early as 31 Month7, and referred to it again on 2 Month8. Despite this, on 24 Month7, RM E told Mrs A that she had not received the report, and on 22 Month8, RM D told Mrs A that she did not receive the report until 13 Month8.

197. The above depicts a picture of poor complaint handling, which stifled resolution. In my view, Mr and Mrs A's right to complain about the care Baby A received was not upheld. Accordingly, I consider that Birthcare breached Right 10 of the Code.

198. I am also very concerned by the misleading conduct of RM E and RM D in their communication to Mrs A about when the DHB's review was received. At such a crucial time in Mr and Mrs A's complaint resolution journey, this is alarming behaviour from senior clinical and operational staff who represent Birthcare. Accordingly, I consider that Birthcare failed to communicate with Mr and Mrs A openly, honestly, and effectively, and breached Right 5(2) of the Code.

199. In addition to an apology from Birthcare, I have recommended that RM E and RM D each provide personal letters of apology to Baby A and his family for their unprofessional communications, and I have recommended that RM E upskill her knowledge of complaint handling.

Open disclosure

200. Mr and Mrs A told HDC that after Baby A's deterioration, there was no communication from Birthcare apart from a greeting card that was sent to them by RM E in late Month1. The greeting card contained RM E's business card.

201. RM E stated: "I sent a card to [Mr and Mrs A] with my business card offering support as well as encouraging them to contact me at any time to talk."

202. Birthcare told HDC that RM C was contacted daily for the first week when Mrs A and Baby A were transferred to the public hospital. It submitted that on every occasion, an offer of support was conveyed through the LMC, and it was also requested that the LMC encourage the parents to contact Birthcare. Birthcare stated: "Given that we did not have any response

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through this channel, we took that as an impression that [Mrs A] and [Mr A] did not want to discuss matters with Birthcare."

203. Notwithstanding the above, Birthcare has accepted that it should have had better communication with Mr and Mrs A soon after the events involving Baby A. It stated that it regrets that it did not engage directly with Mr and Mrs A. Birthcare further accepted that its Reportable Events Policy was not followed, and stated: "[T]he expected disclosure did not occur in this instance. Birthcare regrets this failure."

204. Birthcare's Reportable Events Policy lists open disclosure and an apology as key steps in the process of managing a reportable event. The policy states:

> "**Open disclosure**
> The [General Manager] or deputy will meet with the client and family/whānau, to discuss the event or unintentional harm … This should occur within 24 hours of the event being recognised.
>
> The following is discussed:
>
> - Factual explanation of what has happened;
> - Any potential consequen[ce]s for the client;
> - Outline of what steps have been take[n] to manage the event and prevent reoccurrences;
> - Timeframe for the investigation, type of investigation and method of feedback;
>
> …
>
> - Provide a copy of 'your rights' pamphlet and discuss the support services available;
> - Provide information on Health and Disability Commission[er] (HDC) advocacy service;
> - Advise that they may be eligible to make an ACC treatment injury claim …
> - Disclosure and subsequent actions are documented in the client notes.
>
> **Apology**
> Provide an apology for any harm suffered. This is the opportunity to say 'we are sorry that this happened to you'.
>
> Acknowledge the seriousness of the event and the distress it has caused. No blame should be apportioned."

205. Mr and Mrs A told HDC that they find it concerning that Birthcare placed the onus on the consumer and LMC to make contact with Birthcare. Mr and Mrs A stated: "All we initially wanted was an acknowledgement and apology from Birthcare about what happened to [Baby A]."

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My opinion

206. Right 6 of the Code gives all consumers the right to be fully informed. Consumers have the right to know what has happened to them. In New Zealand, provider organisations have a legal duty to take steps to ensure that open disclosure is practised by staff and supported by management.[21]

207. Disclosure should include acknowledgement of the incident, an explanation of what happened, how it happened, why it happened and, where appropriate, what actions have been taken to prevent it happening again. A disclosure should include a sincere apology.[22]

208. Open disclosure standards are included in the Health and Disability Services Standards (2008), which must be followed by all health and disability service providers under the Health and Disability Services (Safety) Act 2001. Standard 1.9.1 states that consumers have the right to full and frank information and open disclosure from service providers. Standard 2.4 states: "All adverse, unplanned, or untoward events are systemically recorded by the service and reported to affected consumers and where appropriate their family in an open manner."

209. The Health Quality & Safety Commission (HQSC) national Adverse Event Reporting Policy (2017) lists open communication as a key underlying principle for adverse event management. It states: "[C]onsumers and their whānau are ethically and legally entitled to truthful and open communication at all times following an adverse event."

210. There is a body of evidence to support that Mr and Mrs A, as Baby A's legal guardians, had a right to open disclosure following Baby A's deterioration. This included direct contact being made with Mr and Mrs A to advise them of what was known of Baby A's incident and what Birthcare intended to do about the incident. Ideally, an apology should have been forthcoming as soon as possible. Sending a "Thinking of You" greeting card and asking for messages to be passed through the LMC was an inadequate and inappropriate response in an open disclosure process.

211. Mr and Mrs A had a right to know that a reportable event process was to occur as soon as one was commenced in Month4. Birthcare told HDC that it did not inform Mr and Mrs A because of the lack of contact from them. To be clear, I do not accept this argument because it is Birthcare's responsibility to uphold Mr and Mrs A's right to open disclosure. However, I note that even when they did make contact by way of a complaint, Birthcare still did not advise Mr and Mrs A of its adverse event process. This is extremely poor practice.

212. It was not until 1 Month9 that Birthcare provided information and an apology to Mr and Mrs A about the care provided to Baby A. This was after they had made a complaint to Birthcare and escalated it to HDC. The timeliness of the disclosure was poor, and very harmful to Mr and Mrs A.

[21] HDC Guidance on Open Disclosure Policies (December 2009).

[22] See above.

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213. For the above reasons, I consider that Birthcare failed to carry out open disclosure with Mr and Mrs A. Accordingly, I find that Birthcare breached Right 6(1) of the Code.

Consumer participation — adverse comment

214. Mr and Mrs A made a complaint to Birthcare on 22 Month7. In an email from RM D to other Birthcare staff, she noted that Mrs A's recollection of events was very different to the accounts of Birthcare staff.

215. Mr and Mrs A told HDC:

> "[W]hen [RM D] became aware [that Mrs A's] perspective and account of events were different to the accounts provided by Birthcare staff … [RM D] and other Birthcare management staff did nothing to remedy the situation.
>
> …
>
> [I]f Birthcare had a genuine intention to openly engage with us, then in light of this 'new' information, why did [RM D] and/or [RM E] not simply approach us directly to engage in a more detailed discussion to find out our point of view as an attempt to identify what might have happened … Instead, Birthcare went silent."

My opinion

216. HQSC's National Adverse Event Reporting Policy (2017) outlines consumer participation as a principle that underpins its policy. It states:

> "Adverse events need to be considered within the context of the whole consumer and whānau experience of care. Including the consumer perspective in the review process enables a broader understanding of the circumstances surrounding an adverse event. It is expected that, at a minimum, consumers and whānau who have been involved in an adverse event will be offered the opportunity to share their story as part of the review process and that review findings and recommendations will be shared with them."

217. I note that the receipt of Mr and Mrs A's complaint in Month7 was an opportunity to bring their experience and perspective into the ongoing adverse event process. This was even more so when it was identified that Mrs A had vastly different recollections of events than Birthcare staff. It concerns me that Birthcare's management staff lacked this insight and/or knowledge.

218. Further, Birthcare's reportable events policy at the time of events omitted the inclusion of consumer participation as a key principle that underpinned its policy. Although the policy was updated following Baby A's incident, the policy of Month9 also does not include this principle. I consider this to be a deficiency with the policy. It is also inconsistent with HQSC's national policy and the provision of patient-centred care generally. I strongly recommend that Birthcare consider including consumer participation in its policy, and ensure that this is implemented as a meaningful part of its reportable events process.

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Conclusion

219. In conclusion, Birthcare has much work to do in a number of important respects to restore public confidence in its commitment to the Code of Health and Disability Services Consumers' Rights. Accordingly, I consider it is in the public interest to refer Birthcare to the Director of Proceedings for a decision as to whether proceedings should be taken.

Responses to provisional opinion

Baby A's parents

220. Mr and Mrs A had an opportunity to review and respond to the factual information contained in the provisional opinion. As part of their response, they submitted an Impact Statement, which describes how this event has impacted Baby A and his parents' lives.

221. With respect to how this event has impacted Baby A, his parents write:

> "We feel that this tragic, preventable event has robbed him of his basic rights and joys of being a little human being — being able to walk, jump, run independently and explore the world, to be able to sing for fun, to talk and express his needs and wants, be able to have a sense of self-determination and independence, and most of all achieve his true potential in life."

222. With respect to how this event has impacted Mr and Mrs A, they talk of the significant trauma and grief they have experienced and the sense of loss of control and autonomy in their lives. They told HDC: "We have been unnecessarily thrown into a lifelong situation where we feel powerless and out of control in **ALL** aspects of our lives."

RM B

223. RM B had an opportunity to review and respond to the relevant parts of the provisional opinion. RM B said that she is open to providing an apology as recommended, and stated that she is genuinely sympathetic to the challenges faced by Baby A and his family.

224. RM B submitted that her care of Baby A must be considered in context, namely, that there were multiple missed opportunities for other practitioners to intervene in Baby A's care, that she made efforts to escalate her concerns about feeding on the morning of 25 Month1, and that her clinical involvement was impacted by her competing obligations to five other women and their babies. RM B maintains that throughout 25 Month1 she was proactive in identifying and addressing concerns about Baby A.

225. Where appropriate, amendments have been made to my decision in light of RM B's submissions.

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Birthcare

226. Birthcare had an opportunity to review and respond to the relevant parts of the provisional opinion. Birthcare stressed that it continues to feel for Mr and Mrs A and their baby around the events that occurred. It noted that since these events, Birthcare's ownership has changed, and it is confident that a situation like this will not occur again.

227. Birthcare advised that it fully accepts that the handling of the complaint by Mr and Mrs A was unacceptable, and that the actions and omissions of its former employee, RM B, fell below expectations.

228. Birthcare made submissions against my provisional criticisms of its actual care of Baby A. Where appropriate, changes have been made to the report.

RM C

229. RM C had an opportunity to review and respond to the relevant parts of the provisional opinion, as it related to her. RM C agreed with the educational comments made about her and confirmed that she has reflected on these. She advised that she would notify HDC of any changes she made to her practice following these events within three weeks of the date of this decision.

Dr L

230. Dr L had an opportunity to review and respond to the relevant parts of the provisional opinion, as it related to him. Dr L told HDC that since this very sad event took place he has made considerable changes to his practice with regard to Birthcare. He advised Birthcare that he is not available for acute management where decisions and actions need to take place quickly. He said that he will still see infants under LMC care at Birthcare, but only if the nature of the clinical problem is such that the review can wait until a time that is convenient for himself, the parents, and Birthcare staff.

Ambulance service

231. The ambulance service had an opportunity to review and respond to the relevant parts of the provisional opinion. The ambulance service advised that it agreed with HDC's recommendations regarding further education for ambulance personnel on identifying neonatal vital signs, and reflecting on the learnings from this incident regarding the roles and responsibilities of ambulance personnel during neonatal resuscitation.

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Recommendations

232. I recommend that Birthcare Auckland Limited:

a) Provide a formal written letter of apology to Baby A, and Mr and Mrs A for the deficiencies identified in this report. The apology should be sent to HDC within three weeks of the date of this decision, for forwarding.

b) Provide evidence to HDC that the "Cross the T's and Dot the I's" education has recommenced, and that this includes documentation of handover and escalation, within three months of the date of this decision.

c) Provide evidence to HDC of the inclusion of emergency skills training in its induction and orientation process, within three months of the date of this decision.

d) Provide evidence that it has confirmed with its staff their understanding of roles and responsibilities during an ambulance transfer, within three months of the date of this decision.

e) Update its Reportable Events Policy to include consumer participation as a key principle, and implement this as a meaningful part of its reportable events process. Evidence of this should be provided to HDC within six months of the date of this decision. I note that in response to the provisional opinion, Birthcare stated that its reportable events processes are now governed by Evolution Healthcare systems.

f) Commission a staff survey on values and beliefs around empowerment to make clinical decisions and escalate concerns and care to senior staff. Evidence that this has occurred, with action points to address any issues that arise, should be provided to HDC within six months of the date of this decision.

g) Share HDC's anonymised opinion with all Birthcare staff, and provide evidence that this has occurred, within three weeks of the date of publication of the anonymised opinion on HDC's website.

h) Request that RM D provide a personal written apology for the deficiencies identified in her communications with Mr and Mrs A. A copy of the apology, for forwarding, should be provided to HDC within three weeks of the date of this decision.

i) Provide oversight of RM E to:

- Review HDC's guidelines on open disclosure found at https://www.hdc.org.nz/making-a-complaint/complaint-process/guidance-on-open-disclosure-policies/;
- Upskill on complaint management by completing HDC's online modules found at https://www.hdc.org.nz/education/online-learning/; and
- Provide a personal written apology for the deficiencies identified in her communications with Mr and Mrs A.

Evidence of completion of the training, and a copy of the apology for forwarding, should be provided to HDC within three weeks of the date of this decision.

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j) Provide oversight to any other senior clinical and/or management Birthcare staff involved in adverse event and complaint management to review HDC's guidelines on open disclosure found at https://www.hdc.org.nz/making-a-complaint/complaint-process/guidance-on-open-disclosure-policies/ and complete HDC's online modules found at https://www.hdc.org.nz/education/online-learning/, and provide evidence that this has occurred, within three weeks of the date of this decision.

233. I recommend that RM B provide a formal written letter of apology to Baby A, and Mr and Mrs A for the deficiencies identified in this report. The apology should be sent to HDC within three weeks of the date of this decision, for forwarding.

234. I recommend that RM C, Dr L, and the ambulance service reflect on the educational comments made in this report, and advise HDC of any changes to practice since these events. This information should be provided to HDC within three weeks of the date of this decision.

Follow-up actions

235. Birthcare Auckland Limited and RM B will be referred to the Director of Proceedings in accordance with section 45(2)(f) of the Health and Disability Commissioner Act 1994 for the purpose of deciding whether any proceedings should be taken.

236. A copy of this report with details identifying the parties removed, except the advisors on this case and Birthcare Auckland, will be sent to the Midwifery Council of New Zealand and the New Zealand College of Midwives, and they will be advised of RM B's name.

237. A copy of this report with details identifying the parties removed, except the advisors on this case and Birthcare Auckland, will be sent to the ambulance service, Te Whatu Ora, the Health Quality & Safety Commission, HealthCERT, and the Accident Compensation Corporation, and placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

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Appendix A: Independent paramedic advice to Commissioner

The following expert advice was obtained from paramedic Mark Bailey:

"**The author has been asked to provide an opinion to the Commissioner on case number 20HDC00715 and has read, and agrees to follow, the Commissioner's Guidelines for Independent Advisors.**

Qualifications, training and experience relevant to the area of expertise

Chair of the Ambulance Sector Adverse Events Review Group

Former member Regional Child and Youth Mortality Review Groups (Capital and Coast DHB, Hutt Valley DHB, Wairarapa DHB)

Member of P8156 review committee: NZS8156:2019 Ambulance, paramedicine and patient transfer services

Member National Ambulance Sector Clinical Working Group

Root Cause Analysis training

Clinical incident investigation and reporting

Clinical audit

Communications Centre Experience (Dispatcher)

Bachelor of Health Science (Paramedic)

Extensive experience working in rural and metropolitan ambulance services, including as an Intensive Care Paramedic and Flight Paramedic, mentor

Research (resuscitation from cardiac arrest): (contributing author) 'Beyond the pre-shock pause: the effect of pre hospital defibrillation mode on CPR interruptions and return of spontaneous circulation'

The Commissioner is seeking an opinion on the care provided by [the ambulance service] to [Baby A] on 25 [Month1].

Advice Requested

1. The timeliness of [Baby A's] transfer to hospital, including;
   a. The priority given to [Baby A's] presentation; and
   b. The time it took for [the ambulance service] to arrive at and depart Birthcare Auckland.
2. The appropriateness and adequacy of the assessments (or lack of) carried out on [Baby A] by [the ambulance service].
3. The reasonableness of the Birthcare midwife retaining responsibility of [Baby A's] care during transportation with reference to the general consensus in the sector on this issue.

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4. The timeliness and adequacy of the paramedic's response to [Baby A] once he showed signs of deterioration during the transfer including:
   a. The interventions prepared and/or carried out; and
   b. The advice to the midwife.
5. Whether [the ambulance service] was expected to report this incident as a Reportable Event and/or take any further steps in relation to the reporting of this event.
6. Any other matters in this case that you consider warrant comment.

Information reviewed

The following information was provided and has been reviewed.

- Letter of complaint (to [the ambulance service]) — 21 [Month10]
- Response (to family) — [ambulance service] — 16 [Month11]
- Clinical notes — [ambulance service]

Resources Consulted

- [Ambulance service] Clinical Procedures and Guidelines, Comprehensive Edition 2019–2022
- New Zealand Standard 8156:2019 Ambulance, paramedicine and patient transfer services
- Emergency Ambulance Service Agreement (National Ambulance Sector Office, 2015)
- Health Quality and Safety Commission guidelines

Background

On 25 [Month1] at 3.55pm, an ambulance was arranged following a 111 call. A call was received by [the ambulance service] requesting ambulance transportation of [Baby A] and his mother, [Mrs A] from Birthcare Auckland to NICU at [the public hospital]. The caller stated that [Baby A] was presenting with a low blood sugar reading and based on this information, a frontline emergency ambulance was dispatched.

At 3.59pm, the nearest available ambulance responded and arrived at Birthcare Auckland at 4.11pm. Birthcare and [the ambulance service] confirm that the Birthcare midwife retained responsibility of [Baby A] during the transfer to hospital. [The ambulance service] departed Birthcare at 4.23pm. During transport, the non-driving paramedic noted that as they approached the immediate vicinity of [the public hospital], [Baby A] appeared to be struggling to breathe and his colour had changed. The paramedic reported observing [Baby A] experience seizure activity for approximately 20 seconds and soon after this he respiratory arrested and he went into cardiac arrest. Due to [Baby A's] deterioration, the ambulance was diverted to the emergency department rather than NICU. The ambulance arrived at [the public hospital] at 4.29pm.

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Summary

In conducting this review, I have not identified any departures from the expected standard of care by [the ambulance service].

The absence of a Reportable Event notification by [the ambulance service] is consistent with sector and contractual expectations.

It is my opinion that [the ambulance service] met all expected standards of clinical [care] and reporting.

Review

1. The timeliness of [Baby A's] transfer to hospital, including:
a. The priority given to [Baby A's] presentation; and
b. The time it took for [the ambulance service] to arrive at and depart Birthcare Auckland.

The transfer of a patient from one medical facility to another, particularly when accompanied by clinical staff from the originating facility, is normally undertaken by the [the ambulance service] Patient Transfer Service. The Patient Transfer Service does not provide clinical staff or equipment for treating critically ill patients during transfers.

Urgent transfers of significantly ill patients can be undertaken by frontline ambulances, crewed by clinical staff (paramedics) who are able to provide (or support the provision of) treatment if required.

The decision to urgently respond a frontline ambulance to transfer [Baby A] indicates that the transfer was given a high priority.

The clinical notes provided by [the ambulance service] detail the following times:

Status	Time	Comment
Time of Call	15:55	As noted in the letter from [the ambulance service] to [Mrs A]
Time of Call	15:58	As documented in the Patient Report Form
Dispatch Time	15:58	Ambulance alerted to the incident
Responding	15:59	Ambulance responding towards the incident
At Scene	16:11	Ambulance arrives at the address
At Patient	Not recorded	Not normally recorded for a patient transfer
Depart Scene	16:23	Ambulance departs with patient onboard
At Destination	16:29	Ambulance arrives at the destination address

There is an apparent discrepancy between the times extracted from the Ambulance Care Summary [25 Month1] and the statement by [the ambulance service] (Response (to family) — [the ambulance service] — 16 [Month11]). The statement notes that 'On 25 [Month1], an ambulance was arranged following a 111 call (via the Health

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Practitioners line) at 1555 hours'. I have assumed that the 111 call was answered at 1555 hours. It is likely that the information required to dispatch an ambulance (address, nature of incident, urgency) was obtained by 1558 hours, at which time the incident was then available to be dispatched. This is the normal length of time taken to verify the address and obtain the necessary information in order to urgently dispatch an ambulance.

The ambulance was dispatched within one minute. This is normal when an urgent response is required.

The ambulance arrived at the BirthCare facility 12 minutes later. I am not able to comment on the time taken for the ambulance to drive to the facility. This is because I do not know where it came from or the degree of traffic congestion encountered en route.

Paramedics spent 12 minutes at the facility. During this time they:

1. unloaded a stretcher and equipment (potentially required to treat the patient)
2. entered* the facility and located the patient, [Baby A]
3. confirmed who was leading the clinical care of [Baby A]
4. loaded and secured [Baby A] onto the stretcher
5. returned to the ambulance
6. stowed the equipment
7. clarified who could/couldn't fit safely in the ambulance
8. ensured clinical staff and passengers were safe and secure in the ambulance

*The letter from [Mrs A] includes a comment about the paramedics 'waiting for the elevator to arrive'. This implies an additional delay inside the facility, beyond the paramedics' control, however I am not familiar with BirthCare and therefore am not able to draw a conclusion from this comment.

[Mrs A] provides a description of the paramedics working which is consistent in my view with the calm, organised and safe approach exhibited by competent paramedics. The actions described are not consistent with ambulance personnel who lack a sense of urgency. I conclude this because all of the actions described were necessary and the overall time taken at the Birthcare facility was shorter than I would anticipate (based on experience).

Conclusion:
Point 1.a The immediate dispatch of the nearest frontline ambulance, crewed by a paramedic and responding urgently, meets the expected standard of care for a child with a potentially life-threatening condition.

Point 1.b It is my experience that a scene-time of 12 minutes at a facility requires an organised and time-conscious approach. Therefore, it is my opinion that the evidence provided reflects prompt, disciplined and safe care being taken to transfer [Baby A] into

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the ambulance and I see no evidence that time was lost during this process. It is my view that there is no departure from the expected standard of care.

It is my opinion that the timeliness of the transfer and priority given to [Baby A's] presentation met the expected standards of care.

The appropriateness and adequacy of the assessments (or lack of) carried out on [Baby A] by [the ambulance service].
When [the ambulance service] is providing transport only and a clinician is accompanying the patient, responsibility for clinical care is not normally transferred to ambulance personnel. It would therefore be very unusual for ambulance personnel to request detailed clinical information about a patient for which they have no clinical responsibility. They can however, as occurred in this instance, offer to assist.

The paramedic documented that she confirmed that the midwife retained clinical responsibility for [Baby A's] ongoing care. The paramedic notes that she was informed that [Baby A] was lethargic, had low blood sugars and poor feeding. This information matched the paramedic's observations of lethargy, as documented in the electronic Patient Report Form. It is my view that [Baby A's] presentation would have appeared consistent with the presentation of a patient being transferred due to a requirement for higher level care.

The paramedic documented that the LMC, a registered health professional, retained responsibility for [Baby A's] care. Therefore it would be, in my opinion, very unusual for the paramedic to start an examination of [Baby A] unless requested to do so.

Conclusion
The lack of a detailed examination by the paramedic in this setting is, in my view, consistent with normal practice and is consistent with the expected standard of care.

The reasonableness of the Birthcare midwife retaining responsibility of [Baby A's] care during transportation with reference to the general consensus in the sector on this issue.
The ambulance sector has clarified clinical leadership responsibilities in situations when ambulance personnel are called to assist midwives. This clarification of responsibilities was established by the National Ambulance Sector Clinical Working Group (NASCWG) during the development of the Clinical Procedures and Guidelines, when the NASCWG consulted with the Midwifery Council and reached agreement on this issue.

In accordance with the above agreement, [ambulance service] Clinical Procedures and Guidelines direct ambulance personnel to always clarify who the team leader is and 'If a lead maternity carer (LMC) is present, they are the team leader and are directing the treatment unless this responsibility is formally handed over to ambulance personnel.'

The documents provided for review reflect that this was clarified verbally by the paramedic and no evidence to the contrary has been provided.

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The absence of a clinical handover in this circumstance was normal practice, as care was not being handed over. The clinician responsible for [Baby A's] care — the LMC, a registered medical professional — was accompanying him. Note, paramedics are not yet registered however paramedic registration is currently being implemented.

Conclusion
It was normal practice, reasonable, and expected, that the Birthcare midwife retained responsibility for [Baby A's] care during transportation.

The timeliness and adequacy of the paramedic's response to [Baby A] once he showed signs of deterioration during the transfer including:
a. The interventions prepared and/or carried out; and

The journey is recorded as taking 6 minutes.

During this time the paramedic reported that she observed changes in [Baby A's] condition and prepared to measure his blood oxygen level. This is the action expected of a paramedic when preparing to assist with the treatment for a patient with distressed breathing.

When [Baby A] had a seizure, the paramedic reported that she began preparing to administer glucose. This is the action expected of a paramedic when preparing to assist with the treatment for a patient showing signs of low blood sugar (which may include seizure activity).

Both of the above actions — preparing to assess the oxygen level and preparing to treat the glucose level — are consistent with the paramedic's role of supporting the LMC.

After [Baby A] suffered a short seizure and then a cardiac arrest, the paramedic documented that she provided airway care and asked the midwife to commence CPR. These actions are consistent with the expected standard of care during the initial minutes of responding to a patient in cardiac arrest.

The paramedic has documented that [Baby A] had a 'weak femoral pulse on arrival at ED', indicating that the interventions provided during his resuscitation were effective at restoring circulation.

b. The advice to the midwife.
The paramedic's description of her actions and directives when [Baby A] experienced a seizure and then respiratory and cardiac arrest are, in my view, consistent with the actions of a majority of paramedics in this situation. Transitioning from a supporting role into the lead role and beginning to direct treatment is, in my experience, considered appropriate by ambulance personnel when a patient's condition has deteriorated unexpectedly and the (initial) lead clinician/s do not appear attuned to the situation, and/or are not familiar with the ambulance environment. Paramedics are accustomed to the challenges of working in a moving vehicle and are familiar with the

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equipment and layout. It is my experience that most, if not all, paramedics would move to a leadership role in this situation.

The expectation of ambulance personnel when treating a person in cardiac arrest is the immediate provision of chest compressions and ventilations. The actions of the paramedic in directing the LMC to provide chest compressions while she (the paramedic) provided airway support and oxygen are completely consistent with the expected actions and standard of care of ambulance personnel in this situation.

The redirection of the ambulance to the emergency department is consistent with my experience of paramedic decision-making, particularly given the proximity of the emergency department at the time of [Baby A's] cardiac arrest. The management of an unexpected cardiac arrest in the back of an ambulance is a challenging situation to manage, particularly as space and the number of clinicians available are limited. It is therefore reasonable and expected that [Baby A] be moved into the emergency department for ongoing resuscitation.

I note that the decision to divert to the emergency department would likely have removed the need for a discussion or decision on who would continue to lead the resuscitation effort, had resuscitation continued in the ambulance.

Conclusion
It is my view that the actions of the paramedic are consistent with the expected standard of care and are accepted practice.

Whether [the ambulance service] was expected to report this incident as a Reportable Event and/or take any further steps in relation to the reporting of this event.
[The ambulance service] is contractually required to report adverse events (Reportable Events) involving the delivery of its own service to the National Ambulance Sector Office and to the Health Quality and Safety Commission.

Based on the information provided, I note that the ambulance personnel would likely have had insufficient background information to determine whether an adverse event had occurred. The provision of care that differed from that provided by the paramedics would need to be based on information not contained within the documentation presented for review. This would include information such as vital sign recordings which would normally be provided at the time of handover, if a handover or briefing occurred.

It is my view that the midwife or other specialist staff involved in [Baby A's] care, with his full medical history available, would be best placed to consider concerns of this nature.

Conclusion
There is no contractual requirement for [the ambulance service] to lodge a Reportable Event related to another agency's care. It is my opinion that the [ambulance service] staff present would likely have had insufficient information on which to base an informed opinion relating to the existence of a Reportable Event."

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Appendix B: Independent midwifery advice to Commissioner

The following expert advice was obtained from RM Mary Wood:

"My name is Mary Wood. After completing a diploma in Comprehensive Nursing at Carrington Polytechnic (now Unitec) in 1989, I completed a diploma in midwifery at AUT in 1990. I then completed a Bachelor of Health Science Midwifery at AUT in 2001. I worked as a midwife in the delivery unit of North Shore Hospital from Jan 1991 until September 1991, after which I began working as an independent midwife on the North Shore in Auckland. I worked as a full time self employed midwife on the North Shore until April 2013, at which time I began working part time as an Associate Clinical Charge Midwife in the birthing suite of North Shore Hospital. As a Charge Midwife I was responsible for the management of the labour ward, co-ordinating, teaching and supporting staff and responding to emergency situations. I combined a part time self employed caseload with my part time work at the hospital until December 2020. As a self employed midwife, I worked with four other charge midwives from WDHB who also managed a small caseload. I provided midwifery care for women throughout pregnancy, from positive pregnancy test through until six weeks after the birth of the baby, delivering either at home or North Shore Hospital. I provide midwifery care for women in both low, moderate and high risk pregnancies.

I have read and agree to follow the HDC 'Guidelines for Independent Advisors' and I have no conflicting interests either professional or personal in this case.

I have reviewed the documents provided by the HDC including:

1. Clinical notes — antenatal and postnatal (LMC and Birthcare)
2. Complaint correspondence from [Mr and Mrs A] [dates]
3. [Three] Birthcare responses dated [2020]
4. Birthcare staff statements from [RM F], [RM G], [RM H], [RM I], [RM B], [RM E], [RM K], [RN J].
5. [RM C's] response dated [2020] including a personal reflection and a letter from student midwife [Ms M].
6. Birthcare Neonatal Hypoglycaemia Policy, Caring for the Vulnerable Baby Guidelines 2018 and Transfer of a Critically Ill Neonate.

You have asked me to consider whether the care provided to [Baby A] by Birthcare and [RM C] was reasonable in the circumstances, and why.

[RM C]:

1. ***Please review the antenatal notes and comment on the appropriateness of the decision to deliver [Baby A] at Birthcare.***

This was [Mrs A's] third pregnancy and although it was an unexpected pregnancy and [Mrs A] did not realise she was pregnant until her mid second trimester, the pregnancy progressed normally. [Mrs A's] age means she is classified as being of advanced

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maternal age, which can raise her risks for pregnancy problems such as hypertension, diabetes and fetal abnormality. [Mrs A] did not develop any actual problems during her pregnancy. Although she did return two high polycose test results her pregnancy glucose tolerance test (GTT) was normal. Polycose testing is not diagnostic, GTT is. [Mrs A] did not have gestational diabetes. Her Ferritin levels in [Month1] were somewhat low, indicating dropping iron stores but she was not anaemic, (her haemoglobin was normal).

Her anatomy scan demonstrated a normal appearing baby and the baby's growth was normal throughout. Her previous births (both normal births) had occurred at 37 weeks and neither of her previous children had been SGA (small for gestational age) at birth. This was a normal pregnancy, and although [Mrs A's] age increased the risk for the development of some pregnancy abnormalities, she did not demonstrate any. Her labour occurred at 37 weeks 1 day.

Given these factors, I believe it was entirely appropriate for [Mrs A] to deliver her baby at Birthcare and most LMC midwives would be happy to care for her at Birthcare.

2. ***Please review each of [RM C's] postnatal visits to [Baby A] whilst he was at Birthcare and comment on the reasonableness of the postnatal care [RM C] provided. This could include but is not limited to testing blood sugar levels and [Baby A's] feeding plan.***

[RM C]:

[RM C] transferred [Mrs A] to the postnatal ward at 1.40 am hours, at which stage [Baby A] was over 3 hours old. [Baby A] had fed well during this time and was warm (37°C). His weight was 2790 gms.

The protocol at Birthcare is for serial blood glucose testing (SBG) to be done on babies under 2800gms. However, [Baby A] was only 10 gms under this weight and had breastfed well during the first hours after his birth. He was over 37 weeks, and was a good size for that gestation. The fact that his birth centile had not been calculated is mentioned several times in the documentation I have reviewed, however his centile was in fact 19.6. As such he was not a small for gestational age (SGA) baby, which would have increased his risk for hypoglycaemia. However, as he was just over 37 weeks he needed to be feeding regularly, (3 hourly) and watched for signs of deterioration, such as poor feeding effort, decreased urine output and failing to maintain his temperature. Babies such as [Baby A] do have the potential for becoming tired and not feeding well during their second day and an awareness of this potential is why the need for effective feeding together with watching his general behavior and urine output is advisable.

Different facilities have differing protocols for serial blood glucose (SBG) monitoring in babies, Waitematā DHB, Lower Hutt DHB, Whangārei Hospital and Warkworth Birthing Centre for example have protocols that require SBG to be done if babies are under 2500 gm or over 4500 gms and any baby with a birth weight under the 10th centile or born earlier than 37 weeks, or any baby of a diabetic mother. Actually at this time the

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Whangārei Hospital protocol does not include weight at all but rather relies on birth centiles.

It is my opinion that given the clinical picture at the time, not doing the SBG after [Baby A's] birth would have been the decision many midwives would have chosen at that time because of the invasive nature of blood sampling and I do not consider this a significant departure from an acceptable standard of care.

[RM C] visited [Mrs A] and [Baby A] at 2.00 pm on the 24th [Month1], the afternoon after [Baby A's] birth (14½ hours old). At this time he was presenting as a normally progressing baby, breastfeeding and being topped up with expressed colostrum (EBM). He had been noted to have passed urine at 9.00 am that morning. It is very common for healthy babies to be very alert in the two to three hours after their birth and then sleepy during the next 24 hours. [Baby A's] initial sleepiness was in keeping with normal behavior of a term infant. [RM C] documented that [Baby A] was breastfeeding and having difficulties latching on to one side, and was to have expressed colostrum with his feeds every three hours.

Serial Blood Glucose recordings are taken within the first 1 to 2 hours after birth and prior to the next three feeds (or until the baby has 3 consecutive normal recordings, or for 12 hours following a low blood sugar result). I can find no indication from the notes that there was any clinical concerns within the first 12 to 24 hours after [Baby A's] birth that would have required blood glucose testing.

Infant Feed Chart: *(used to assess breastfeeding efforts)*
Assessing the breast feed:

1. ***Offered but baby not interested***
2. ***Interested but not latching***
3. ***Latches but slips on and off***
4. ***Latches but sucking not coordinated***
5. ***Slow rhythmical sucking, swallowing < 10 mins***
6. ***Slow rhythmical sucking, swallowing > 10 mins***

[RM C] made a second postnatal visit to see [Mrs A] and [Baby A] on the ward at 9.40 am the following morning, after [Mrs A] had expressed her wish to be discharged. At this time [Baby A] was 34 hours old and the notes indicate that his feeding had not been going well since around 7.00 pm the previous night. Since that time his breastfeeding assessments had been scoring 1. (*See infant feed chart*). [RM C] was unhappy for [Mrs A] and [Baby A] to be discharged at this time as he was not feeding well and the plan was for them to stay at Birthcare so [Mrs A] could receive ongoing support with breastfeeding and expressing. At that time the decision was made to leave [Baby A] to sleep for a further 2 hours (as he was noted as being tired) then to feed [Baby A] 3 hourly and for [Mrs A] to call for assistance with feeding.

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With the benefit of hindsight this would have been a good time to consider a random blood glucose to be done given his breastfeeding efforts since the previous night had been inadequate and because of his ongoing sleepiness. However he was noted to have passed urine at 8.00 am which was reassuring and he was later described by [RM C] to have been pink, warm and vigorous when he was awake. Although I do feel a RBG would have been wise at this time, not doing so would not constitute a departure from acceptable standard given the circumstances at that time in my opinion.

[RM C] documented that she had encouraged 3 hourly feeding with EBM colostrum top ups. She had requested in the initial postnatal care plan for [Baby A] to have routine postnatal care, for assistance with establishing breastfeeding and for baby's (urine) output to be monitored. There had been an initial discussion between [RM C] and [RM F] regarding serial blood glucose monitoring and [RM C] had advised against this at that time. She describes advising [RM F] to use her clinical judgment regarding blood glucose monitoring. It has been my experience that this is typical of the conversations midwives have when a woman and baby is transferred from the birthing suite to the maternity suite and the ongoing midwifery care is handed over to the core midwives. The care plans documented by LMCs are not usually highly specific or prescriptive in my experience and do rely on the autonomy of midwives in making decisions. Such decisions are made depending upon the ongoing needs of the mother or baby and discussed with the LMC.

The NZ College of Midwives consensus Statement on the roles and responsibilities in the hospital setting state 'The New Zealand College of Midwives expects that self-employed and employed midwives will respect each other's right to autonomous practice and their accountability for that practice.'

3. ***Any other matters in this case relating to [RM C] that you consider warrant comment.***

I have no further comment.

Birthcare:

4. ***Please review each shift prior to [Baby A's] transfer to hospital and comment on the reasonableness of the care provided. This could include but is not limited to assessment and monitoring of [Baby A's] feeding and his feeding plan, as well as testing blood sugar levels.***
5. ***Please review the care provided by [RM B] including her response to [Baby A's] deterioration from approximately 1100 h onward including during [Baby A's] transfer to hospital.***

I have discussed [Baby A's] care up until 9.40 am in the above comments. Up until this time the care [Baby A] had received meets the standard I would expect given the circumstances, ie his gestation, his size, his output and his behaviour. Although, again with the benefit of hindsight there were warning signs in that [Baby A] had not been latching overnight.

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By 11.50 am [Baby A] was noted by [RM B] to continue to be sleepy and was found to be cold. His temperature was noted to be 36.2°C. (36.5°C to 37.5°C is normal.) At this point I would have expected a RBG to have been done given [Baby A's] behaviour and feeding history since 7.00 pm the night before. [Baby A] was placed skin to skin to warm him and the plan was to recheck his temperature 30 mins later. No consideration was given to performing a random blood glucose and there was no discussion with the LMC at this time.

It is my opinion that not performing a RBG at this time was a moderate departure from acceptable standard of care. Breastfeeding was attempted again at around 12.30 pm but [Baby A] was sleepy, not able to latch and feed (BF L1 R1) and he was given 0.8 ml of expressed colostrum. Again there appears to be no consideration of checking his blood sugar at this time, nor any discussion with the LMC. At some time between 12.30 and 13.10 pm [Mrs A] reported to [RM B] that she was concerned as she had seen [Baby A] displaying eye rolling. [RM B] did not observe any concerning features about his eyes so appeared to have disregarded [Mrs A's] concern and her description. In her retrospective additional clinical notes made on the 26 [Month1] [RM B] described [Baby A] 'baby opened his eyes, was looking at me.' Eye rolling and fixed staring are signs of seizure activity and again, given [Baby A's] developing lethargy and his temperature concerns and lack of feeding I would have expected some escalation of his monitoring, especially a blood glucose to have been carried out.

At 24 to 48 hours of age, a baby of [Baby A's] size would be needing 25 to 26 ml of breastmilk or formula 3 hourly. (75 ml per kg per 24 hours is the formula used to calculate the nutritional needs at this age.) Given that [Baby A] had not been able to latch and suck since 7.00 pm the previous evening, top ups of less than 1 ml of colostrum 3 hourly was insufficient by this time.

At 3.00 pm a further attempt to breastfeed was attempted and was again unsuccessful, no EBM was offered at this time. [Mrs A] was then advised to leave [Baby A] to sleep until 4.00 pm, and to express. However, at 3.15 pm [Baby A] was noted again to be dropping his temperature (36.4°C) and was noted to be 'bluish'. I am concerned that when noted to be 'bluish' a pulse oximeter was not immediately used to check [Baby A's] oxygen levels. Cyanosis (blue) is a serious concern and an indication of low oxygen levels and in my opinion should have demanded immediate action, especially given his lethargy, temperature drop and feeding history during the course of the day.

I would regard this omission as a significant departure from expected standard of care by the midwife.

The Infant Feed Chart records that [Baby A] was given 0.5ml of EBM via syringe at 3.30pm, (although this is disputed by [Mrs A] and [RM B]) had two low BSL (blood sugar levels) and was then offered IF (infant formula). No dextrose gel was administered which would have been the quickest way to bring [Baby A's] blood sugar levels up and is recommended in the Birthcare policy provided. (Treatment for hypoglycaemia.)

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At between 3.15 and 3.30 pm [Dr L] was phoned and describes giving his usual advice, which was perform a RBG, then to administer oral dextrose gel followed by an infant formula feed. This would be consistent with the advice given by paediatricians in circumstances such as this in my experience. [Dr L] denies any mention of possible seizure activity or concern about [Baby A's] colour. [RM B] describes informing [Dr L] that [Baby A] was 'bluish in colour'. [Dr L] does mention that there was some reception issues during the phone call and this may have contributed to him not fully hearing some of the message.

It is my opinion that oral dextrose should have been offered immediately upon the discovery of [Baby A's] low blood sugar. I cannot find his actual blood sugar level recorded in the documentation from Birthcare, but [RM C] states that it was 0.6 on page 5 of her letter of [2020]. A blood sugar level this low would constitute an emergency situation and the immediate administration of dextrose gel was an action that could have improved this and did not require [Dr L] to initiate. It is my opinion that not doing so was a significant departure from expected practice given the circumstances.

[Baby A's] transfer to Hospital:
After the final conversation with [Dr L], an ambulance was called for an urgent Priority 1 transfer to NICU at [the public hospital]. The ambulance arrived at Birthcare at 4.11 and departed at 4.23 pm.

Birthcare's Transfer of a Critically Ill Neonate Policy states that '*Staff will arrange for referral and transfer to secondary care*'. There are situations in outlying areas that this would become the responsibility of the LMC midwife because of staffing availability, but in this situation it is my opinion that it was the responsibility of the Birthcare staff. [RM C] was attending to another woman in labour at Birthcare during this time and was informed by [RM B] about what was happening and that [Baby A] was being transferred to NICU. Keeping [RM C] informed and updated with the events was appropriate but I do not agree that it was [RM C's] responsibility to provide the midwifery care during the transfer in these circumstances.

The transfer policy also states under Essential Information to include: current status including vital signs (temp, heart rate, respirations, oxygen saturation level, feed elimination, colour, behaviour). I cannot find any record of these things being recorded prior to his transfer. The oxygen saturation monitor was placed on [Baby A] by the paramedic during his transfer, this would have recorded his heart rate as well as his oxygen levels. [RM B] refers to [Baby A's] heart rate as being 170 and his oxygen saturation levels to be 87 to 88% during the transfer. Oxygen saturation levels at this age should have been above 95% and his heart rate below 160. These recordings were further indication that [Baby A] was compromised, however it does not appear that this was recognised by either the midwife or the paramedic. [RM B] describes the oximeter being removed from [Baby A] to enable him to be removed from the transport capsule for resuscitation. I am not sure why it was not immediately placed back on him as this would have been part of the expected action during a resuscitation such as this. [RM B] comments on this but did not request the oximeter to be put back on [Baby A]. The

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Paramedic describes witnessing seizure activity in [Baby A] prior to his collapse and describes alerting [RM B] to his deteriorating condition, but [RM B] did not believe [Baby A] was displaying seizure like activity, and states that [Baby A] was sleeping, cried loudly and his skin became pink again. She does not comment on what colour [Baby A's] skin was prior to this.

It appears there was some confusion about who was responsible for [Baby A] during the transfer. [RM B] understood that the responsibility was shared between herself as the accompanying midwife and the paramedic. The ambulance staff understood that the midwife was retaining total responsibility during the transfer and that this meant they were not to intervene unless specifically asked.

It has been my experience that a midwife will always accompany a woman or baby during a transfer between hospitals or facilities. The midwife is there as an escort and to oversee the wellbeing of the woman/baby as she/he would be most likely to recognise any deviation from normal quickly, given it is the midwife's area of expertise. However, any emergency, especially a full resuscitation would be jointly managed by the paramedic and the midwife. The midwife may have a deeper understanding of what is happening with the woman or baby but in the back of a moving ambulance using equipment the midwife may not be completely familiar with is a situation that calls for a combined co-ordinated effort in the management.

6. ***Please review Birthcare's relevant policies and procedures and evaluate Birthcare's Staff's adherence and understanding of these.***

There has been some comment on the fact that [RM C] did not require serial blood glucose testing for [Baby A] after his birth and that his birth centile was not calculated at the time. As I have discussed above, [Baby A] was only 10 grams under the 2800 gram weight limit and had no other risk factors. [RM C's] care plan for [Baby A's] ongoing care while in Birthcare was for him to have routine postnatal care and for his (urine) output to be monitored and for assistance to be provided to help establish breastfeeding. The plan extended to include 3 hourly supervised feeds and top ups with expressed colostrum after [RM C's] visit at 9.40 am the following morning. Review of [Baby A's] feeding chart demonstrates that he had in fact not been feeding since the previous night and had only the expressed colostrum as I discussed above.

At the time of [Baby A's] birth there was not a requirement at Birthcare for all babies to have their birth centile calculated. This was introduced in [Month5] according to the letter of response to the HDC (item 14). In the maternity facilities I have checked with, all babies currently have their birth centile calculated after birth, usually prior to their transfer to the postnatal ward and the decision to perform routine blood glucose testing is based on that calculation (among other factors). As regards the birth centile, babies on or under the 9th or over the 95th have routine blood glucose testing done at 1 to 2 hours of age then before the following feeds until they have demonstrated 3 normal blood glucose levels. [Baby A's] birth centile was 19.6 so even if this policy had been in place at the time, he would not have fitted into this requirement.

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The policies and procedures at the time this event happened at Birthcare were in keeping with the policies in other maternity facilities, other than the birthweight of 2800 gms (rather than 2500 gms) being a requirement for serial blood glucose monitoring in newborns. The policy for the treatment of hypoglycaemia was in place but was not followed, in that [Baby A] was not given oral dextrose gel when his blood glucose was tested and found to be very low.

7. ***Any other matters in this case relating to Birthcare and Birthcare staff that you consider warrant commen***t.

I have no further comment.

LMC and Birthcare:

8. ***Please comment on [RM C's] and Birthcare's communication and cooperation with each other and the interface and responsibilities of LMC and core midwives in a setting such as this complaint.***

In her letter of response to the HDC dated [2020], [RM D] states 'Throughout the postnatal period, [Mrs A] and her baby remained under the care of the lead maternity carer. [The] (ACC Advisor) refers to the Ministry of Health referral guidelines and indicates that consultation should have occurred. The consultation requirements imposed by the guidelines are on the LMC.'

However, the Maternity Facilities Access Agreement Term and Conditions of Access to a Maternity Facility or Birthing Unit, under Obligation of Both Parties, 5. Referral Guidelines states 'both parties will take into account the Guidelines for Consultation with obstetric and related specialist medical services that identify clinical reasons for consultation with a specialist and that are published by the Ministry of Health from time to time when providing primary maternity services.'

The NZCOM Standards for Practice are standards for the practice of all midwives in NZ regardless of the workplace setting.

NZCOM Standards of Practice:

Standard 6
Midwifery actions are prioritised and implemented appropriately with no midwifery action or omission placing the woman (or baby) at risk

Standard 7
The midwife is accountable to the woman, to herself, to the midwifery profession and to the wider community for her practice
**Taking own responsibility for safety of woman and baby — whatever setting for practice*

The **Scope of Practice of a Midwife** states '*The midwife may practise in any setting, including the home, the community, hospitals or in any other maternity service. In all*

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settings, the midwife remains responsible and accountable for the care she provides' (Midwifery Council of New Zealand, 2010)

It is the expectation of LMC midwives, when the care of a woman and baby is handed over to the staff at a maternity facility for postnatal care, that the responsibility for the midwifery care is that of the maternity facility midwives when the LMC is not present. The expectation is that there is appropriate consultation between the maternity facility midwife who is responsible for looking after that woman and baby and the LMC midwife if and when there is a change in the status of either the woman or baby. In the situation where an emergency has occurred, the conversation with the LMC may often be retrospective as the focus of the staff will be on the wellbeing of the woman or baby during the process of dealing with the emergency, and the conversation with the LMC is that of informing/updating her/him with what has occurred once the emergency has been dealt with.

It is my opinion that while both [RM C] and [RM B] were responsible for ongoing care of [Baby A], there was no conversation or consultation between them after [RM C's] visit that morning. There was a brief update given to [RM C] at around 3.00 pm while she was engaged in providing midwifery care to another woman in labour regarding [Baby A] being cold and continuing to not be interested in feeding and that she ([RM B]) was going to consult the paediatrician. In light of this [RM C] had no way of knowing that [Baby A] had deteriorated throughout the day and the decision making in the midwifery care he received was therefore the responsibility of [RM B]. It is my opinion, that a phone consultation between [RM B] and [RM C] should have taken place when [Baby A] was first found to be not maintaining his temperature and was still not feeding at 1150. In not consulting [RM C], [RM B] is solely responsible for the decisions she made in the care she was providing [Baby A].

I agree with [RM D's] statement in her letter of 9 [Month10] paragraph 8 '*once he had difficulties feeding, and certainly once he continued to be cold, blood sugars should have been checked*'. However she goes on to say '*Importantly, decisions as to what should occur, including glucose tests ultimately rested with the LMC who determined that the tests were not required*.' From the notes I have reviewed, I cannot find any discussion about blood sugars level for [Baby A] other than the initial question asked when [RM C] transferred [Baby A] and [Mrs A] to the postnatal ward and handed over care to the Birthcare staff and at this time there was no apparent problem. From what I can determine, [RM C] was not involved in the decision making process about [Baby A's] care after her visit at 9.40 am on the morning of the 25th [Month1], other than a brief update at 3.00 pm, while she was busy with another woman and it was during this time that [Baby A's] condition appeared to be deteriorating.

The documentation reflects that there was no consultation between [RM B] and [RM C] about the deteriorating picture that developed during the day of the 25th [Month1], in particular after [Baby A] was found to have dropped his temperature during the morning. It would appear from the notes I have reviewed that in fact there was no recognition of [Baby A's] deterioration prior to around 3.00 pm. While an LMC is

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responsible for the overall care planning for the woman and baby during a postnatal stay, the responsibility for the provision of care lies with the midwife who is actually providing the care and is present at the time. If a core midwife is unhappy with the care prescribed by the LMC there is the option of escalating the concern to senior staff, usually the clinical charge midwife or clinical co-ordinating midwife.

I note that the core midwives on the ward that day were caring for 6 women each, including the co-ordinating midwife and it was a very busy day with significant acuity. In the provision of care on a maternity postnatal ward, babies are not counted as separate from their mothers. This means that although the midwives were looking after 6 women each, in fact they were responsible for 12 people. With the co-ordinating midwife needing to take on a patient load herself, (which is a common situation within maternity facilities at this time) it is not possible for her to then be fully aware of what is happening in the broader sense on the ward. I recognise that this may well have contributed to this tragic situation for [Baby A] and his whānau.

Mary Wood
Midwife Expert Advisor, April 7th 2021

References:
NZCOM Consensus Statement: Roles and Responsibilities in the Hospital Setting
NZCOM Handbook for Practice
Midwifery Council of NZ: Standards of Clinical & Cultural Competence & Conduct 2010"

The following additional midwifery advice was obtained from RM Woods:

"***Addendum:***
[Mrs A] had her first scan to determine her dates on [date]. This scan indicated fetal measurements that gave a gestational age of 18 weeks 1 day (+/- 10 days). This EDD was confirmed two weeks later … when her anatomy scan demonstrated 'appropriate size for gestational age of 20 weeks and 2 days' which was consistent with the initial scan. I agree that without an early scan to determine precise dates, the EDD that was used may not have been exact. However it is my opinion that the majority of midwives would have relied on the given EDD that was indicated in both of these scans and would have used this EDD, together with [Mrs A's] clinical growth during her pregnancy, to determine the appropriateness of [Mrs A] birthing at Birthcare, and would have been happy to deliver at Birthcare in this instance.

[Mrs A] did not have a history of having SGA babies, her first two children had been born at 37 weeks gestation and had birth weights of 3100 grams and 2900 grams, both of which are healthy weights for this gestation.

[RM B] comments in regards the possibility that [Mrs A] was earlier than 37 weeks, '[Mrs A] should not have delivered the baby at Birthcare: they should have been transferred to Birthcare from [the public hospital] only if things had gone well:'

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Had [Baby A] been born at [the public hospital], given the normality of his clinical presentation at that time, (his birthweight, his behaviour following birth especially regarding breastfeeding and his temperature) [Mrs A] and [Baby A] would have been transferred to Birthcare for their postnatal in hospital stay.

[The DHB's] policy would have been for [Mrs A] and [Baby A] to be transferred to Birthcare from Delivery Suite following the birth given [Baby A's] clinical presentation following his birth and this would have taken place 2 to 4 hours after his birth.

It is my opinion that [Baby A's] place of birth was not a determining factor in what occurred on 25 [Month1].

Transfer to Birthcare within 12 hours. ([DHB] document)

Primary Births

Women who have had a vaginal birth and who are well should (as per transfer agreement) usually transfer to Birthcare within 12 hours of the birth. Ideally the mother and the baby should transfer directly from Labour and Birthing Suite usually within 4–5 hours.

Contact the shift co-ordinator at Birthcare: phone 374 0800 to clarify if there are concerns. Non-eligible women will be required to pay the full Birthcare schedule of fees (not subsidized by the DHB) on arrival for the planned length of stay. Refer women to Birthcare for further information.

- It is the LMC's responsibility to organise the woman's transfer to Birthcare. This includes prescribing pain relief. The LMC is responsible to ensure the woman is informed of the necessity for a suitable infant car restraint for the transfer home or to Birthcare.

- If handover to secondary care has occurred, the team is responsible to ensure follow-up arrangements are in place and ACC documentation completed before transfer back to primary care occurs (e.g. for 3rd degree tears).

Birthcare accept women with the following:

- Intravenous luer
- Intravenous antibiotics (3rd degree tears)
- Urinary indwelling catheters
- Third and fourth degree tears (requires planned follow-up clinic appointment) (physiotherapy service on site at Birthcare)
- Maternal Mental health Service care
- Gestational diabetes (diet and insulin)
- Essential hypertension with no added complications.
- Multiple births
- Postpartum haemorrhage with a subsequent stable clinical assessment

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- Adoption mothers for parent craft
- Hepatitis B positive
- High BMI with no other complications

Birthcare accept babies with the following:

- Large for dates glucose monitoring, after first normal blood sugar
- Babies of gestational diabetic mothers following first normal blood sugar
- Babies born with intrauterine growth retardation (>2400gms)
- 36 weeks gestation requiring extra monitoring following normal blood sugar and neonatal assessment

NB. Babies who are likely to need paediatric supervision need to be discussed with a paediatrician before they are transferred to Birthcare.

A private paediatrician can facilitate transfer and review at Birthcare

NB. Women who have had:

- An epidural for safety reasons should be observed 4 hours from the last epidural top up or following a PCEA after the last self-administered dose
- An instrumental birth (forceps or ventouse) may be transferred within 12 hours

In his letter (11/06/21) [Birthcare's lawyer] comments that 'it would also have been helpful if [RM C] had recorded on the Birthcare neonatal record whether there was vernix present on examination of [Baby A] at the time of the birth examination. This could have assisted in helping determine [Baby A's] birth gestation as being less than 37 weeks.

While it is very often seen in preterm babies, vernix is present on many babies at birth, even post dates babies can present with vernix. It is not in my experience a reliable indicator of gestation.

[Birthcare's lawyer] comments that it is unlikely that [Baby A's] birth gestation was 37 weeks 1 day and has asked me to revisit my opinion on this.

While [Mrs A] had not had an early scan to determine exact dates, she did have two antenatal scans (18 and 20 weeks) that were both consistent with the EDD being [date]. She had a history of birthing at 37 weeks twice before and did not have a history of small for gestational age babies. [Baby A] was a good size for a baby of 37 weeks, in that his birth Centile (although not documented in the clinical notes as it was not required at that time at Birthcare) was in fact 19.6. [Baby A's] behaviour was consistent with his gestation being over 37 weeks in that the documentation from all of the midwives who interacted with him during that first day described a baby that was able to latch to the breast effectively, that audible swallows were heard during feeding, that he had normal tone and responsiveness for a term infant. There were no notes that I could find that were

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consistent with him being a significantly preterm infant. Generally, babies who are born earlier than 37 weeks often are unable to latch to the breast effectively as their sucking reflex can be still somewhat immature, although some early babies do latch well even at 35 to 36 weeks.

[Birthcare's lawyer] comments that I do not take into account the statement made by [RM B] on 02/10/19 regarding a conversation she held with [Mrs A] about the accuracy of the dating scan and [Baby A's] gestation. In considering this statement however, [Mr and Mrs A] give a completely different version of this conversation and recall the conversation being in a completely different context. They deny having any concerns that the dating scan was inaccurate nor being concerned that [Baby A] was born earlier than 37 weeks. The comments about [Baby A's] feeding behaviour was in the context of his behaviour on 25 [Month1].

In a later statement [RM B] comments 'I was not aware of the possibility that [Baby A] could be a pre-term baby' ([2020]).

It is my opinion that the EDD giving [Baby A] a gestational age at birth of 37 weeks 1 day would have been regarded as reliable by the majority of practitioners.

*Serial Blood Sugars:

Hypoglycaemia in the neonate ([DHB] document)

How long to monitor

If feeding well — at least 12 hours (i.e. 3 normal blood glucose measurements)

Any recorded hypoglycaemia — at least 12 hours after last low level

Consider monitoring for longer or recommencing monitoring if there are new clinical concerns, and request paediatric review.

Notify the neonatal paediatric service if the blood glucose is < 2.0 mM at any stage.

Management Algorithm

1. Continue monitoring blood glucose concentrations until three consecutive blood glucose concentrations have been > 2.6mM
2. Notify the neonatal paediatric service if the blood glucose is <2.0 mM at any stage.

The LMC had not required Serial blood sugars to be done on [Baby A] in the immediate 12 hours after his birth, based on her clinical judgement that he was a good birthweight for 37 weeks, and he had behaved normally after his birth, in that he was vigorous, had breastfed well and was warm. [RM C] asked for [Baby A] to be given routine postnatal care, including assistance with establishment of breastfeeding and ensuring good (urine) output.

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[RM C] states that when she transferred [Mrs A] and [Baby A] to the postnatal ward at 0200 on 24 [Month1] she did not ask for routine serial blood sugars to be done but rather told the core midwife [RM F] to use her clinical judgement. Although [RM F] doesn't refer to this in her statements the conversation is confirmed by [Ms M] who was a third year midwifery student working with [RM C] at the time and was present when this conversation took place.

[RM F], who provided the midwifery care until 0700h when the shift changed and the midwifery care was taken over by [RM G]. [RM G] details a conversation with the LMC and student midwife during this shift where the LMC refers to [Baby A] as being over 37 weeks and weighing over 2.5kg. (Rather than 2.8 kg.)

[RM G] states that the lower weight limit (for SBG monitoring) had been 2.5 kg but had been changed to 2.8kg at some stage but was unsure when.

Neither of the Midwives who were providing care for [Mrs A] and [Baby A] during the morning and afternoon of 24 [Month1] describe any concerns with [Baby A's] behaviour or feeding. The midwifery care was then handed over to [RM I] and then to [RN J] at 2245 that night.

Although the serial blood glucose had not been done in the first 12 hours, the midwives involved in [Baby A's] care throughout the morning and day of 24 [Month1] describe him as behaving normally, feeding as expected for a baby of his gestation and giving no indication that he was unwell. [RM I] states that there was no indication for a random blood glucose throughout this first day. [RN J] describes [Baby A] as being pink and warm, alert and vigorous. His urine output had been normal. She describes him as being mucousy and I would agree with her comment that mucousy babies often do not feed well. She goes on to describe that there were no clinical signs of hypoglycaemia, that he was pink, warm and alert nor were there any signs that he was clinically unwell during her shift which ended at 0700 on 25 [Month1].

However, [Baby A] had not been latching well overnight and as I stated in my initial report, with the benefit of hindsight, given that he was only just term, this was a warning sign. When reviewing an event such as this, one is looking at the whole picture at once and the outcome is known, but in reality these situations unfold gradually. As such, I reiterate it is with the benefit of hindsight that by around 0930 on the morning of 25 [Month1] a random blood sugar would have been advisable. It was during this time that the indicators for possible hypoglycaemia were beginning to appear. However, although some midwives may have performed a RBG at this time, the focus here was on getting [Baby A] to improve his intake. A plan was put in place for 2 to 3 hourly feeds together with top ups of expressed colostrum. This was appropriate and although it would have been wise, I do not consider that not performing a RBG at this time was an error.

[Birthcare's lawyer] comments on my referral to the conversation that occurred between [RM C] and [RM F]. I was referring to the initial handover conversation that took place on the morning of 24 [Month1]. [RM F] states that [RM C] specifically

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declined SBG but [RM C] denies that she gave a specific direction for no blood sugar to be done but rather advised the core midwife ([RM F]) at handover, to use her clinical judgement. This conversation took place in the presence of [Ms M], who confirms the details of the conversation.

There is a distinction between serial blood glucose (SBG) and random blood glucose (RBG) in that SBG are done during the first 10 to 12 hours after birth, initially 1–2 hours post birth and then 3 hourly with subsequent feeds as a screening tool, until there have been 3 consecutive normal blood glucose recordings. RBG are done to check a baby's blood glucose level when there has been a specific event such as hypothermia that may have impacted a baby's blood glucose level, or when a baby is showing signs that may be indicative of low blood sugars. [Baby A] did not show signs that there was a problem until he was over 24 hours old. It is my opinion that SBG done during his first 12 hours of his life was unlikely to have made a difference to the later events.

Hypoglycaemia in the neonate ([The DHB])

How long to monitor

If feeding well — at least 12 hours (i.e. 3 normal blood glucose measurements)

Any recorded hypoglycaemia — at least 12 hours after last low level

Consider monitoring for longer or recommencing monitoring if there are new clinical concerns, and request paediatric review.

Notify the neonatal paediatric service if the blood glucose is < 2.0 mM at any stage.

Management Algorithm

1. Continue monitoring blood glucose concentrations until three consecutive blood glucose concentrations have been > 2.6mM
2. Notify the neonatal paediatric service if the blood glucose is <2.0 mM at any stage.

I have now seen the retrospective note from [the] Midwife Lactation Consultant. This is a short undated statement where she recalls seeing [RM C] and student midwife ([Ms M]) come out of [Mrs A's] room in a frustrated manner and discuss [Mrs A's] reluctance to breastfeed [Baby A] as she had been advised.

[The lactation consultant] asked if she ([RM C]) wanted Lactation Consultant (LC) input but [RM C] declined. She doesn't specify what time this occurred but I assume from the documentation that it occurred around 0940 following her PN visit after [Mrs A] had requested to be discharged home. The notes record this visit but were made retrospectively at 1100 am that morning as [RM C] was in the process of attending another woman in labour and was busy. The core midwife ([RM B]) was in the room and present during the interaction when breast feeding had been discussed and [Mrs A] had been advised and encouraged to feed [Baby A] breast and expressed colostrum 2 to 3 hourly. [RM C] notes that [Mrs A] had been expressing overnight and was wanting to do

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this herself. [Mrs A] had an excellent breastfeeding history in that she had breast fed twice before for about a year each time. She had been offered help by the midwives who had been caring for her and [Baby A] and she had been somewhat reluctant to hand express. From the notes I have reviewed, it was not that [Baby A] was unable to latch but rather had become fussy and was becoming sleepy and refusing the breast during the early morning of 25 [Month1]. [The lactation consultant] may have been able to offer further advice than what the midwives were already offering but it is unclear whether this would have made any difference to the events of later that day.

I maintain my opinion that not performing a RBG at 1150 when [Baby A] dropped his temperature was a moderate departure from acceptable standard of care. While there were warning signs earlier that morning that his feeding was inadequate and he was becoming lethargic, given the overall picture that was unfolding, this temperature drop at 1150 was a clinical indication. Placing [Baby A] skin to skin and initiating further feeding were both appropriate actions but a RBG should have been done while he was skin to skin at this time in my opinion.

[Birthcare's lawyer's] letter states 'there was no indication that [Baby A] was sleepy at this time between 1150 and 1230' but the clinical notes record '1230 Tried to latch baby on with assistance but *still* very sleepy+++'.

[RM B] writes in the clinical notes at 1150 'Also baby not interested at all in feeding' and a plan was then made to recheck his temperature in 30 mins (after being placed skin to skin). At 1230 [Baby A] was given 0.8 ml of expressed colostrum.

At 1350 the notes record that the baby was awake but does not note that the baby fed at that time. [RM B] notes that she advised [Mrs A] that [Baby A] needed to be woken to feed again at 1500 and be offered expressed colostrum again at 1530 if he does not latch at that time. At 1500 [RM B] notes that [Baby A] was still asleep and she advised to let him sleep a bit longer and try hand expressing again. At 1525 he was noted to be bluish and still very sleepy, at which stage [Dr L] was consulted.

I am unsure how [Birthcare's lawyer] concluded that there was no indication that [Baby A] was sleepy between 1150 and 1230.

In reference to [Birthcare's lawyer's] comments under [RM C's] and Birthcare's communication and cooperation:

My comments were referring to the lack of communication between [RM B] and [RM C] *after* the 0940 LMC visit. It is my opinion that a consultation should have happened at 1150 after [Baby A] was found to continue to be lethargic and had dropped his temperature.

In the comments in [Birthcare's lawyer's] letter regarding Birthcare's busyness, it is noted that there were 15 discharges on the morning of 25 [Month1] which in my experience would have meant the midwives were extremely busy during the course of that morning. [RM K] in her statement ([2020]) notes that the six midwives (including

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herself) were rostered on that day, and were providing care for 36 women that morning. Six women and six babies each together with 15 discharges that morning in my experience would have made for an extremely busy morning. I am not meaning this to be a criticism of Birthcare but just a statement of fact that can give some context to the situation that was playing out during the course of the morning of 25 [Month1].

[RM B] makes comment on my opinion regarding the failure to use the pulse oximeter to monitor [Baby A's] oxygen levels when she noted him to be 'bluish'. I agree that being cold is not a reason to apply an oximeter but being cyanosed (blue) is. It is my experience that the only reason a baby would appear 'bluish' would be if his oxygen levels were impaired and this in my opinion called for immediate action.

[RM C] refers to [Baby A's] blood sugar levels as having been 0.6 in her statements. [Mr and Mrs A] write that [RM B] told them that [Baby A's] blood glucose was too low to register. I am assuming that 0.6 [RM C] refers to was what his blood glucose was on arrival at NICU.

[The public hospital's] document 'Hypoglycaemia in the neonate' Management Algorithm advises if Blood glucose < 1.2 mM 'Consider giving 0.5ml/kg oral 40% dextrose gel while arranging admission' (to NICU).

I have not changed my opinion that not administering Oral Dextrose Gel to [Baby A] immediately upon finding his blood glucose was dangerously low was a departure from acceptable standard of care.

Mary Wood
Expert Midwifery Advisor
25 July 2021"

Additional midwifery advice was obtained from RM Wood:

"*1.Please clarify whether you consider there were any departures from accepted practice in your original advice on '[Baby A's] transfer to hospital' (pg 6) especially:*

A) No recordings of vitals prior to transfer

The Birthcare 'Transfer of a Critically Ill Neonate' document identifies current status, including vital signs as essential information required in arranging a transfer of a critically ill infant, and that time of departure and baseline observations on the baby are to be taken prior to transfer, as well as the documentation of observations taken during transit. [Baby A] was already known to be a seriously ill baby as his blood glucose recordings done at Birthcare had demonstrated a blood glucose level too low to register. While [Baby A's] temperature had been monitored during the afternoon I can find no reference to any other recordings being done either during the afternoon or prior to his departure in the ambulance, other than his blood glucose.

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It is my opinion that failing to perform vital signs prior to his transfer was a significant departure from accepted practice and would be considered serious given this particular situation.

B) Recordings indicating compromise but it does not appear that this was recognised by either midwife or paramedic (Comment only on midwife)

In her statement [RM B] states that the paramedic placed a pulse oximeter on [Baby A] when he was placed in the ambulance and his oxygen saturation was noted at that time by [RM B] to be 87 to 88% but his heart rate was normal. However in her retrospective note she states his heart rate was around 170 bpm. Neither of these recordings are normal and in my opinion should have alerted [RM B] that [Baby A] was requiring further help, such as oxygen administration and monitoring of his respiration rate. When [Baby A] collapsed the oximeter was removed by the paramedic in order to remove him from the transport incubator to commence CPR. In my experience the oximeter should not have needed to be removed but rather the lead which would (normally) have been attached to [Baby A's] right hand or wrist and plugged into the oximeter, could have been unplugged from the oximeter and simply plugged in again once he had been removed from the incubator. This is something [RM B] could have done, or she could have asked the paramedic to replace the oximeter once [Baby A] had been removed from the incubator.

As discussed in my original opinion, the purpose of the midwife accompanying a baby (or woman) as an escort during a transfer to hospital in situations such as this, is for the express purpose of monitoring the ongoing status of the baby (or woman) and recognising and responding to any deterioration quickly. In describing the events during [Baby A's] transfer, [RM B] writes in her response letter of 30/05/21 'He did not show seizure-like movements. [Baby A] was sleeping, then he just cried loudly and his skin became pink again'. There is no comment regarding what colour [Baby A] was prior to this however. The paramedic clearly describes [Baby A] demonstrating seizure activity prior to his collapse ([Baby A's] head and neck were arched back and he was displaying rhythmic twitching movements).

[RM B] noted [Baby A's] recordings and his apparent deterioration during the ambulance transfer (the fluctuations in his colour, his low oxygen saturations, his tachycardia and his unresponsiveness) but did not respond as would have been expected. It appears from reading the documentation that she did not recognise the seriousness of his condition until his collapse. It was [RM B's] responsibility to monitor [Baby A] during the transfer and liaise with the attending paramedic throughout.

It is my opinion that this failure to recognise and respond to [Baby A's] deteriorating condition was a serious departure from accepted practice in this situation.

2. Evaluating the policies/procedures in place and what is known to have occurred from the clinical notes and statements, whether the process of arranging ambulance transfer for [Baby A] was appropriate.

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The Birthcare policy 'Transfer of a Critically Ill Neonate' appears clear, succinct and easy to follow. After the second phone consultation with [Dr L], [RM K] (the shift coordinator) appropriately arranged for an urgent ambulance transfer while [RM B] prepared [Baby A] and [Mrs A] for the transfer. Other Birthcare staff members made the appropriate phone calls required in this situation and photocopied the relevant documentation that would be accompanying [Baby A]. In an emergency situation such as this, the staff are under some pressure to get everything organised quickly prior to the ambulance arriving and it is usual in my experience for a number of staff to be involved.

However, in not recording [Baby A's] vital signs prior to the transfer the policy was not adhered to.

3. Resuscitation in ambulance

a) Adequacy/appropriateness of [RM B's] role during resuscitation.

[RM B] retained the responsibility for monitoring [Baby A's] ongoing condition during his transfer to hospital as would be usual in situations such as this. As discussed already [RM B] did not appear to recognise [Baby A's] deterioration and seems to have been confused about her role and responsibility during the transfer.

[RM B] describes feeling unsupported throughout this time. ('I felt I had to do everything myself and at the same time'.) Her comments in her statement ([2020]) page 13 (f) 'I simply followed the Birthcare policy, and accompanied the family in the ambulance' suggests to me that she did not understand that it was her responsibility, as the escort, to provide care for and monitor [Baby A's] wellbeing during the transfer, rather than just to accompany the family, and that the ambulance staff were there to assist her in that if required. [RM D's] letter ([2020]) states 'it is normal practice for a midwife to retain responsibility for a mother or baby during an ambulance transfer to the hospital. This has been [the ambulance service's] rules for several years. The midwife should request support and assistance if needed'.

There are differing descriptions of the resuscitation given by [RM B] and the attending Paramedic:

[RM B] describes the paramedic applying the pulse oximeter and the ECG leads to monitor [Baby A's] heart rate and oxygenation saturations. The Paramedic states that only the oximeter was placed on [Baby A], not ECG leads. The oximeter would normally be used as this equipment monitors heart rate as well as oxygenation and would have been sufficient to do this. [RM B] describes trying to stimulate [Baby A] with vigorous back rubbing when he became unresponsive and floppy and being handed a disassembled ambu bag by the paramedic and being asked to start ventilation. She also describes commencing CPR and asking the paramedic to ventilate [Baby A] with the ambu bag.

[RM B's] description is that she was left to manage [Baby A's] sudden collapse and resuscitation unsupported by the paramedic, that she was handed an unassembled

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ambu bag and left to commence monitoring [Baby A's] respiration and heart rate, apply positive pressure ventilation and chest compressions by herself. In this situation [RM B] was leading the resuscitation and as such should have been directing the paramedic as to what actions she wanted her to undertake, with chest compressions or ventilation.

I would consider [RM B's] actions in this situation to be a mild departure from expected standards.

The paramedic's description differs, in that she describes intervening as soon as [Baby A] began demonstrating apparent seizure activity prior to his respiratory and cardiac arrest. Her description is that [RM B] did not request support, but did not appear to recognise the seriousness of [Baby A's] condition nor his deterioration and the apparent seizure activity prior to his collapse.

The paramedic's description is that [RM B] did not recognise [Baby A's] collapse nor respond appropriately which led her to take over the lead role in managing the resuscitation and direct [RM B] to monitor [Baby A's] heat rate and commence chest compressions, but that [RM B] did not appear to understand and instead started applying back blows.

She describes handing the ambu bag to [RM B] and states it was not disassembled but rather just needed the mask attached. (This would be normal as the masks vary in size depending on the size of the baby, so in some situations the appropriate mask would not be attached until needed.) The paramedic describes instructing [RM B] to commence chest compressions after she had removed [Baby A] from the transport incubator while she administered oxygen and airway support but that [RM B] did not appear to understand and instead began back slaps in an attempt to stimulate [Baby A].

In this situation I would consider [RM B's] actions would be considered a serious departure from expected standards of practice.

It has been my experience that in situations such as this, the midwife escort takes the lead in monitoring the baby but works in close liaison with the paramedic and seeks support as required if the situation is deteriorating. From reviewing [RM B's] descriptions of the events in the ambulance it is my opinion that she did not monitor [Baby A] appropriately nor react appropriately to the situation that developed during the transfer.

Overall, the documentation describes a somewhat confusing description of the events in the ambulance and I am unable to comment on which description most accurately portrays the situation as it unfolded.

b) Adequacy/appropriateness of [RM B's] resuscitation techniques:

[RM B] describes administering vigorous back rubs to stimulate [Baby A] after his collapse. [Baby A's] heart rate had been 170 bpm prior to his collapse, the pulse oximeter was removed to facilitate his removal from the transport incubator and was not put back on. [RM B] states that after the oximeter had been removed she asked the paramedic to commence ventilating [Baby A]. [RM B] describes asking for a stethoscope

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(to listen for [Baby A's] heart rate) and feeling for a brachial pulse which is appropriate, but she goes on to say 'At some point I started CPR as I had no indicator of [Baby A's] heart rate due to the ECG lead being taken off. I asked the ambulance officer to ventilate [Baby A] using the ambu bag.'

Applying back rubs or back blows to an unresponsive baby who appears to be in cardiac and respiratory arrest is inadequate. Rather the baby should be positioned so as to open his airway, ventilation immediately commenced (with oxygen depending on his heart rate) and if his pulse is absent, or low then immediate chest compressions should then be commenced.

NZ Resuscitation NLS Algorithm

The NLS Algorithm defines a step by step guide to the management of a resuscitation of a babe, which in this situation would have required:

Open airway (positioning)
Stimulate
Assess respiration and heart rate
Commence positive pressure ventilation
Commence chest compressions

These steps would normally be undertaken almost simultaneously so as to ensure effective resuscitation was taking place as soon as possible and would have needed both the midwife and paramedic working together.

It is my opinion that [RM B's] resuscitation techniques were inadequate in this situation, however I appreciate the difficulty and extreme stress of managing a situation such as this in the back of a moving ambulance. The journey from Birthcare to [the public hospital] is very short, and in fact took only 6 minutes according to the documentation so these events occurred over only a few minutes.

I would consider [RM B's] actions to be a moderate departure given the situation that was presenting itself at that time.

Other comments

a) Consider whether there are any standards or guidelines that would support your advice and include these as well.

New Zealand Resuscitation Council Guidelines: Newborn Life Support (NILS) Algorithm.
https://www.resus.org.nz/assets/Guidelines/Newborn-Life-Support-Jan-2016.pdg

b) If there are any recommendations you consider would be appropriate for the midwife or Birthcare to consider, we would be grateful for your advice on this too.

I have no other comments to make.

Mary Wood, Expert Advisor
August 2022"

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Appendix C: Independent paediatric advice to Commissioner

The following advice was obtained from paediatrician John Doran:

"My name is John Doran and I am a practising General Paediatrician currently working as a consultant in Taranaki Base Hospital where I have been in post since October 1991.

I qualified MBChB (Otago) in 1978, gained a Diploma Child Health (Lon) in 1982 and completed my general paediatric fellowship training in 1990 (FRACP).

I have reviewed the HDC's Guidelines for Independent Advisors.

This response is based on the documents provided by the office of the HDC which include:

1. Letters of complaint dated 25 [Month10] and [2021]
2. [Dr L's] response dated 1 [Month11] and [2021]
3. Retrospective note dated [2021]
4. [RM B's] response dated [2020]
5. [Baby A's] Birthcare clinical notes

I was specifically asked to consider the care provided to [Baby A] by [Dr L] and in particular

1. The appropriateness of the advice provided to [RM B] by [Dr L]. To consider both recollections alongside the clinical documentation and if advice differed depending on whose recollection HDC favoured provide advice in the alternative
2. The adequacy of [Dr L's] documentation
3. Any other matters in this case that warrant comment

Response
My initial comment is that there are clearly two different versions of what occurred presented in the documentation and correspondence particularly in relation to the advice given. I base my response on what has been written in the clinical notes. I also note that [Dr L] was not on duty or on site at the time he was contacted.

Phone call 1:
In response to the first telephone call the advice to check a blood sugar was appropriate and would be standard response to this situation. It is not possible to comment on the clinical information offered or sought as there is disagreement about the content and the clinical documentation (maternity notes and [Dr L's] retrospective note) is brief.

Phone call 2:
Again the documentation is brief but the random blood sugar is 'low' and therefore [Baby A] requires glucose. All current protocols would recommend Dextrose gel as first line followed by milk, either breast milk if sufficient available or formula milk if not and

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this would be the expected standard of care. The other point to make is that if the reading is 'lo' there is urgency in treating and hence the importance of dextrose gel.

[Dr L's] retrospective 'note' and written responses state that is what he recommended, which differs from [RM B's] documentation in the clinical maternity notes. I am unable to judge these differing views.

If the HDC favoured the recollection of [RM B] then [Dr L's] advice is incomplete as oral Dextrose gel would be the first part of the management of hypoglycaemia of the newborn, especially where the capillary blood test recording is indicating a 'lo' reading, as it is more rapidly acting in reliably increasing the blood sugar. It is applied directly and is not dependent on the baby ingesting and metabolising the milk (human or formula).

If the HDC favoured the recollection of [Dr L] then [RM B] has failed to give Dextrose gel.

An additional part of the advice if the baby had both gel and milk should be to repeat the blood sugar 30 minutes after the Dextrose gel to ensure the expected response has occurred. I do not see that advice given nor any evidence that a follow up blood sugar was done while [Baby A] was at Birthcare.

I have not seen the Birthcare protocol for management of Newborn Hypoglycaemia but if it is consistent with other similar protocols, e.g. Starship Child Health Newborn Intensive Care Guideline, then a follow up blood sugar would be part of that.

I note that from his note and written response [Dr L] does not direct [RM B] to follow the institutional protocol or to check a blood glucose 30 minutes after dextrose given and if it had not been given blood sugar level should definitely have been repeated to understand what was happening before ambulance arrived.

I think this is a departure from accepted standards BUT really this should be a very protocolised action so that anyone giving dex gel or treating hypoglycaemia should know to check the glucose level after a period of time so would consider it only a minor departure.

Phone call 3:
The advice to arrange transfer to NICU is appropriate. The hypoglycaemia required urgent management and if that was not possible in Birthcare then [Baby A] needed to be retrieved/transferred expeditiously.

Neither of the clinical documents indicates what the priority of that transfer should be. It does not appear that [Dr L] gave any additional advice nor checked to see if Dextrose gel had been given, only having the information that [Baby A] had not fed ('can't feed'). He also comments that 'BS still very low' in his retrospective notes (3) but from the clinical documents in the maternity notes I cannot identify that there has been a repeat blood sugar.

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My understanding of the clinical notes is that a capillary blood sugar was done by [RM B] and then repeated immediately to verify the initial 'Lo' reading which would be a typical practice to rule out technical errors causing the first 'Lo'.

I am unable to see from the documentation whether or not advice was given by the NICU contact to repeat the Dextrose gel or recheck the blood sugar on receiving the transfer request and this represents a lost opportunity to optimise [Baby A's] treatment.

I consider that although the advice was appropriate it was very minimal in content as judged from the documentation and would be below expected standard.

I would consider this minor because it is clear that the desired action is referral to [NICU].

Adequacy of [Dr L's] documentation:
If this is in relation to [Dr L's] retrospective handwritten note, I am uncertain of the context of the note and where it is filed. It does not appear to be a part of [Baby A's] clinical file nor of his mother's maternity notes and therefore I assume it is a brief personal note/reminder for himself regarding the conversation the previous day and not part of a set of clinical notes. In this case it cannot be seen as a clinical document but a memo.

If it does represent clinical documentation it is dated but not timed or signed. Additionally the information is minimal and lacks key clinical information such as the gestation, birth weight and age of [Baby A] as well as feeding history and other basic clinical information such as temperature, heart and respiratory rate, notwithstanding it was written retrospectively. As a clinical document it would be below expected standard of documentation and a moderate departure from accepted practice.

I acknowledge the reason why it was written in retrospect given that [Dr L] was off site off duty at the time of the phone calls.

Other comments:
I have not viewed the newborn guidelines used in Birthcare and do not have an understanding of the lines of responsibility in relation to patient care. Once a problem is identified then it is important what the next steps in solving that problem are. In this case it appears to have been to contact the Paediatrician 'on call', although it is not clear that there is such a designated role for Birthcare as a unit but an ad hoc agreement with a number of different private Paediatricians including [Dr L].

By accepting the phone calls and continuing to give advice [Dr L] accepted responsibility for maternity advice even though he was 'off duty'. He did indicate this position to [RM B] but still gave advice on each occasion phoned rather than recommending communicating concerns with another available Paediatrician or [NICU] until recommendation to transfer at third phone call.

I understand that he was trying to be helpful and give advice though not 'on call'.

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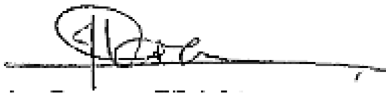
Birthcare should have a very clear 'roster' or similar so communication lines are clear.

I am sure there would have been a Birthcare guideline or protocol relating to the identification and management of Newborn Hypoglycaemia as this is a very common and important problem even in term newborns. As it is common the expectation should be that all staff caring for newborns would be familiar with this policy and therefore the early use of Dextrose gel to manage hypoglycaemia and its follow up. I do not see evidence of that from the actions described.

I hope that this response answers the questions posed and I am happy to clarify further if there are any specific areas of uncertainty.



John Doran, FRACP
Paediatrician
22/11/2021"

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