Midwife, RM B

District Health Board

A Report by the

Deputy Health and Disability Commissioner

(Case 17HDC02110)

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

Contents

Executive summary

1. This report highlights the importance of LMC and core midwives working collegially and communicating effectively.

2. A woman's LMC midwife assisted her to deliver her baby at a public hospital, but following delivery the baby refused to feed and showed ongoing signs of respiratory distress, and the midwife observed meconium in the birthing pool and on the placenta. The midwife did not seek assistance from the core midwives or a paediatrician. When the baby deteriorated, the midwife did not activate the emergency bell or the call bell, but instead moved the baby to a resuscitaire[1] in the corridor. She left the baby on the resuscitaire, without medical supervision, while she sought assistance.

Findings

3. The Deputy Commissioner considered that the care provided by the midwife was deficient, and that she breached Right 4(1) of the Code.[2] The Deputy Commissioner was critical of the midwife's failure to seek support from the core midwives, and of her failure to escalate the baby's care to other medical staff when his condition deteriorated. She was also critical of her decision to leave the baby in the corridor without medical supervision, and her failure to convey the appropriate information to hospital staff when the baby was transferred to SCBU.

4. The Deputy Commissioner was not critical of the care provided by the district health board (DHB).

Recommendations

5. The Deputy Commissioner recommended that the Midwifery Council of New Zealand conduct a review of the midwife's competence, should she wish to return to practice, and that she apologise to the woman.

6. The Deputy Commissioner recommended that the DHB consider how its relationships with LMC midwives could be improved, and whether it is clear to LMC midwives that the resuscitaire is not to be used in the corridor.

[1] A resuscitaire is a machine that combines a warming platform with the components needed for a clinical emergency and resuscitation.
[2] Right 4(1) of the Code of Health and Disability Services Consumers' Rights states: "Every consumer has the right to have services provided with reasonable care and skill."

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Complaint and investigation

7. The Health and Disability Commissioner (HDC) received a complaint about the services provided by Registered Midwife (RM) RM B at a district health board.[3] The following issues were identified for investigation:

- *Whether RM B provided Baby A with an appropriate standard of care in 2017.*
- *Whether the district health board provided Baby A with an appropriate standard of care in 2017.*

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

9. The parties directly involved in the investigation were:

Ms A	Consumer
RM B	Midwife and Lead Maternity Carer (LMC)
The DHB	Provider

10. Further information was received from:

Midwifery Council of New Zealand (Midwifery Council)	
RM C	Midwife (core midwife)
RM D	Midwife (core midwife)
RM E	Midwife (core midwife)
Dr G	Resident Medical Officer (RMO)

11. Expert advice was obtained from HDC's in-house midwifery advisor, Nicolette Emerson, and is included as Appendix A.

Information gathered during investigation

Introduction

12. At 26 weeks' gestation, Ms A registered with RM B as her midwife and LMC.

13. This report concerns the care provided by RM B to Ms A's baby following his birth at the DHB.

[3] In 2017, the DHB completed a case review of the events outlined in this report and sent the report to the Midwifery Council asking the Council to follow up on the findings in the report. The DHB advised the Council that RM B's access agreement had been suspended and that it intended to complete a critical systems analysis. The Council referred the notification to HDC under section 64 of the Health Practitioners Competence Assurance Act 2003. HDC advised Ms A of the complaint, and Ms A said that she would support the investigation.

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Delivery

14. Ms A went into labour, and at 6.05pm she presented at the DHB. Ms A was at 39 weeks and four days' gestation. RM B met Ms A at the DHB.

15. Ms A was greeted by core midwife RM D, and was shown to a delivery room. RM D stated that she spoke to RM B and "informed her that she should let [her] know if she needed any assistance at all".

16. The labour was uneventful. At 8.34pm, RM B assisted Ms A to deliver her baby in the birthing pool. The Apgar[4] score at the time of birth was assessed as 9.[5]

17. RM B told HDC:

> "[Ms A's] baby was birthed in water and immediately brought to the surface. He was born in good condition but a little mucusy. I did not call a second midwife — events overtook me a little. I felt confident regarding the situation and was surrounded by supportive people and was aware staff assistance was just a call bell away (ie seconds)."

18. The baby was placed skin-to-skin with Ms A, and mother and baby were covered with towels.

19. Core midwife RM E was coordinating the Maternity Ward. She stated:

> "[Midwife] [RM B] was in the birth room and did not call for a second midwife at all throughout the evening while I was on shift.
>
> [RM B] entered the midwives office and documented on the whiteboard that she had birthed at 8.34pm, I checked my watch as I thought she had written down the wrong time as it was only 8.36pm, I asked [RM B] who advised that this is correct. [RM B] was then in and out of the office for the rest of my shift, at no stage did she ask for any assistance, I left the ward at approximately 11.45pm."

Events after delivery

20. At 9.00pm, Ms A and Baby A were assisted out of the pool and on to a bed so that the placenta could be delivered. RM B recorded in the Baby Notes: "Baby mucusy — clear — expected at [water]birth."

21. At 9.06pm, the placenta was delivered. RM B stated:

> "[I] left the checking of the placenta/whenua until later. [Ms A] was not bleeding so there was no urgency."

[4] The APGAR score is a test given to newborns soon after birth. The test checks a baby's Appearance (skin colour), Pulse (heart rate), Grimace response (reflexes), Activity (muscle tone), and Respiration (breathing rate and effort).
[5] A score of 8 to 10 is normal.

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22. At 9.30pm, RM B noted: "Offered breast — not interested. Good tone and pink. Sl[ightly] grunty[6] at times."

23. RM B told HDC:

> "I attributed this [grunting] to swallowing water and acknowledging that babies born in water can be mucusy post birth, hence grunting: he had cried at birth but not with 'gusto'. This, I surmised was due to the gentle birth and a need to clear his lungs with good inhalation."

24. At 10pm, RM B administered vitamin K to Baby A, and noted: "[G]runting stopped, remains mucusy."

25. At 10.10pm, Ms A attempted to breastfeed Baby A again, but RM B recorded that he was "licking only".

26. At 10.15pm, RM B recorded: "Some sternal recession[7] but remains good tone and pink."

27. At 10.30pm, 0.2ml of expressed breast milk was given to Baby A with a syringe. RM B recorded in the Baby Notes that this "may act as a stomach washout".

28. At 10.35pm, RM B checked the placenta that had been delivered 90 minutes earlier. She recorded: "[I] noticed it to be old meconium[8] stained and gritty."

29. At 10.40pm, RM B observed meconium in the empty bath. She told HDC:

> "[Ms A] was now in the shower and we were organising transfer to the postnatal room (tidying up and packing things away). Whilst doing this, I noticed what appeared to be old meconium, around the sides of the now empty birthing pool."

30. At 10.45pm, RM B recorded:

> "Good colour and tone. Sl[ight] sternal recession continues. Baby encouraged to cry as still mucusy — and pale around the mouth, otherwise pink generally."

31. RM B stated:

> "With the transient episodes of respiratory distress, the discovery of meconium in the pool, the meconium stained placenta and the fact he had not fed, I planned to call the paediatric RMO; it was not an emergency situation but required referral and further investigation. I planned a full set of baby observations — including a blood sugar, to provide a full clinical picture for the RMO and midwifery staff."

[6] Grunting in a newborn is a sign of possible respiratory distress.
[7] Sternal recession is a sign of respiratory distress.
[8] Meconium is a baby's first stool.

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32. RM B did not call the paediatric RMO or the hospital midwifery staff, nor did she take observations of the mother's or baby's vital signs.

33. At 11pm, RM B transferred Ms A and Baby A to the postnatal room.

34. In the postnatal room, RM B attempted to assess the baby's blood sugar levels using a blood sugar monitor. She stated that she attempted to obtain a reading three times, but the monitor showed either "error" or it did not respond.

35. RM B left the postnatal room to seek assistance. She stated: "I was quite frustrated and was informed by one of the core midwives to get the NNU glucometer[9] as it was much more reliable."

36. RM C[10] was in the maternity ward office. She stated:

> "At one point (although I cannot remember the time exactly), [RM B] came into the office after the handover and asked for advice about how to use the glucometer. She thought the glucometer she was using might have broken. Staff gave her advice on how to insert the test strip. I tested the glucometer on myself and it was functioning correctly. I understand that [RM B] never managed to test Baby A's blood sugar and she made no further requests for assistance on this from staff."

37. RM B told HDC that at approximately 11.05pm she attempted to contact the RMO, Dr G, but her first attempt was unsuccessful. She told HDC:

> "I recall that I paged him again. I think I may not have paged him correctly initially as he now responded. I advised him that I had conducted a waterbirth and provided a full clinical picture — except the blood sugar; I added that I had just discovered old meconium in the bottom of the pool and just checked and old meconium stained placenta. I requested a review."

38. RM B returned to the postnatal room to undertake another blood glucose test, but the baby's condition deteriorated before she was able to do so. RM B stated:

> "[T]he baby became dusky.[11] The sat[uration] monitor showed a heart rate of 170bpm and oxygen sat[uration levels] of 70%."

39. The DHB said that there were two call systems available in the postnatal room — one was a call bell that could be used by an LMC to call for assistance from hospital staff, and the other was an emergency bell to signify an emergency.

40. RM B did not activate either of the bells.

[9] A glucometer is a device for determining the concentration of glucose in the blood.
[10] RM C is a registered midwife at the DHB. She was on the night shift and advised that she received a handover from the afternoon shift between 10.45pm and 11.10pm.
[11] When the baby's skin colour is pale, blueish, or a grey tone. This can be a sign of respiratory distress.

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41. At 11.15pm, RM B moved Baby A to a resuscitaire[12] that was positioned in the corridor. She stated:

> "[W]hen his condition deteriorated, I instinctively took him directly to the nearby resuscitaire (as I had done in many other maternity units), knowing it was very near with appropriate equipment — where I soon realized there was no call bell. This on reflection was not a good move."

42. RM B said that she checked Baby A's airway and it was clear. She said that there was no alarm bell by the resuscitaire, and she could not see any hospital staff. She stated:

> "I therefore gave [Baby A] facial oxygen and then removed the mask to observe him more clearly. Baby responded and 'pinked up' within seconds with oxygen saturations of 100%.
>
> I was in a difficult situation and 'Nanna'[13] was with me, so I asked her to hold the free flowing oxygen over the baby's nasal area while I summoned help. She was happy to be involved. It was quicker for me to go to the office myself rather than ask her to go. I showed her where and how to hold the tubing. It was a challenging situation — but I could hear the sat[urations] monitor and the office was only a few metres away. However I now recognize this placed the baby and myself in a vulnerable position.
>
> I went to the office to seek help for what I recall was less than a minute, to see if the RMO had responded. I recall seeing a midwife in the office on the phone."

43. RM C noticed that there was activity in the corridor around the resuscitaire and asked RM D to investigate.

44. RM C said that she was then called to the resuscitaire by RM D. RM C said that two family members were providing Baby A with facial oxygen, and that they did not know where RM B was. RM C stated:

> "[Baby A] had an oxygen sat[uration] monitor on his wrist which showed oxygen was 94–96% and a heart rate was 170bpm. He was grunting, nasal flaring[14] and had subcostal recessions.[15]"

45. RM D stated that she called RM C to the resuscitaire, and then called the operator and requested that the paediatric RMO be asked to attend the ward.

46. RM C stated that she assessed Baby A as requiring immediate admission to SCBU,[16] and that he was transferred at 11.30pm. She said that the RMO, Dr G, arrived at the Maternity

[12] A resuscitaire is a machine that combines a warming platform with the components needed for a clinical emergency and resuscitation.
[13] Stated on a "Consumer Feedback for LMC Midwife" form that she is Baby A's relative, and that she provided oxygen at the resuscitaire along with Ms A's mother.
[14] Can be a sign of respiratory distress.
[15] The in-drawing of the chest wall below the ribs, which is a sign of respiratory distress.

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Unit after Baby A had been transferred, and that she suggested that he go to SCBU to assess Baby A, as a blood sugar reading had not been obtained.

47. RM B recorded a different sequence of events in her retrospective Baby Notes. She documented:

> "RMO responded and attended — briefing of events given. [RM C] in corridor with baby. For transfer to [SCBU] for observation. — ? mec[onium] aspiration."

48. However, the progress notes written by RM B shortly after the events do not state whether or not Dr G attended the baby in the Maternity Ward.

49. Dr G's statement to HDC indicates that he first attended Baby A at SCBU. Dr G stated:

> "I was called to see a baby around [11.30pm[17]]. When I arrived the baby was pink, with high [respiratory] rate and reduced [oxygen saturation levels]. I quickly examined the child and found it to have crep[itations][18] to lung bases but otherwise normal. The notes were not with the child and were in Maternity [Ward]. I think I asked them to call the consultant. I went to Maternity [Ward] and ascertained that the baby examined normally at birth and had meconium liquor at birth. When I arrived back at SCBU [the paediatrician] was there and I verbally handed over."

50. At approximately 11.45pm, the paediatrician arrived at SCBU to attend to another baby. The DHB stated that the paediatrician had not been informed of Baby A's arrival at SCBU, and it has no explanation for why he was not called or notified that the baby was en route to SCBU.

51. Blood gases and a chest X-ray were undertaken while Baby A was in SCBU, and 12ml of meconium was aspirated from Baby A's stomach.

52. Baby A was diagnosed with meconium aspiration syndrome and, at 5.45am the following day, a team from a main centre hospital arrived to transfer him there. Baby A was later transferred back to the DHB before being discharged home.

Documentation

53. After Baby A was transferred to SCBU, RM B went to the Maternity Ward office. She stated:

> "I commenced writing up my notes but could not find my rough notes/aide memoire. I was now really stressed inside. I suspected I may have thrown it away or caught it up in the linen."

[16] Specialist Care Baby Unit.
[17] Dr G stated: "I was called to see a baby around 10.30pm." However, the sequence of events suggests that this is a typographical error and that the time is more likely to be 11.30pm.
[18] A dry, crackling sound that may indicate the presence of fluid in the lung.

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54. RM B stated: "I was compelled to write a summary or synopsis of events in the absence of my aide memoire." She recorded the summary in the progress notes, and the progress notes were transferred to SCBU.

55. Two days later, RM B found her rough notes and completed a retrospective account of the events. This account was recorded in the Baby Notes and the Maternity Notes. RM B said that these notes document the sequence of events. She said that the progress notes, although written immediately after the events, do not accurately reflect the sequence of events.

Observation of meconium

56. The progress notes record that at 8.34pm (the time of the delivery) Baby A "passed mec[onium] +++, cord meconium stained". The progress notes record that at 9.06pm the placenta and membranes were also noted to be meconium stained.

57. However, RM B told HDC that the placenta and membranes were actually checked at 10.35pm, and the empty bath was inspected at 10.40pm. Meconium staining was observed at both times and was recorded in the retrospective Maternity Notes.

58. RM B said that she did not identify meconium at 8.34pm and at 9.06pm, as stated in the progress notes. She stated:

> "[T]he reference to passing mec[onium] +++ at birth was based on my later finding of meconium in the empty pool and to provide [SCBU] staff with a sequential record."

Information from the DHB

59. The DHB stated:

> "[RM B] set up practice as a lead maternity career (LMC) in 2017 and was granted an access agreement to [the DHB] maternity facilities in 2017, with some reservations expressed by the chief executive at that time … [RM B] was strongly encouraged to ensure she sought help whilst caring for women in the unit and to participate in any case reviews/review processes, as well as complying with the policies and procedures of [the DHB]."

Information from Midwifery Council

60. The Midwifery Council advised HDC that in 2017, RM B became subject to a section 38[19] order concerning her competence. She was required to undergo training and to engage with a Midwifery Council approved mentor.

61. In 2017, as a result of the events in this report, the section 38 order was amended to require RM B to practise under supervision.

[19] Section 38 of the Health Practitioners Competence Assurance Act 2003 provides that if, after conducting a review under section 36, the authority has reason to believe that a health practitioner fails to meet the required standard of competence, an order can be made.

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62. The Midwifery Council advised HDC:

> "The current situation is that [RM B] remains under the s38 order but has not practised since [2018] when she voluntarily relinquished her practising certificate, owing to fitness to practise concerns. [RM B's] practising certificate will not be reinstated until the concerns around her fitness to practise have been addressed."

Changes made by the DHB

63. The DHB told HDC that as result of a case review and a critical systems analysis, the location of the resuscitaire has been reviewed. It stated:

> "The area in question is only for storage of the resuscitaire. If the resuscitaire is needed for patient care, then it should be moved to the room where the baby is located and connected to the appropriate air mixer. This will ensure that an emergency bell is in close proximity to the baby, as there are emergency bells in all maternity rooms."

64. In addition, the DHB advised that it has reviewed its handover policies and updated the Referral to Paediatric Services and the Management of Post Hand Over Midwifery Care policies accordingly.

Further statement from RM B

65. RM B told HDC:

> "[T]he events also exposed a cultural issue and some systems failures in the maternity unit, which can make LMC's vulnerable as some individuals do not work in a collegial manner."

66. RM B also told HDC that she did her best in the circumstances, and she trusts that her decision to leave practice will provide some reassurance to Ms A.

67. RM B also stated:

> "[I] apologised to [Ms A] and her family directly over the course of the postnatal care and [do] not consider that a formal written apology at this stage is necessary."

Further statement from Ms A

68. Ms A told HDC:

> "I feel as though [RM B] may have apologised but I do not remember as my focus was my baby at the time. However, I do remember her telling us that this could happen to any baby and no one is to blame but as I said before I do not remember her apologising or taking/accepting any responsibility for what had happened.
>
> But however I don't want to push her in to writing an apology if she does not believe it as needed as it will not be sincere."

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Responses to provisional opinion

Ms A

69. Ms A was given an opportunity to comment on the "information gathered" section of the provisional opinion. Where relevant, her response has been incorporated into the "information gathered" section above.

RM B

70. RM B was given an opportunity to comment on the provisional opinion. Where relevant, her response has been incorporated into the "information gathered" section above.

DHB

71. The DHB was given an opportunity to comment on the provisional opinion. It advised HDC that it does not wish to make any further comment.

Opinion: RM B — breach

Delivery room — 8.34pm to 10.45pm

72. Baby A was delivered at 8.34pm. RM B said that he was delivered "in good condition but a little mucusy".

73. By 10.45pm, three episodes of respiratory distress had been recorded. The first episode was at 9.30pm, when Baby A was noted to be "slightly grunty at times". The second episode was at 10.15pm, when RM B recorded "some sternal recession", and the third episode was at 10.45pm, when RM B noted: "[S]light sternal recession continues. Baby encouraged to cry as still mucusy — pale around the mouth."

74. Baby A also showed no interest in breastfeeding. RM B recorded that at 9.30pm he was "offered breast — not interested". At 10.10pm, when Ms A attempted to breastfeed Baby A again, RM B noted that he was "licking only". At 10.30pm, Baby A was given expressed breast milk by syringe.

75. Meconium was noted on the placenta and in the pool in which Baby A had been delivered. There is conflicting evidence about when the meconium was first observed by RM B. The progress notes suggest that meconium was noted on the cord when Baby A was delivered at 8.34pm, and that at 9.06pm the placenta was noted to be meconium stained. However, RM B told HDC that the information recorded in the progress notes is incorrect, and that the meconium-stained placenta was observed at 10.35pm, and the meconium-stained pool was seen at 10.40pm.

76. Given the lack of contemporaneous notes, I am not able to determine precisely when the meconium was first noted. However, it is clear that by at least 10.40pm, meconium had been observed both on the placenta and in the pool.

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77. RM B said that she recognised that by 10.45pm Baby A required further investigation and referral. However, RM B did not call the core midwives or the RMO for assistance. Nor did she call for a paediatrician. Instead, RM B decided to transfer Ms A and her baby to a postnatal room.

78. Clinical advice was obtained from in-house midwifery advisor Nicolette Emerson. Ms Emerson was concerned that RM B treated the three episodes of respiratory distress, the failure to breastfeed, and the meconium staining in isolation, and did not apply the "multiplier effect" of all of these factors operating together. Ms Emerson was also concerned that RM B did not take observations, that she did not keep adequate contemporaneous notes, and that she did not inform or seek the support of the core midwives, the RMO, or the paediatrician.

79. Ms Emerson advised that the poor assessment of the baby and the failure to seek assistance at 10.45pm were both moderate departures from the accepted standard of care.

80. I am critical that despite three recorded episodes of respiratory distress, the baby's failure to breastfeed, and the discovery of meconium, RM B did not seek immediate assistance from a core midwife and an urgent paediatric review. Further, instead of calling for assistance from a core midwife, an RMO, or a paediatrician, RM B decided to transfer the mother and baby to another room. At least 20 minutes passed before she attempted to contact the RMO. This delay is unacceptable.

81. I am also critical that given that there were clear signs of distress, no observations were taken at any stage before Ms A and Baby A were transferred to the postnatal room.

Postnatal room

82. Between 10.45pm and 11.00pm, RM B helped Ms A and her baby to transfer to the postnatal room.

83. RM B said that when she transferred Ms A and her baby to the postnatal room her plan was to taken a full set of observations, including a blood sugar reading, to provide to the RMO. A blood sugar reading was indicated because Baby A had not breastfed since his birth.

84. RM B did not take a full set of observations. She also had considerable difficulty in locating and operating the blood sugar monitor.

85. RM B said that she called the RMO at 11.05pm.

86. At 11.15pm, RM B had still not managed to obtain a blood sugar reading, and the baby's condition had started to deteriorate. RM B did not call for assistance from the core midwives by using the call bell in the room, or for emergency paediatric assistance by pressing the emergency bell in the room. RM B instead decided to transfer the baby to a resuscitaire in the corridor.

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87. Ms Emerson was critical of RM B's decision not to call for assistance. Ms Emerson advised:

> "In my opinion, the reluctance to seek assistance at or before 10:45pm and to further delay to 11:05pm [when RM B says that she called the RMO] was an omission of care that placed [Baby A] at risk and for the reasons above, in my opinion is a moderate departure of accepted practice."

88. Ms Emerson was also concerned that when Baby A had a dusky episode and an oxygen saturation level of 70% at 11.15pm, RM B did not ring the emergency bell for help.

89. I share Ms Emerson's concerns, and I am critical that Baby A's deterioration at 11.15pm did not trigger an immediate emergency response by RM B, and that neither the call bell nor the emergency bell was activated.

Resuscitaire

90. At 11.15pm, RM B transferred Baby A to the resuscitaire in the corridor instead of calling for assistance and having the resuscitaire brought to the room. RM B checked Baby A's airway and applied facial oxygen. She recognised that she required medical assistance for the baby, and decided to leave him on the resuscitaire in the care of his grandmother. RM B instructed a family member on how to apply oxygen, and left them in the corridor so that she could find a staff member to assist her.

91. RM B said that the baby was stable, with an oxygen saturation level of 100%, and she was absent for only a few minutes and the grandmother was happy to be involved.

92. I note that at 11.15pm the baby's oxygen saturation levels were 70%. Following RM B's departure to seek assistance, RM D observed a saturation level of 94–96%, a heart rate of 170bpm, nasal flaring, and subcostal recession. The RMO stated that when he examined the baby at about 11.30pm, the baby had a high respiratory rate and reduced oxygen saturation levels.

93. Ms Emerson advised:

> "[I]t is my opinion that a baby who required attention at the resuscitaire should not have been left in the care of the whānau … [I]t was a mild to moderate departure from accepted practice to leave a baby on the resuscitaire with whānau while leaving to summon help."

94. I agree that Baby A required medical attention, and I am critical that RM B left him on the resuscitaire without medical supervision, even if it was for only a few minutes.

Transfer to SCBU

95. RM B did not call the paediatrician and, as a result, the paediatrician was not aware that Baby A was in SCBU until he arrived to assess another baby at approximately 11.45pm.

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96. RM B did not have a set of notes to accompany Baby A to SCBU. She said that she could not find her rough notes, and that she was "compelled to write" a summary in the absence of any notes.

97. Ms Emerson advised:

> "[T]he hand over of [Baby A] was not adequate and … appropriate notes were not available in assessing [Baby A] … [I]n my opinion this represents a moderate departure from the accepted standard."

98. The core midwives were unaware of the deterioration of the baby until they saw him on the resuscitaire at 11.15pm. RM B's failure to involve hospital staff at an earlier time, combined with her failure to keep adequate contemporaneous notes, meant that the appropriate information was not available to the hospital staff when Baby A was transferred to SCBU. I am critical that the appropriate information was not conveyed to hospital staff at handover, and that RM B did not call the paediatrician and advise him of Baby A's transfer.

Conclusion

99. RM B was responsible for the care of Baby A until his care was handed over at approximately 11.30pm. The care provided by RM B was deficient in several respects:

- Before 10.45pm, despite ongoing indications of respiratory distress, RM B failed to seek the support of a core midwife or a paediatrician.
- After 10.45pm, despite three recorded episodes of respiratory distress, the baby's failure to breastfeed, and the new discovery of meconium, RM B still did not seek immediate assistance from a core midwife and an urgent paediatric review.
- At 11.15pm, when the baby deteriorated, RM B did not escalate the baby's care to hospital medical staff by activating the emergency bell or call bell.
- The baby was not supervised by clinical staff while he was on the resuscitaire.
- The appropriate information about Baby A's condition was not conveyed to hospital staff at the time of the baby's transfer to SCBU.

100. For the reasons above, I find that RM B failed to provide Baby A with services with reasonable skill and care, and that as a result she breached Right 4(1) of the Code of Health and Disability Services Consumers' Rights (the Code).[20]

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

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Opinion: District health board — no breach

101. I am not critical of the care provided to Baby A by hospital staff at the DHB. The core midwives were unaware of the baby's deterioration, but when they saw him on the resuscitaire they acted promptly and escalated his care to SCBU. I have no concerns about the care that was provided to Baby A in SCBU.

102. RM B said that she found it difficult to communicate with the core midwives. However, I note that RM B did not ask for any assistance from the core midwives except to discuss the blood sugar monitor.

103. I accept Ms Emerson's advice that RM B's perception that it was difficult to communicate with the core midwives should not have affected the care she provided to Baby A.

104. This case highlights the importance of LMCs and core midwives working collegially and communicating effectively.[21] This is an opportunity for the DHB to work with its core midwives to reflect on the professional relationships between core midwives and LMC midwives to ensure good communication at all times.

105. At the time of these events, the resuscitaire was stored in the corridor, with the expectation that if a resuscitaire was needed, it would be taken to the birthing room. I note that as result of this case, the DHB reviewed the location of the resuscitaire. However, if the resuscitaire is still stored in the corridor, the DHB should confirm that it is clear to all LMC midwives that the resuscitaire is not to be operated where it is stored, but should be moved to the room where the baby is located.

Recommendations

106. I recommend that RM B provide a written apology to Ms A and her family for the breach of the Code identified in this report. The apology should be provided to HDC within three weeks of the date of this report, for forwarding to Ms A.

107. I recommend that should RM B return to practice, the Midwifery Council conduct a review of her competence.

108. I recommend that the DHB consider: (a) how it can improve relationships with LMC midwives; and (b) whether it is clear to LMC midwives that the resuscitaire is not to be used in the corridor, and provide HDC with a response within three months of the date of this report.

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[21] Midwifery Council of New Zealand (2007). The competencies for entry to the register of midwives. Competency 4.13 states: "The midwife works collegially and communicates effectively with other midwives and health professionals."

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Follow-up actions

109. A copy of this report with details identifying the parties removed, except the expert who advised on this case, will be sent to the Midwifery Council of New Zealand, and it will be advised of RM B's name.

110. A copy of this report with details identifying the parties removed, except the expert who advised on this case, will be sent to the NZ College of Midwives and placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

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Appendix A: Independent advice to the Commissioner

The following advice was obtained from HDC's in-house midwifery advisor, Nicolette Emerson:

"**CLINICAL ADVICE — MIDWIFERY**

CONSUMER: [Ms A]

PROVIDER: LMC Midwife [RM B]

FILE NUMBER: C17HDC02110

DATE: 17/07/2018

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1. Thank you for the request that I provide clinical advice in relation to the complaint from [Ms A] about the care provided by LMC Midwife [RM B]. In preparing the advice on this case to the best of my knowledge I have no personal or professional conflict of interest. I agree to follow the Commissioner's Guidelines for Independent Advisors.

2. I have reviewed the documentation on file: complaint from [Ms A], 4 December 2017, [NZCOM] 15 January 2018, Additional concerns [Ms A] 18 January 2018, Clinical Notes [RM B] [dates], [DHB] clinical notes [Days 1-2[22]], Email from [Dr G], Review from [DHB Midwifery Advisor] [2017].

3. **Background:** [Ms A] booked under the care of LMC Midwife [RM B] at 26 weeks' gestation. She birthed her baby in water on [Day 1] 8:34pm. The baby showed signs of respiratory distress from one hour post birth but was not referred for consultation until 3 hours later at 11:15pm. [Baby A] was subsequently transferred to [a main centre] Neonatal Unit for Respiratory distress thought to be secondary to Meconium aspiration.

4. **Advice Request:** I have been asked to advise specifically on

   - The appropriateness of [RM B's] assessment of the baby
   - The appropriateness of not seeking RMO input until 11:05 pm
   - The adequacy of the handover to the RMO
   - Whether delay in assessing the placenta was appropriate/acceptable
   - The appropriateness of leaving the baby in the care of the whānau while [RM B] sought assistance vs. ringing the call bell

There appear to be two sets of notes from [RM B] in the HDC file

- One set is written on [DHB] clinical note paper at the time of birth [Day 1]

[22] Relevant dates are referred to as Days 1-3 to protect privacy.

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- The other set is in the LMC MMPO notes and is written retrospectively (two days after birth).

There are some differences observed between sets of notes. As the notes written on [Day 1] are closer to the time of birth, for this report, I will refer to the LMC notes written on [Day 1] unless otherwise stated.

1) The appropriateness of [RM B's] assessment of the baby

[Ms A] was a young woman in her first pregnancy; she booked with [RM B] at 26 weeks' gestation. There is no medical or obstetric history of note. There was concern regarding fetal growth at 38 weeks' gestation and [Ms A] was appropriately assessed and scanned, noting a reduction in amniotic fluid surrounding the baby. According to [RM B's] complaint response (5 February 2018) the amniotic fluid was assessed again at the bedside on [date] and this was reassuring.

Spontaneous labour occurred prior to a follow up scan to assess amniotic fluid and [Ms A] went on to birth [Baby A] in water on [Day 1] following an uneventful labour.

Following the birth, [Baby A] was brought straight to the surface and reported to be in good condition though a little mucousy.

[Ms A] birthed her placenta (3rd stage of labour) outside of the pool.

There is a discrepancy in documentation noted here, contemporaneous notes state that meconium staining was observed on the umbilical cord at delivery (8:34 pm) and meconium staining was observed on the placenta and membranes (9:06pm).

Retrospective notes ([Day 3]) and the complaint response (5 February) do not mention the meconium staining until 10:35 pm when the placenta and membranes are assessed.

[RM B] accounts for this discrepancy in her complaint response (5 February)

Equally, the reference to passing mec +++ at birth was based upon my later finding of meconium in the empty pool to provide NNU staff with a sequential record i.e. time of birth, mode of delivery, condition of the baby and other relevant comments. My thinking was the meconium probably followed the baby out at some point after the birth, because there was no meconium seen on the baby at any stage. The towels baby was wrapped in were not meconium stained. I observed no meconium around the anus or mouth and nose at the initial examination, therefore the comment of 'passing meconium +++' was to provide the NNU staff with background information to tie in with my observation of meconium in the pool.

The statement above appears to conflict with an earlier statement in [RM B's] response

(I had just discovered old meconium in the bottom of the pool and just checked an old meconium stained placenta. The meconium indicated to me that he must have passed

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it in utero at some stage — because it was old — [RM B] complaint response 5 February 2018)

The statements above indicate a conflict in [RM B's] statement regarding whether the meconium was passed inter utero or post delivery.

I have considered both of the above statements, the contemporaneous and retrospective notes and have answered the above question based on the following.

I. Regardless of whether the meconium was first observed at birth (8:34pm) or at the inspection of the placenta and membranes (at 10:35 pm) [Baby A] was displaying respiratory symptoms from 9:30pm, in addition he had not fed since birth at 8:34pm.

II. If [RM B] was unclear as to whether the meconium was passed in utero or following birth then it would have been prudent to seek the advice and assessment from a paediatrician earlier rather than later to discount the possibility of meconium aspiration (baby breathing meconium into lungs) and its sequelae.

If it is accepted that the meconium was first observed at 10:35 pm then

I. [Baby A] had been displaying respiratory symptoms since 9:30pm

II. Baby had not yet fed and [RM B] considered it prudent to attempt to obtain a blood sugar level from [Baby A]

III. [RM B] planned a full set of vital signs and blood sugar level prior to paediatric assessment

IV. [Baby A] had a 'Dusky episode', the paediatrician attended and the baby was assessed and transferred to the Neonatal Unit from the resuscitaire. Subsequently transferred to [the main centre hospital].

The occasional grunting is noted at 9:30pm, disinterest in feeding 10:00pm, sternal recession at 10:15pm, and the discovery of placental and pool staining with meconium at 10:35.

[Baby A] is noted to have further sternal recession and is pale around the mouth at 10:45pm; this is followed by a 'dusky episode' at 11:15 pm requiring transfer to the resuscitaire.

The emergency bell is not activated at the resuscitaire and whānau members are left with the baby while [RM B] seeks further help.

[RM B] contends that the respiratory symptoms were transient and at no time was the baby tachypnoeaic (abnormally rapid breathing). She contends that she was observing vital signs but I can find no contemporaneous notes to support vital signs having been completed prior to transfer to the Neo Natal Unit (NNU).

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1a) My concern regarding the assessment of [Baby A] is

I. [RM B] viewed respiratory symptoms in isolation and did not apply a multiplier effect (discussed in detail Question 2)

II. The hesitation to inform and seek the support of midwifery colleagues in the unit

III. The delay in paediatric assessment of [Baby A]

IV. The contention that the culture of the unit prevented [RM B] from seeking support

V. This was a first birth as an LMC following a period of absence from Midwifery for two years

In summary, for the above reasons in my opinion [RM B's] actions are a moderate departure from accepted practice in not seeking help when required, not keeping contemporaneous notes that include observation of [Baby A's] vital signs and not recognising the multiplier effect of individual components of [Baby A's] history.

[RM B] has addressed these issues in her complaint response.

She reflects that '*This was my first birth at the hospital after two years away. In hindsight, I recognise that my actions have been hampered by my vulnerability, lack of confidence and being watched'*.

My own individual assessment of clinical presentation in this working environment is an issue; where there are potential deviations from normal, there is no one to corroborate my clinical judgement.

1b) The actions that [RM B] has taken to address the above issues are:

- She will now use the white board in the delivery room to scribe and then photograph on her iPad so she has contemporaneous notes to work from.
- Attended PROMPT course [date] and planned orientation day in the unit (2017)
- Intention to call a second midwife for delivery (LMC partner happy to support this until confident)
- [RM B] has a midwife mentor
- [The DHB has] instigated a 'support plan' for her access agreement which [RM B] is required to follow

If the above remedial actions are in place, it is my opinion that they will reduce the likelihood of a reoccurrence.

2) The appropriateness of not seeking RMO input until 11:05 pm

[Baby A] was birthed in water at 8:34 pm on [Day 1]. Meconium was noted to be passed at birth and to have stained the cord, placenta and membranes.

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The following respiratory symptoms were noted and documented by [RM B]:

I. 9:00 pm baby noted to be mucousy (clinical notes [Day 1] [RM B])

II. 9:30pm Baby was offered the breast but was not interested, slight grunting was noted, baby pink colour (clinical notes [Day 1] [RM B])

III. 10:00 pm attempt to breastfeed, baby not interested, grunting reduced (scrap of paper and clinical note [Day 1] [RM B])

IV. 10:10 pm Baby still not breastfed (scrap of paper [Day 1] [RM B])

V. 10:15 pm sternal recession (retrospective notes [Day 3] [RM B])

VI. 10:35 pm Placenta and membranes checked (scrap of paper, clinical note [Day 1] [RM B])

VII. 10:45 pm Sternal recession noted, slight grunting, pale around mouth (retrospective notes [Day 3] [RM B])

VIII. 11:00 pm Attempted to take baby's blood sugars as he hadn't fed yet

IX. 11:00 pm Baby taken to postnatal room (Mec aspiration?) (clinical notes [RM B] [Day 1])

X. 11:15 pm Baby Dusky and taken to Resuscitaire (retrospective notes [RM B] [Day 3])

XI. 11:23 pm RMO [Dr G] and was briefed by [RM B]. High respirations, lung creps, reduced oxygen saturations, colour pink. ([statement [Dr G]])

XII. 11:45 pm [the paediatrician] arrived and found [Ms A's] baby had been brought to SCBU (special care baby unit) without him being informed

In responding to the above question I have considered the following:

A. [Ms A's] baby was born into water with dimmed lights

B. Meconium staining had been observed on the cord, placenta and membranes

C. There had been a history of reduced amniotic fluid and [RM B] was sufficiently concerned to order an additional scan in the community despite a reassuring bedside scan. (28 September, Complaint response [RM B] 5 February)

D. The opinion of a midwifery colleague was not sought at any stage in assessing the need for paediatrician review of [Baby A]

E. Contemporaneous documentation

The first signs that [Baby A] was experiencing some respiratory compromise occurred at 9:30pm when [Baby A] declined to breastfeed and was observed to be grunting. At 10:15pm (response to complaint 5 February 2018) *as per my records I undertook the initial birth examination and noted some sternal recession in isolation — he was less mucousy, with no grunting and he remained pink with good tone*. I note there are no contemporaneous notes to support the above statement; however retrospective notes [Day 3] do support the above statement.

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The following statement is recorded in [RM B's] response:

10:45 pm With transient episodes of respiratory distress, the discovery of meconium in the pool, the meconium stained placenta and the fact that he had not fed, I planned to call the paediatric RMO; it was not an emergency situation but required referral and further investigation. I planned a full set of baby observations — including a blood sugar, to provide a full clinical picture for the RMO and midwifery staff.

If the above statement is accepted, I continue to have concerns regarding the care provided by [RM B] as it was a further 40 minutes before [Baby A] was assessed by a paediatrician.

i. [RM B] had now documented respiratory symptoms in [Baby A] on 3 occasions since birth

ii. It was now more than two hours after birth and [Baby A] had not fed, necessitating the need for a blood sugar to be obtained

iii. Meconium was noted on the cord, placenta and membranes. Old meconium was also noted in the empty pool.

If [RM B] intended to complete a set of observations and obtain a blood sugar prior to speaking to the paediatrician, in my opinion at this point a colleague (staff midwife) should have been called to help take the necessary observations. It was a further 15 minutes before blood glucose equipment was obtained and 15 minutes after that, the dusky episode occurred, requiring oxygen. (Noting that a blood sugar was not obtained as [RM B] had difficulty with the equipment.)

When the baby was taken to the Resuscitaire at 11:15pm with a dusky episode and Oxygen saturation of 70%, the bell was not rung to access help.

In her statement [RM B] felt that she was not supported by her colleagues and they did not help her with the use of the glucose equipment. I do note however, at no point did [RM B] report her concerns regarding [Baby A] to the staff midwives or request their help. She did not ring the bell to summon help when she transferred [Baby A] to the Resuscitaire at 11.15 pm.

The baby had demonstrated respiratory symptoms, had not fed, and old meconium had been observed on the placenta, membranes, cord and in the pool. It would have been impossible to discern the quantity of meconium (thin, moderate, thick) as the membranes had ruptured into water and in poor light.

Without the knowledge of the quantity of meconium and considering the reluctance to feed, coupled with respiratory symptoms, it is my opinion that a paediatric consultation should have occurred at 10:45 pm (at the latest) and not delayed. In my opinion it was the responsibility of the paediatrician not the midwife to provide a differential diagnosis for the respiratory symptoms that [Baby A] was displaying. In my opinion midwifery responsibility lay with the prompt referral to the paediatrician.

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In my opinion, had the meconium been passed at birth, [Baby A] fed and there was no evidence of meconium staining on placental tissue and pool, then it may have been reasonable to observe the baby for meconium exposure as planned.

In this case it was reasonable to consider that [Baby A] could have aspirated some meconium and consultation with a paediatrician was now required.

I note that [RM B] felt that she received no support from the core midwives and was reluctant to ask for their assistance. In my opinion the culture of the DHB may have impacted on the ability of [RM B] to request assistance; however this should not have impacted on the care given to [Ms A] and her baby.

Any concerns [RM B] felt regarding the culture of the environment should have been addressed at a later time.

In my opinion, the reluctance to seek assistance at or before 10:45pm and to further delay to 11:05pm was an omission of care that placed [Baby A] at risk and for the reasons above, in my opinion is a moderate departure of accepted practice.

NZCOM Standards of Midwifery Practice: Standard six: *Midwifery actions are prioritised and implemented appropriately with no midwifery action or omission placing the woman at risk.*

3) The adequacy of the handover to the RMO

[Baby A] was born into water in good condition and brought immediately to the surface at 8:34pm on [Day 1]. From an hour post birth, [Baby A] displayed respiratory symptoms. He had a 'dusky episode' at 11:15 pm which required transfer to the neonatal unit and subsequently to [the main centre hospital].

The RMO Dr G had been phoned by [RM B] and met [RM B] and staff midwife RM C at the resusitaire and [Baby A] was then wheeled to the neonatal unit.

[The paediatrician] arrived in the unit at 11:45pm to find [Baby A] had been transferred and that he was not made aware of this in advance.

In considering my response to the above question, on the balance of the information provided it would appear that the hand over of [Baby A] was not adequate and that appropriate notes were not available in assessing [Baby A].

In my opinion, the factors that contributed to this are the lack of contemporaneous notes, reluctance to seek help from core staff and reluctance to ring emergency bell when [Baby A] decompensated and had a dusky episode accompanied by a drop in oxygen saturation.

For the reasons above, in my opinion this represents a moderate departure from accepted standards.

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4a) Whether delay in assessing the placenta was appropriate/acceptable?

[Ms A] birthed her baby in water at 8:34pm on [Day 1] at [the] Hospital. He was immediately brought to the surface of the water. Copious amounts of meconium were observed to be passed by [Baby A] at birth and the cord was observed to be stained by meconium ([RM B] clinical notes [Day 1] 8:34 pm).

I. [Ms A] got out of the water to birth her placenta. The placenta and membranes were noted as meconium stained on their delivery at 9:06 pm ([RM B] clinical notes [Day 1]) and noted as 'complete'.

II. [RM B] states in her response to the complaint that at 10:35pm '*it was now almost 2 hrs post birth; I checked the placenta and noticed it to be old meconium stained and gritty'.*

III. In her response to the complaint [RM B] states that at 9:06 pm '*she pushed the trolley away for more space and left the checking of the placenta/whenua until later. [Ms A] was not bleeding so there was no urgency'.*

4b) In my response to this question, I have considered the following:

I. Meconium staining was observed on the umbilical cord at birth, 8:34 pm ([RM B] clinical notes [Day 1])

II. The placenta and membranes were noted as meconium stained at 9:06 pm and noted as complete ([RM B] clinical notes [Day 1])

III. The main reason to inspect a placenta and membranes in a timely manner is to observe completeness in the presence of bleeding (retained placental tissue and/or membranes can be a source of significant vaginal bleeding and/or uterine infection)

IV. [Ms A] was not documented to be unduly bleeding when the placenta was birthed or at any time in the 2 hours following the birth, prior to the inspection of the placenta

It would appear according to [RM B's] notes, that an in depth inspection of the placenta and membranes was delayed because [Ms A] 'had acceptable post birth vaginal bleeding'. In my opinion the delay based on vaginal bleeding would be appropriate in the circumstances, however I have some concern.

My concern is not the delay in the inspection of the placenta and membranes until 2 hours following the birth; but rather that they were inspected enough to note that there was meconium staining on both the membranes and the placenta and this does not appear to have been considered (9:06pm [RM B] clinical notes [Day 1]).

In the presence of the respiratory symptoms that the baby was experiencing from one hour post delivery, given the observation of meconium on the placenta, membranes and cord, it would be reasonable for [RM B] to consider meconium aspiration as a contributor/cause of the baby's symptoms and not to delay consulting for a paediatric assessment.

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[RM B] states that she considered that the meconium staining when inspecting the placenta (10:35pm) was a result of in utero exposure *(I had just discovered old meconium in the bottom of the pool and just checked an old meconium stained placenta*. *The meconium indicated to me that he must have passed it in utero at some stage — because it was old* — [RM B] complaint response 5 February 2018). She goes on to say that she knew that the meconium wasn't thick.

I am not aware of any protocols other than observations for meconium births and the national guidelines, which require consultation to a paediatrician for moderate or thick meconium. This was not the case, but I was concerned enough to refer for a review in the presence of meconium.

I wonder on what basis [RM B] could ascertain the degree of meconium. This could not be accurately assessed as the membranes ruptured in the pool (8:15pm Delivery summary [the DHB] [Day 1]) (hence meconium having a diluting effect in the water) and in the presence of poor lighting.

In addition there was a history of reduced amniotic fluid (with an in utero environment of reduced amniotic fluid, the proportion of meconium to amniotic fluid is increased).

[RM B] was sufficiently concerned about following up the amniotic fluid volume antenatally to order an additional scan (following 2 scans to assess amniotic fluid — 28 July, 29 September) prior to [Ms A] going into labour (she went into labour before having the scan) but [RM B] does not appear to have taken this into account when assessing the meconium staining.

In my opinion, based on the observation of meconium staining on the membranes, cord and placenta (8:34 pm and 9:06pm [RM B] clinical notes [Day 1]) coupled with respiratory symptoms present in [Ms A's] baby, first noted at (9:30pm (grunting) it would have been prudent to consider the meconium staining already observed.

In my opinion it is not the delay in undertaking a full inspection of the placenta that is of concern, it is the delay in considering the meconium staining as a contributor of respiratory distress.

- Given the absence of vaginal bleeding
- The observation of meconium staining and completeness of the placenta

In my opinion, the delay in assessing the placenta fully does not represent a departure of accepted practice; I have addressed my concern regarding the observation of the meconium staining in question 1.

5) The appropriateness of leaving the baby in the care of the whānau while [RM B] sought assistance vs. ringing the call bell

[Baby A] was taken to the Resuscitaire in the hallway by [RM B] following a 'dusky episode' at 11:15pm. Oxygen was administered via facial mask and whānau were left

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to continue to provide facial oxygen whilst [RM B] went to seek assistance from the office which was a few metres away. On her return she remembers seeing a midwife at the Resuscitaire and the RMO (Registered Medical Officer).

In answering this question I have considered the following:

I. [RM B] states that she could hear the oxygen saturation monitor when she was walking to the office which was metres away (5 February [RM B] complaint response) and [Baby A's] Oxygen Saturation had improved.

II. There was no call bell at the hallway Resuscitaire.

III. [Baby A] had been displaying respiratory symptoms for over two hours.

IV. This was [RM B's] first birth following an absence from the unit for 2 years.

V. There are no notes available that evidence any clinical vital signs documented for [Baby A] in the hours immediately following the birth and prior to being transported to the resuscitaire.

[RM B] states in her complaint response that 'I instinctively took him to the nearby resuscitaire, knowing it was very near with appropriate equipment — where I soon realised there was no call bell'.

[RM B] reflects that '*this was not a good move'* and states that *'I should have called for help when the baby went to the resuscitaire, but this would have instilled panic in the whānau so I was clear that I needed to keep things calm'*.

I have considered [RM B's] response and noted that she has reflected on her actions as not being ideal. I have considered that there was no call bell at the resuscitaire. I note the case review from [the DHB] ([Director of Nursing] [2017]) one of the recommendations (recommendation 34 page 10) is that corridor resuscitaire should have a call bell in easy reach.

In taking the above into account it is my opinion that a baby who required attention at the resuscitaire should not have been left in the care of the whānau.

While they may have been very capable of continuing as instructed, they were not equipped to recognise or act accordingly if [Baby A] had deteriorated suddenly. In my opinion this was an unsafe position for both [Baby A] and his whānau to be placed in.

[RM B] states that she thought it was quicker for her to go to the office to get help and while this may be true, this action may have been quicker but it was not safer.

Based on [RM B's] complaint response, oxygen saturation had improved quickly from 70% to 100% and [Baby A] was breathing spontaneously. In the absence of the call bell, it was a difficult situation however in my opinion based on the above, it was a mild to moderate departure from accepted practice to leave a baby on a resuscitaire with whānau while leaving to summon help.

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Summary

In summary of the care provided by [RM B] to [Ms A] in labour and in the following hours I have been asked to comment on specific questions.

In preparing this report I acknowledge the differing versions of clinical notes, both retrospective and contemporaneous; however I have not been required to resolve the discrepancies of the accounts.

I remain concerned that [RM B] has made contradictory statements in her complaint response regarding the meconium and the contemporaneous and retrospective notes are significantly varied. I acknowledge that antenatal notes for [Ms A] meet accepted standards.

I have considered all notes and documents in the file supplied and I have considered [RM B's] response to the complaint and the plan in place to address the issues identified.

In my opinion [RM B] has moderately departed from accepted practice in her care for [Baby A]; however the remedial measures implemented by the DHB, her mentor and the intention to call a back up midwife, if implemented could reduce the circumstances of this care reoccurring.

Nicky Emerson BHSc — Midwifery
Midwifery Advisor, Health and Disability Commissioner"

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