



DECEMBER 2008 NEWSLETTER

WELCOME, TENA KOUTOU KATOA, KIA ORANA, TALOFA LAVA, MALO LELEI, FAKAALOFA ATU.

Welcome to the fourth and final issue of the Maternity Services Consumer Council Newsletter for the year. The December newsletter is a slightly bigger issue than normal as there has been lots happening in the maternity sector over recent months.

The release of the report on the review of maternity services in the Wellington region was a welcome surprise in that the report contained some excellent recommendations for much needed improvements to the national maternity sector. Some of them are issues that consumers have been lobbying on for decades. See page 4 for more on this. But if we had our hopes up for ending the year on a truly positive note, they were quickly dashed when a few hours after the release of the report the Ministry of Health saw fit to release its Maternity Action Plan. Submissions on this dreadful document were due by 31 December 2008 but have now been postponed till early next in order to allow time to brief the new Minister of Health, Tony Ryall.

New pamphlets

Since we sent out our last newsletter the MSCC has been kept very busy mailing out copies of our two new pamphlets – the Burmese translation of our *Choices for Childbirth* pamphlet, and ***Screening During Pregnancy: Your Choice***. The demand for the latter is extremely high, particularly following the Midwifery Conference that was held in Auckland in mid-September. The conference was attended by hundreds of midwives who took copies with them and have been ordering them in the hundreds ever since.

Requests to have the *Screening During Pregnancy* pamphlet translated into other languages are rolling in and the MSCC is already working on grant applications to meet this need.

What's in this issue of the newsletter

This issue of the MSCC newsletter contains a letter to the editor from the West Coast, a report on the review of maternity services in the Wellington region, an article on the dangers of infant formula, and a summary of some recent reports from the Office of the Health and Disability Commissioner.

We wish you a very happy Christmas, and hope you all have a really relaxing break over the summer holidays. Thanks to those of you who have come to our meetings during the year, and have continued to support the work we do.

Letter from the West Coast

Dear Lynda

I am really worried for the birthing women of the West Coast. Our climate and geography is vast, beautiful and at times inhospitable. Our nearest tertiary centre is Christchurch Public & Women's Hospital. For one half of the Coast (Buller) they are closer in this current situation to accessing Secondary services from Nelson Marlborough District Health Board.

As a DHB when we needed to transfer patients in 2006 there were 54 days when we couldn't fly people and they had to go by road due to the weather - sometimes on those days the roads were impassable also.

We are a hardy and independent lot here on the Coast and there isn't a huge population but at the last census for the first time in 10 years we had a population increase of 2% We have tourism, farming, mining, fishing and forestry as our income earners. At the best of times these industries can be hazardous. When we choose to live and work here we choose to accept this risk. Now our birthing population is being subjected to needless and unnecessary stress by having access to only primary birthing services here on the Coast.

Historically, as in the rest of New Zealand, we have centralized our maternity services maintaining secondary obstetric care based in Greymouth where the bulk of the Coast population actually lives. We have a primary birthing unit in Westport, too, staffed by 4 committed LMC midwives. (I won't even go into gynaecological services here but again another area of women's health that is severely neglected in the current situation).

Our DHB has seen fit to employ locum O&Gs at vast expense to give us sporadic "3-day weekend cover and clinics." They then turned around and seemingly arbitrarily declared that even when we do have an O&G present on the Coast "We are NOT to provide secondary care for any pregnant/ birthing women unless is it an emergency C-section" Chris Le Prou Manger WCDHB Secondary Services 2nd October 2008.

The committed and experienced team of local DHB midwives who cater for the majority of birthing women on the Coast find themselves not able to manage a caseload without referring off the Coast frequently.

This means the reality is that even minor issues for birthing women become major decision points for them. If the woman has a history of uncomplicated postmaturity too bad! She will have to go to Christchurch for that.

If the woman is a primip and otherwise healthy she can have a homebirth. If the woman feels uncertain of her abilities and situation she can go to Christchurch, Nelson or Dunedin

(depending on the circumstances, risk factors and personal support) with very poor support from the DHB for all the financial and emotional stress of a long distance separation. Women who already have children and need secondary services or feel they may need secondary services are in an even more difficult situation - alone and in a low budget motel room on Riccarton Road!

I cannot even begin to describe the kind of pressure and stress this puts onto our birthing women.

Demographically our women are younger when they have their first babies and have slightly more than the national average number of babies.

This is election year. Midwives are being pilloried for raising the maternal and neonatal morbidity and mortality rates. I don't care who the government is but open your eyes and look at some of the planning, policies and managers we have in place, see the gaps in our whole birthing workforce and give me a good reason to stay being a midwife on the West Coast.

I pose the question for all of us who want to keep intervention rates in birth to a minimum that is consistent with health and longevity - Would you really be happy to have your baby 4-6 hours away (on a good weather day) from any secondary back up obstetric services??

Please WCDHBs and all the DHBs and Ministry of Health be sensible, practical and supportive. Show some leadership for the middle ground!

Yours sincerely

Robyne Bryant

Awhi Whanautanga Hokitika

Independent Midwife

Elected WCDHB member 2001 - 2007

Woman/Mother living and working on the Westcoast for the South Island.

"REVIEW OF THE QUALITY, SAFETY AND MANAGEMENT OF MATERNITY SERVICES IN THE WELLINGTON AREA"

At the beginning of October the Ministry of Health released the report of the review into maternity services in Wellington. The review was commissioned following the death of a baby during a birth that took place at the Kenepuru Maternity Facility in June 2008. While the report enabled the Minister of Health David Cunliffe and Associate Health Minister Steve Chadwick to reassure Wellington women and their families about the quality and safety of maternity services in the Wellington region, it highlighted a number of areas in which improvements were needed in the provision of maternity services both in Wellington and nationally.

Among the review team's conclusions on maternity services in Wellington:

- There are not enough midwives or obstetricians to meet the needs of women requiring maternity services in the Wellington area.
- There was dissatisfaction with the postnatal care provided in Wellington's maternity facilities.
- Information provided to pregnant women about maternity services available is currently variable and sometimes inadequate.
- Both Kenepuru and Paraparaumu Birthing Units' access to emergency services need to improve.
- Relationships between health practitioners working across the spectrum of maternity care need to significantly improve.

However, it is the recommendations attached to the national issues identified by the review team where the real significance and importance of this report lies.

Lack of leadership

The report states that "the lack of national leadership and strategy for maternity services has contributed to New Zealand's maternity services not being accorded the priority they require as a fundamental component of a national health system."

It must be noted at this point that consumer groups have been writing letters to the various Ministers of Health about this very issue for the past six years. The Maternity Services Consumer Council (MSCC) first wrote to the then Minister of Health Annette King towards the end of 2002, following the departure of Barbara Browne, the Ministry of Health's national manager of maternity services. The MSCC strongly objected to the decision the Ministry made then to "disestablish the position of a national maternity manager." The MSCC warned the Ministry of what would happen. The group received the typical fob-off letter from the Minister/Ministry in response.

Over the following years the MSCC wrote several more letters. In September 2006, following the appointment of Stephen McKernan as Director General of Health the MSCC wrote another letter emphasising:

"the necessity of appointing a high level manager for maternity services who has oversight of all issues pertaining to maternity across all the silos that the Ministry of Health has devolved itself into. These silos have not served the maternity sector at all well.

Since that time the MSCC has seen the gradual disintegration of the collegial relationships that had been developed by the Ministry of Health's last maternity manager, Barbara Browne, the loss of knowledge of the history of maternity services and why various policies and procedures were consulted upon and put in place, and the production of one of the worst consultation documents

(on the Section 88 Maternity Notice) the maternity sector has ever seen. The maternity sector is now lost in what can best be described as a leaderless wilderness.

It is absolutely essential that the position of a senior level maternity manager is re-established and for there to be someone at the Ministry level who has some knowledge of the history of the maternity sector, understands maternity services issues and is responsible for overseeing what is happening at both a national level and a DHB level. Maternity services are not the same as other health services and it is important for the Ministry to do a great deal more than just have someone who is responsible for maternity contracting. The events of the past year or so which have seen a very critical spotlight turned upon maternity services is in itself an indictment of the very sorry state of affairs that the Ministry has allowed to develop. The MSCC is therefore urging you to take the matter in hand and appoint someone to take up the challenge of leading the maternity sector back out of the wilderness and re-establishing good working relationships between all the stakeholders."

The new DG also chose to ignore the problems arising as a result of the lack of leadership – problems that were very obvious to not only consumer groups. In fact, things got even worse as some officials in the maternity section in the Ministry were moved onto other areas of the health system and others left. The MSCC received yet another condescending letter from the Ministry reassuring the Council that all was well in maternity-land.

Ambiguities in the Maternity Notice

The report noted that wording of some of the clauses in the Section 88 Maternity Services Notice is unclear "and is being interpreted differently by different professional groups and providers. This has resulted in unnecessary tension that has contributed to poor relationships between providers." No surprises there either, and the Ministry was repeatedly warned about this in both face-to-face meetings, some of which got quite heated, as well as in various submissions and letters.

Information on maternity outcomes

Consumer groups protested vigorously when the Maternity and Neonatal Information Systems advisory committee was disbanded in 2003. The regular production of the annual national maternity reports ground to a halt. In August 2005 the MSCC wrote to the Minister of Health asking for information as to when the 2004 report would be published. The MSCC pointed out that "*the disbanding of the MNIS advisory committee was a retrograde step and our organisation is advocating for this committee to be re-established to ensure that the annual maternity reports are produced on time and with consumer input.*"

Needless to say, the MSCC received another falsely reassuring letter from the Minister/Ministry. It was be another two years before the 2004 report appeared and we are still waiting for the 2005 report despite receiving reassurances from the Ministry last year that it would be out in 2007. While these annual reports were not without their limitations, the MNIS advisory committee put considerable effort into overseeing improvements to each year's report. The disbanding of the advisory committee was yet another example of the Ministry of Health's wilful disregard of the need to ensure that maternity services remained a top priority. The lack of robust data on national maternity service outcomes has been a concern for health professionals, administrators as well as consumers for well over two decades. Maybe now the Ministry will do something about it.

Mentoring and supervision of new graduate midwives

The report recommends that a mandatory supervision programme be developed and incorporated into the current Ministry-funded Midwifery First Year of Practice programme to ensure that first-year midwifery graduate self-employed midwives initially attend births under direct supervision. It is also

recommended that this should apply to employed midwives who enter self-employed practice for the first time.

Almost two decades after resisting the evidence and recommendations for a four-year course for direct-entry midwives, following the passing of the Nurses Amendment Act in 1990, the Ministry of Health has now agreed to fund a Midwifery First Year of Practice supervision programme. The programme has been in existence for the past two years but will become mandatory at the beginning of 2009.

Poor relationships

The review team noted that “there is a lack of respect, collegiality and collaboration between the obstetric and midwifery colleges that is reflected in some very poor relationships between individual midwives and obstetricians” and recommended that both colleges identify as one of their key roles and functions the need to work collaboratively with each other. The College of Anaesthetists should also have been added into the mix as the unwarranted influence and power that anaesthetists often attempt to exert over birthing in hospitals has had a significant impact on the rising intervention rates. The increasing role of anaesthetists in maternity hospitals around the country has been a talking point at maternity service meetings and forums for many years.

The need to maintain good relationships between all maternity service stakeholders was something that the last MOH maternity services manager understood and worked hard to develop and maintain.

“Management” of normal labour

From a consumer perspective one of the report’s most exciting recommendations concerns the need for obstetric registrar training to include attachment to the practice of a self-employed LMC midwife in a primary or community setting, and involvement in births in this setting. Consumer groups have argued for decades that obstetricians and GPs should be required to attend home births as part of their training in obstetrics. This issue has also been raised by consumers at the National Women’s Annual Clinical report days much to the amusement of the medical professionals present at these events.

The recommendation followed the review team’s observation that “fundamental differences in the approach of obstetricians and midwives to management of a normal labour have contributed to tensions between the two professional groups.”

The preference for caesareans

The report also referred to the fact that emergency obstetric skills had reduced in recent years due to a preference for caesarean sections rather than assisted vaginal births and noted that few obstetric registrars had had the experience of delivery breech births or assisted vaginal births. The recommendation of the review team was that “ongoing obstetric education should include regular updating of emergency obstetric skills and knowledge.” This will also be introduced at the beginning of 2009.

Consumer groups believe there is a need for obstetric registrars to learn techniques for breech births from midwives experienced in delivering breeches, since 30% are undiagnosed and every practitioner will encounter one or more at some stage during their practice.

The role of the media

The media impact on maternity and midwifery issues was also addressed:

“The media have played a significant role in both shaping public opinion of maternity services and the working environment of maternity services health practitioners in the Wellington area.

The front-page coverage given to things that have, or sometimes just appear to have, gone wrong, prior to full investigation of the event, may help to sell newspapers, but is exceptionally damaging to individuals involved in such events. Trial by media can never be fair or objective, and health practitioners working to do their best deserve better than this.”

The lack of leadership within the Ministry for the past six years has resulted in many of the problems highlighted in this report. Hopefully the Ministry will now take this on board and implement the recommendations.

- A copy of the 124-page report can be accessed on the MOH website: www.moh.govt.nz/moh.nsf



MATERNITY ACTION PLAN 2008 - 2012

Several hours after releasing the Wellington maternity report, the Ministry released a draft Maternity Action Plan, and called for public submissions.

The vision for maternity services outlined in the draft plan is that “women will experience pregnancy and motherhood as normal life events with confidence in their ability to give birth.” The vision is supported by a list of eight principles.

The report identified a number of issues as requiring action:

- Leadership of maternity policy, strategy and service development
- The interface of primary maternity service provision with secondary and tertiary maternity services including funding issues
- Alignment of maternity services with primary health care services
- Quality assurance issues including maternity service standards and clinical guideline development and/or review
- Maternity information systems, data collection and analysis including outcome and performance indicators
- Inequalities in maternity outcomes, particularly for Maori and Pacific peoples
- Current and future strategies to address workforce issues
- Professional relationships and multidisciplinary co-operation

Note that the issue of leadership is highlighted again in the action plan. However, the Ministry’s reluctance to provide this badly needed leadership is revealed in the following sentence which featured on the first page in the Introduction:

“The Maternity Action Plan (MAP) is set in the context of existing work and emerging programmes, and establishes the maternity sector as the leader in the protection, promotion and support of birth as a normal life event in this country.”

Who gets to be the leader in the maternity sector and who gets control of the ‘map’ is obviously going to determine whether pregnant women continue to get led up the garden path or are empowered to give birth without being encouraged to succumb to a whole host of interventions and are then supported to begin mothering as nature intended.

Submissions on the Maternity Action Plan were due by 31 December 2008 but due to the change in government have been postponed till early next year. The Ministry of Health is also planning to run regional forums, hui and fono over November and December to discuss the draft Plan. The MSCC will keep you posted on where and when these will be held.

A copy of the Maternity Action Plan can be accessed on the MOH website: www.moh.govt.nz/publications

THE DANGERS OF INFANT FORMULA

The considerable risks associated with the use of infant formula in many developing countries have been graphically highlighted in the media this year in a series of articles and stories focused mainly on the addition of melamine, a substance used in the production of plastics and fertilisers, to milk products including infant formula in China. It is essential that this particular scandal is not seen as a one-off event as the use of infant formula is responsible for the deaths of thousands of babies every year.

The problem with contaminated infant formula isn't unique. After all, the Chinese have been caught out adding melamine to food products before. Early last year it was discovered that melamine had been added to pet food for the same reason – to disguise the low levels of protein. The contaminated pet food was subsequently linked to kidney failure and death in cats and dogs in the USA. So the use of melamine by farmers who were adding the toxic chemical to conceal the fact that they had watered down the milk they supplied to San Lu, China's largest producer of powdered milk, should have come as no surprise. The claims by Fonterra, San Lu and other companies affected by the scandal that the chemical was not tested for in their quality control programme because "you can't test for every poison out there" and "there isn't a dairy company in the world that tests for melamine," lack credibility and simply do not hold water. When it comes to products that are made in China or India, especially foods and medicines, previous experience should tell us that anything is possible, including infant formula made from chalk and water that contained no milk powder or nutritious ingredients at all – another Chinese scandal that people seem to have forgotten about.



The news that lethal bacteria have also been found in some of San Lu's milk powder received far less media coverage, although this is a potential risk factor with all infant formulas both here in New Zealand and elsewhere. It is one of the reasons why premature babies should not be fed with infant formula. A few years ago a premature baby in the Waikato died as a result of being fed contaminated infant formula.

At the end of September Mata Pida, a reporter in Bangladesh was interviewed on National Radio. Referring to the Chinese infant formula scandal, he stated that the Bangladesh government had banned two brands of Chinese milk products in the wake of the scandal. He then went on to describe the deadly impact that the use of infant formula has in Bangladesh. Every year over 10,000 babies die of diarrhoea and infection resulting from the use of infant formula. Over the past 25 years aggressive marketing strategies by the manufacturers of infant formula has seen a huge increase in the use of infant formula by vulnerable mothers who do not have access to safe clean water and who cannot afford the cost of the formula. When asked why mothers would give up breastfeeding and switch to formula-feeding their babies, Mata Pida described how doctors in Bangladesh are being aggressively targeted by infant formula companies and convinced to

recommend formula when mothers go to the doctor with problems with their babies and/or with breastfeeding difficulties.



In a general ward in the main diarrhoea hospital in the capital city of Dhaka, around 70% of the patients are babies. Twenty-five years ago small babies were almost unknown as patients in this hospital. All the babies in the ward are bottlefed. The formula these babies have been given has been mixed with dirty water and because the bottles are not sterile the babies develop diarrhoea.

For many families the cost of buying infant formula is simply too much which results in them using less of the milk powder in order to make it last longer. Or they resort to ordinary powdered milk because it is a lot cheaper to buy that branded infant formula. Both solutions to the high cost of the infant formula can prove lethal to their babies.

When asked about the role of grandparents, village elders and traditional healers in promoting breastfeeding as being best for the baby, Mata Pida said that doctors often discredit traditional healers, referring to them as quacks, and even the village elders and grandparents have fallen victim to the allure and promise of the posters in doctors' surgeries showing healthy European babies bottlefed with infant formula.

Doctors, nurses and ward attendants are given gifts by the drug companies, including pens and notepads with pictures of infant formula on them. The mothers, many of them illiterate, will take the piece of paper to their local shop or pharmacy and ask for that particular product by pointing to the picture or by simply searching the shelves for a tin identical to the one in the picture on their piece of paper.

Nestle is the maker of Lactogen, one of the leading brands of infant formula in Bangladesh. Nestle is also the company that has been the subject of an international boycott of all its products for more than 30 years due to their unethical methods of promoting infant formula over breastmilk to vulnerable mothers in Africa. The boycott was launched on 4 July 1977 in the USA and quickly spread to Australia, New Zealand, Canada and Europe. Following the World Health Assembly's adoption of the International Code of Marketing of Breastmilk substitutes in 1981, Nestle met with the boycott co-ordinators in 1984 and agreed to implement the Code and the boycott was officially suspended. In 1988 accusations that infant formula companies were flooding health facilities in the developing world with free and low-cost supplies led to the boycott being relaunched the following year. The boycott is still in force today with many European universities, colleges and schools banning the sale of Nestle products from their shops and vending machines. In the UK hundreds of businesses, health groups, consumer groups, faith groups, local authorities, trade unions, education groups, politicians, and celebrities all supporting the boycott.

Even New Zealand is not immune to problems caused by infant formulas. At the beginning of September irate parents began using the Trade Me message board to compare notes about the Nurture brand of infant formulas that were making their babies sick. They complained about their baby's reaction to the formula describing symptoms that included vomiting, severe diarrhoea, bleeding nappy rash, wind and constipation. Six weeks after, the first of more than 70 parents first began contacting Heinz, the company which owns Nurture Baby, the company finally swung into damage control. Heinz admitted that their Starter and Follow-On formulas were no longer being made in New Zealand and supplies were now coming from its sister company in the UK. However, the company said that it is planning to switch again to an Australian supplier. Heinz said every effort was made to ensure that the UK produce matched the previously NZ-made formulas nutritionally but some ingredients were produced differently. It didn't state what these ingredients were, how the production of the ingredients differed, or why these would cause such severe reactions in babies.

One mother whose 5-month old daughter got very sick on the new formula commented: "With all these babies being sick on Nurture it does just play on the back of my mind – what have I been feeding my baby?"

It's a question all mothers who choose to put their babies on breastmilk substitutes should be asking themselves, as no-one talks much about the risks of what is actually in a can of infant formula.





TRAUMA AND BIRTH STRESS STUDY DAY

Trauma And Birth Stress – Support and Education Group - presents

“IDENTIFYING AND CARING FOR PEOPLE WITH PTSD RESULTING FROM CHILDBIRTH”

FRIDAY 13TH FEBRUARY 2009 8.30AM – 4.30PM
CCS TRAINING ROOM, 14 ERSON AVE, ROYAL OAK, AUCKLAND

“WHAT IS POST PARTUM PTSD AND THE TREATMENTS”

- PAULINE GRIFFITHS (CLINICAL PSYCHOLOGIST)

“HEARING FROM TABS”

- SUE WATSON (CHAIRPERSON OF TABS & CHILDBIRTH EDUCATOR)

“IMPLICATIONS FOR CARE”

- NIMISHA WALLER (SENIOR LECTURER MIDWIFERY, AUT)

“WHO READS THE NOTES AND WHAT DO THEY MEAN?”

- GLENDA STIMPSON (MIDWIFE, NATIONAL WOMENS HEALTH)

“COUNSELLING AND SUPPORTING PEOPLE WITH PTSD”

- PAULINE GRIFFITHS (CLINICAL PSYCHOLOGIST)

- CHERIE MORAN (MIDWIFE & COUNSELLOR),

- SUSAN GOLDSTIVER ((PSYCHOTHERAPIST)

- AND SEVERAL COMMUNITY GROUPS

“HEARING FROM FATHERS” - SUE WATSON & VIDEO OF ROB

***“HOMOEOPATHY AND EMOTIONAL WELLBEING AROUND
CHILDBIRTH” - NATURO PHARM LTD (RESIDENT HOMOEOPATH)***

APPROVED BY NZ MIDWIFERY COUNCIL, - 10 POINTS REGISTER EARLY, LIMITED NUMBERS

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REGISTRATION, AFTER 13TH JAN \$150.00**

ENQUIRIES TO: AKFEB09@TABS.ORG.NZ OR 09 5757 404, AH. CHEQUES PAYABLE TO:
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REFUNDS SUBJECT TO A \$45.00 ADMIN FEE BEING RETAINED, NO REFUNDS AFTER 13TH JAN 09.

HEALTH AND DISABILITY COMMISSION

SUMMARY OF REPORTS – SEPTEMBER TO NOVEMBER 2008

Case 07HDC08615 – Released 14 October 2008

Overview (summarised from page 3 and 4 of the report)

Mrs A, aged 34 years, went into labour with her first baby in the early hours of 7 September 2005. She was monitored by LMC midwife Ms B at a maternity unit. Mrs A initially laboured in water, however, when a prolonged episode of dips in the foetal heart rate was noted at 10.43am, Ms B assisted Mrs A from the bath. At 10.48am, Ms B called for urgent assistance, and midwife Ms C arrived to help. Shortly after arriving in the delivery room, Ms C called for an ambulance because Baby A's heartbeat was still low – two further staff also arrived to assist.

The ambulance arrived at 11am. The baby's heartbeat had returned to normal, and the ambulance crew were asked to remain on standby because the birth was imminent. Baby A was birthed at 11.04am, dark grey in colour, floppy and making gasping movements. She was taken to the resuscitation table where full resuscitation was carried out. The chest compressions brought the baby's heart rate up, but this was not sustained and her heart rate dropped to 40bpm. Ms C decided that Baby A needed added assistance to breathe and attempted to intubate Baby A. Her first attempt at 11.25am was unsuccessful. At 11.27am the public hospital's Neonatal Intensive Care Unit (NICU) was notified of the situation and the retrieval team requested to attend. Ms C's second intubation attempt at 11.35am was successful and the baby's heart rate stabilised but her condition did not improve. The Neonatal Retrieval Team arrived at midday.

Midwife Ms D assumed responsibility for Mrs A's care while Ms B and Ms C were resuscitating the baby. Mrs A haemorrhaged following the birth of the placenta and required resuscitative support. The ambulance was recalled and transferred her urgently to hospital.

Baby A was admitted to NICU and was found to have sustained a major brain injury presumed to have been the result of the delay in establishing effective resuscitation.

Complaint and investigation (as per page 2 of the report)

On 18 May 2007 the Health and Disability Commissioner (HDC) received a complaint from Mrs A about the services provided by independent midwives Ms B, Ms C and Ms D. The following issues were identified for investigation:

- *Whether midwife Ms B provided Baby A with appropriate treatment and care on 7 September 2005*
- *Whether midwife Ms B provided Mrs A with appropriate treatment and care on 7 September 2005*
- *Whether midwife Ms C provided Baby A with appropriate treatment and care on 7 September 2005*
- *Whether midwife Ms D provided Mrs A with appropriate treatment and care on 7 September 2005*

An investigation was commenced on 6 September 2007. It has been delayed by challenges by the parties to the provisional opinion, necessitating clarification of some factual issues and further expert advice.

Summary of the report

This is a large report (58 pages), with many facets to it. It is also a tragic case for all concerned, with far reaching impacts on the parents, the baby girl and all the practitioners involved in her care. A copy of the report can be found on the HDC website: www.hdc.org.nz

The key issues examined under the report were:

- Maternal assessment during labour and birth
- Neonatal resuscitation
- Third Stage care and PPH
- Documentation

Opinion

Breach – Ms B (pages 20 to 26 of the report)

“As Mrs A’s LMC, Ms B had overall responsibility for the maternity care provided to Mrs A. Ms B’s care of Mrs A and Baby A was deficient in several respects. Her assessment of Mrs A and resuscitation of Baby A were not of an appropriate standard, in breach of Right 4(1) of the Code. Ms B also failed to comply with professional midwifery standards in relation to her documentation of events and breached Right 4(2) of the Code.” *Page 26*

Breach – Ms C (pages 26, 27 and 28 of the report)

- “I accept my expert’s advice that Ms C did not resuscitate Baby A with reasonable care and skill. Accordingly, Ms C breached Right 4(1) of the Code.” *Page 28*
- “There is no evidence that Ms C documented any of her actions. By failing to collate and document “comprehensive assessments of the ... baby’s health and wellbeing”, Ms C did not comply with standard three of the NZCOM *Midwives Handbook for Practice* (2005) and breached Right 4(2) of the Code.” *Page 28*

Breach – Ms D (pages 29 and 30 of the report)

“In my view, having assumed responsibility for Mrs A’s care, Ms D should have been more vigilant. By failing to remain with Mrs A during the third stage of her labour when she was at risk of a postpartum haemorrhage, Ms D did not provide midwifery services with reasonable care and skill. Accordingly, Ms D breached Right 4(1) of the Code.” *Page 30*

Recommendations (page 38 of the report)

I recommend that Ms B:

- Apologise for her breaches of the Code. The apology should be sent to HDC by **30 September 2008** for forwarding to Mr and Mrs A.
- Review her practice in relation to her documentation and the use of water in labour and delivery, and confirm that she has done so by **30 September 2008**.

I recommend that Ms C:

Apologise for her breaches of the Code. The apology should be sent to HDC by **30 September 2008** for forwarding to Mr and Mrs A.

I recommend that Ms D:

Apologise for her breach of the Code. The apology should be sent to HDC by **30 September 2008** for forwarding to Mr and Mrs A.

GUTHRIE CARDS IN DANGER OF BECOMING A NATIONAL DNA DATABASE

The blood taken from babies through a heel-prick test and placed on a card known as the Guthrie Card has been stored indefinitely and is now in danger of becoming a de facto national DNA database. More than two million DNA samples are currently stored with the National Screening Unit and there are cards dating back nearly 40 years since the heel-prick test was first introduced in New Zealand in 1969.

Privacy Commissioner Marie Shroff has raised concerns over what the data could potentially be used for in a submission to the Health Ministry and has recently spoken out on national radio about the plans to continue storing the cards. Ms Shroff believes the cards should be destroyed after 16 years as no parents has given permission for their child's Guthrie card to be stored indefinitely, or accessed and used by a third party. The National Screening Unit has come under pressure from public health researchers to retain the cards and make them available for research. However, Ms Shroff believes that before that happens there needs to be wide public consultation, and a completely separate body should be set up and legislation enacted to protect this database from secondary uses.

Returning the Guthrie Card

Those parents who wish to request that their child's Guthrie card be returned to them can write to the National Testing Centre, PO Box 872, Auckland for a form to fill in, or download the 2-page form from the National Screening Unit website. As the form is difficult to find on the NSU website, try googling "return of Guthrie card."

MSCC MEETING DATES FOR 2009

Please make a note of the following MSCC Steering Group meeting dates for 2009 in your diary and come along to our monthly meetings. You can be assured of a warm welcome. The MSCC meets on a Tuesday morning – meetings start at 10 am – and the days have been fitted around school holidays.

The meetings are held on the 2nd floor, 27 Gillies Avenue, Newmarket. The meeting dates for 2009 are: **10 February, 3 March, 7 April, 5 May, 2 June, 30 June, 4 August, 1 September, 13 October, 3 November and 1 December.**

So if you have an issue of concern or would like to share information about women's experiences of maternity care then do come along. Babies and toddlers welcome.

We look forward to seeing you – on the 2nd floor, 27 Gillies Avenue.