Investigation calls for more coordination between midwife and ambulance services

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Deputy Health and Disability Commissioner Rose Wall has released details of a case raising concerns about the communication and coordination of care between midwives and ambulance providers when transferring newborn infants to hospital.

In 2019, a woman had an unplanned home birth. She gave birth to her son with her registered midwife present. When the midwife noticed that the baby was in respiratory distress, she called an ambulance and conveyed that a newborn baby with signs of respiratory distress needed to be transported to hospital.

The ambulance arrived with a paramedic and an emergency medicine technician. However, the ambulance did not have an appropriate neonatal-sized oxygen probe for monitoring the baby's oxygen levels, or an appropriate setup for the safe transfer of a baby. Instead the baby was transferred to hospital in a car seat.

The baby was not monitored during the ambulance journey. The midwife was seated and belted approximately one metre away and was unable to lift the baby's chin to increase his airflow. Both ambulance officers sat in the front of the ambulance, and did not assess the baby.

The ambulance provider told HDC that previously it had formally agreed with the New Zealand College of Midwives that if a midwife is present, the midwife is in charge of the situation (care provision and decision-making) unless the midwife formally hands over to the ambulance staff. However, the Midwifery Council of New Zealand told HDC that "as the Responsible Authority", it was not aware of any such agreement. The ambulance provider maintained that the midwife remained in charge in the case.

When the baby arrived at the local hospital he was hypothermic and grunting, with increased work in breathing. Subsequently, he was diagnosed with a brain injury due to the lack of oxygen flow to his brain.

During the investigation, issues were also raised about the size of the baby and the lack of GROW charts (software used for customised assessment of growth and birth weight) used during the pregnancy.

The Deputy Commissioner identified three key issues: the lack of national consensus regarding the use of GROW charts, the absence of specific neonatal equipment in New Zealand front-line ambulances, and the lack of guidance and clarity on lines of responsibility between midwives and ambulance providers during the transfer of neonates to hospital.

"I'm satisfied that the individual providers in this case were not solely responsible for the poor care of [the baby], and that wider systemic change is needed in order to prevent similar occurrences," Ms Wall said.

Ms Wall has written to the following national organisations to outline her concerns: the Midwifery Council of New Zealand, the New Zealand College of Midwives, ACC,

the Director-General of Health, the Paediatric Society of New Zealand, Ambulance NZ, and HQSC. Noting the specific issues raised by this case, she recommended that these groups initiate conversations and work together to address the issues and improve patient safety. She also made five suggestions for improvement to be used as a starting point to initiate conversations and promote further collaboration between the relevant groups.

“I hope that these suggestions will go some way towards strengthening the cooperation and coordination between midwifery and ambulance services within New Zealand,” Ms Wall said.

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