HEALTH & DISABILITY COMMISSIONER
TE TOIHAU HAUORA, HAUĀTANGA

Midwife failed to monitor baby appropriately following birth

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1. On 26 May 2022, Te Tatau o te Whare Kahu | Midwifery Council (the Council) notified the Health and Disability Commissioner (HDC) of concerns relating to the care that Ms A and her son, Baby A, received from registered midwife (RM) B in August 2019. Sadly, Baby A died shortly after he was born as a result of the events outlined in this report. I extend my sympathies to his whānau for their loss.

Information gathered

2. In August 2019, Ms A presented to the birthing facility at week 38 of her pregnancy. She gave birth to Baby A by vaginal delivery at 11.16am with no complications. Baby A was healthy, with APGAR scores[1] of 10 at one minute and five minutes of age. Baby A was placed on his mother's chest for breastfeeding and skin-to-skin contact.

3. Ms A sustained a second-degree perineal tear[2] during labour, which required suturing. The midwife who had been assisting during labour left the room following the birth of the placenta. Ms A's partner, Mr A, also left the room to make a phone call.

4. According to Ms A, RM B briefly left the room to collect equipment for suturing, returned, and checked Baby A before she began perineal suturing. Suturing began at 12.05pm, and RM B estimated that the procedure was completed between 12.20pm and 12.25pm. Ms A was provided Entonox (nitrous oxide) gas for pain relief. For the duration of the procedure, Baby A lay skin-to-skin with Ms A. From her position at the end of the bed, RM B was unable to see Baby A's face while she was suturing.

5. RM B said that she recalled checking with Ms A twice during the procedure about Baby A's condition – if he was warm enough and what he was doing – to which Ms A replied that he was warm and that he was sleeping.

6. Action to Improve Maternity (AIM)[3] responded to the provisional opinion on behalf of Baby A's whānau, stating that RM B should have made her own observations of Baby A's condition, noting that it was inappropriate to rely on Ms A's opinion as she may have been experiencing side effects from Entonox gas.

7. AIM stated that Ms A's line of sight to Baby A was obstructed by the mask she was wearing to receive the Entonox gas. AIM also advised that, during perineal suturing, women are

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[1] Standing for 'appearance, pulse, grimace, activity, and respiration', the APGAR score is a standardised assessment used to measure the health of a newborn baby at one and five minutes of age. The criteria provide a score out of 10, with results from seven to 10 considered normal, whereas lower scores may indicate the need for urgent medical care.
[2] A tear to the tissue between the vaginal opening and the anus.
[3] AIM is an organisation that seeks to improve New Zealand's maternity system.

Names have been removed to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

usually required to lie flat on their back. This position would have further affected Ms A's ability to closely monitor Baby A.

8. When suturing was completed, RM B briefly left the room to turn on the shower for Ms A. At 12.30pm, she lifted Baby A up to complete a full postnatal check. Upon picking him up, RM B realised that he was unresponsive and had stopped breathing. Efforts were made to resuscitate Baby A but were unsuccessful. The Coronial post-mortem report found that the probable cause of Baby A's death was accidental asphyxiation. I again extend my sincere condolences to Baby A's whānau for this tragic and unexpected outcome.

9. The Ministry of Health's guidelines, *Observation of mother and baby in the immediate postnatal period: consensus statements guiding practice July 2012* set out the following recommendations for all practitioners supporting mothers and babies in the immediate postnatal period:

- 'All mothers and their babies must receive active and ongoing assessment in the immediate postnatal period, regardless of the context around their birth. During this time, the mother and baby should not be left alone – even for a short time.
- Ongoing assessment is for a minimum of one hour. Assessment will be longer than one hour if the mother or baby has experienced factors that increase their risk of adverse outcomes.
- Monitoring the baby's wellbeing includes ongoing assessment of the baby's colour, tone and respirations at all times, with particular care during periods of skin-to-skin contact. If there is any question about the baby's wellbeing, a full assessment should be carried out.'

10. As part of the coronial process, the Coroner obtained expert advice from a registered midwife and a neonatal paediatrician. Both advisors refer to the Ministry of Health guidelines (set out above) for the monitoring of mother and baby in the immediate postnatal period.

11. In the RM advisor's opinion, RM B followed the relevant guidance for the most part by remaining in the room (leaving only briefly to gather suturing equipment and to turn on the shower), checking Baby A immediately before suturing, and making verbal enquiries to Ms A about Baby A's condition during suturing. However, the RM advisor stated that, in retrospect, RM B could have removed Baby A from skin-to-skin contact while suturing, noting the absence of another clinician or whānau member in the room who was able to directly observe his condition for the duration of the procedure. Alternatively, RM B could have delayed suturing until someone else was available to oversee Baby A while the suturing was completed.

12. The neonatal paediatrician's advice concluded that closer observation of Baby A during the suturing procedure was warranted and may have informed RM B of his deterioration earlier. The advice also considers that RM B leaving the room on two occasions went against guidelines for the observation of mother and baby.

Responses to provisional opinion

13. Baby A's whānau was given the opportunity to comment on the 'information gathered' section of the provisional opinion. As stated above, AIM provided comments on behalf of Baby A's whānau. These comments have been incorporated into this report where relevant.

14. RM B was given the opportunity to respond to the provisional opinion. She advised that she accepts my decision and has provided a letter of apology for forwarding to Baby A's whānau.

Opinion: RM B — breach

15. Although this complaint raised several concerns about RM B's care (consultation with hospital/paediatric services, provision of adrenalin, emergency call button activation, and use of an oximeter),[4] the focus of the investigation is on the post-birth supervision of Baby A in August 2019. The other issues have been addressed separately with Ms A.

16. RM B accepted that she breached Right 4(1) of the Code of Health and Disability Services Consumers' Rights (the Code),[5] in that she failed to provide appropriate post-birth supervision for Baby A and Ms A.

17. The Ministry of Health's guidelines on post-birth supervision state that active and ongoing assessment must be completed for a minimum of one hour post-birth. This monitoring requires assessment of the baby's colour, tone, and respirations at all times. The guidelines also note that particular care must be taken during periods of skin-to-skin contact.

18. Baby A was born at 11.16am, and RM B began suturing Ms A at 12.05pm, within the minimum one-hour window for active monitoring. The procedure meant that RM B's attention was occupied, and she did not have a clear view of Baby A for approximately 25 minutes. Baby A lay in skin-to-skin contact with Ms A throughout this period. During the suturing, there was no other person in the room who could provide supervision of Baby A and Ms A.

19. I consider that RM B's practice departed from the Ministry of Health's guidelines when she chose to begin suturing during the one-hour window in which active supervision was required and without ensuring that Baby A was able to be actively monitored by herself or another suitable person. I acknowledge that, while she was suturing, RM B asked Ms A for two updates on Baby A's wellbeing, but I do not consider that this met the threshold for active monitoring as required by the guidelines, especially noting that particular attention is required during periods of skin-to-skin contact, as was the case at the time. While suturing, RM B was unable to directly observe and assess Baby A's colour, tone, and breathing. It would have been appropriate for RM B to remove Baby A from skin-to-skin contact for the duration of the procedure or to delay the suturing until another person was available to appropriately monitor him. I am therefore critical of RM B's failure to adhere to the guidelines for supervision of mother and baby following birth.

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[4] Device used to measure blood oxygen saturation and pulse rate.

[5] Right 4(1) of the Code states: 'Every consumer has the right to have services provided with reasonable care and skill.'

20. For the reasons outlined above, and with RM B's agreement, I consider that the failure to provide adequate post-birth supervision for Baby A and Ms A departed from acceptable standards of care and was therefore a breach of Right 4(1) of the Code.

Changes made since the events

21. The Council completed a Competence Screening Assessment and decided that RM B should undertake a competence programme.

22. In her response to HDC, RM B advised that she has retired from midwifery practice, and the Council has confirmed that she did not renew her practising certificate when it expired on 21 March 2022.

Recommendations and follow-up actions

23. In my provisional decision, I had recommended that RM B provide a formal written apology to Baby A's whānau for the issues identified in this report. In response to my provisional decision, RM B provided an apology for forwarding to Baby A's whānau. I therefore consider this recommendation complete.

24. Noting that RM B has retired and is no longer practising midwifery, I have no further recommendations.

25. A copy of this report will be sent to the Council.

26. A copy of this report, with details identifying the parties removed, will be sent to the New Zealand College of Midwives and placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

Rose Wall
Deputy Health and Disability Commissioner