Maternity Services Consumer Council

MARCH 2009 NEWSLETTER

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

Welcome to the first issue of the Maternity Services Consumer Council Newsletter for the year. It is already shaping up to be another interesting year for maternity services in New Zealand. We wait with considerable interest to see what will come of the new government's pre-election promise to extend in-patient postnatal care from two to three days, and when the consultation on the Ministry of Health's *Maternity Action Plan* will be resumed.

The media got into the act early with a lengthy article at the end of January in the *Listener* magazine on "Birth: the Kiwi Way" which was a rehash of the old doctors vs midwives argument and how the move to midwifery care for the vast majority of childbearing women has been another "unfortunate experiment" on women. The hidden agenda feeding this story is only briefly alluded to in the article – the attempt by Australian obstetricians to prevent the Australian government from including midwifery care as part of the Medicare maternity care payment scheme, using a letter from the Royal Australian and New Zealand College of Obstetricians and Gynaecologists to present the case that New Zealand's maternity system is "a disaster that the rest of the world would learn from." The next four issues of the *Listener* have included many letters written in response to the article, including one from the MSCC.

A copy of the Australian "Report of the Review of Maternity Services" is available at http://www.health.gov.au/internet/main/publishing.nsf/Content/maternityservicesreview-report

Screening for HIV during pregnancy

The three District Health Boards in the Auckland region have been given the go ahead to start antenatal HIV screening, implementing the National Screening Unit's HIV screening programme which is already underway in most other DHBs around the country. Of course, many Auckland GPs have been ordering HIV tests on their pregnant patients for many years – with or without their knowledge and consent. Hopefully the training both GPs and midwives have now undergone will mean few women will now be tested without their expressed consent.

What's in this issue of the newsletter

This issue of the MSCC newsletter begins with a report from Jennie on the Meaning of Motherhood conference, and is followed by an executive summary of a new report on Evidence Based Maternity Care, an article on the presence of Bisphenol A in baby bottles and other plastic containers and the danger this chemical poses to both mothers and babies, a summary of recently released reports by the Health and Disability Commissioner, and a news item on a new method of foetal monitoring.

Happy Reading!

THE MEANING OF MOTHERHOOD

On Friday, 28 November 2008 I had my role as a mother validated! The Centre for Attachment "conversation" (as opposed to conference) brought together like-minded people to explore and more importantly, celebrate, maternal love, modern culture and the essence of family.

The day started with the first of the keynote speakers, Naomi Stadlen, a mother and grandmother from London, who also works as a psychotherapist, counselor and authored *What Mothers Do … Especially when it looks like nothing*. Naomi described mothering as the "summer time" of our lives and that women need to clear both a physical and internal space to welcome their babies into their "heart" room. She talked about mothering being responsive and that the internal space we create is 'elastic' – hence why we can love more and more children and grandchildren! Naomi also acknowledged that for some women transitioning to motherhood, their inner space may be designed not to welcome her baby, but to keep him out. For those women their journey is no less valid or real than for the mother who is able to quickly create heart room for her new child. More importantly, Naomi validated the role of women as mothers and suggested that rather than dismissing mother's observations as anecdotal we should acknowledge them instead of always looking to the research.

> *"If we see "nothing" when we look at a mother who is quietly being a mother, it is easy for her to feel that she is doing nothing too. If she thinks she is doing nothing, and we thing she is doing nothing, there is only the speechless baby to experience how much good she is doing."*
> *Naomi Stadlen, What Mothers Do*

Following Naomi's heartfelt presentation was Melbourne based mother of two, Anne Manne. Anne also works as a journalist, social philosopher and authored *Motherhood: How should we care for our children?* Anne noted that the culture of mothering is strongly linked to economic agendas. In our society of high consumption, indebtedness and unaffordable housing many policies focus on women only being productive if they are in the paid workforce. Anne bravely discussed the risks of early childcare and challenged the ideology that "we have to work to make us fully human." She also suggested that if every child matters, then we must explore the opportunity cost of not returning to work and give women a "real" choice so they are not economically penalised for remaining at home and mothering their children.

> *"Family life is being reshaped by the new economy. Although it is rarely made explicit, the new capitalism is contingent on a trade-off; higher productivity is translated not into more time at home but more hours worked per family per year to service our consumption habit."*
> *Anne Manne, Motherhood: How should we care for our children?*

Lauren Porter, mother of two and co-founder of the Centre of Attachment also challenged the audience to embrace motherhood as a learning experience with their children as the teachers. For this to happen, we need to open our "heart" room and really listen to our children and their teachings.

In the afternoon I attended two presentations focused on Becoming a Mother and Resilience & First-Time Motherhood. Both of these presentations reinforced that the transition to motherhood is a significant step for women and that they need their role to be recognised and validated, to have a sense of self-efficacy, to be able to ***choose*** to re-enter the paid workforce or stay at home and to receive supportive, practical and flexible advice. Mothering the Mother was a strong and consistent theme from the day and with the increasing numbers of women returning to the paid

workforce it reduces the numbers of women at home who are available to support. This in turns makes support groups and agencies of even more value in the modern context.

Liz Muir, mother, grandmother and semi-retired psychotherapist gave the final presentation of the day and challenged us all to reclaim the role of mothering and not allow ourselves to be described as a "caregiver" – a term she could not even find in her Oxford dictionary! Mothers do not just give care, we surrender ourselves to our role, create heart room and "hold" our children – our role is much bigger, deeper and richer than the role of a caregiver or educator.

The day was attended by a vast array of people including Pat Tuhoy and Christine Stewart from the MoH, Well Child Nurses, psychologists, therapists and mothers of any description. The themes of the day resonated strongly with us all and Gerry Smith, a Lactation Consultant from National Women's, has agreed to spearhead the development of a New Zealand based group that aims to put mothering back on the agenda! If you would like to be involved with this group, then email Gerry at g.smith@vivid.net.nz.

There were many powerful comments raised throughout the day – far too many to list here - however I want to leave the last quote to Adith Stoneman, Auckland based mother, LLL Leader and Childbirth Educator:

> *"In a traditional society women who become mothers often gain status, however in our culture they seem to lose status."*
>
> *Adith Stoneman*

I challenge you all to assist in raising the status of mothers in New Zealand!

Jennie Valgre

"EVIDENCE-BASED MATERNITY CARE: What it is and What it can achieve"

In October 2008 a report on evidence-based maternity care was released. It represents a collaboration of three American agencies – the Childbirth Connection (CC), the Reforming States Group (RSG) and the Milbank Memorial Fund (MMF). The report presents a discussion of current maternity care in the US health care system and identifies key areas where improvement is needed. The report summarises results of the many systemic reviews that could be used to improve the quality of maternity care, identifies barriers to the use of evidence-based maternity care, and offers policy recommendations and other strategies that could lead to wider implementation of evidence-based maternity care in the USA. Although produced in the United States, there is much in the report that applies equally well to maternity care in New Zealand.

The report's target audience is broad and includes many stakeholder groups, as well those who are involved with maternity care, including health professionals and health profession educators, hospital administrators, researchers, childbearing women and their families, consumer advocates, and journalists.

The executive summary of the report begins by stating:
"Effective maternity care with least harm is optimal for childbearing women and newborns. High-quality systemic reviews of the best available research provide the most trustworthy knowledge about beneficial and harmful effects of health interventions. A large, growing body of systematic reviews is available to help clarify effects of maternity practices, yet these valuable resources are grossly underutilised in policy, practice, education, and research in the United States. Practices that are disproved, or are appropriate for mothers and babies in limited circumstances, are in widespread use, and beneficial practices are underused. Rates of use of specific practices very broadly across facilities, providers, and geographic areas. In large part because of differences in practice style and other extrinsic factors rather than differences in needs of women and newborns. These gaps between actual practice and lessons from the best evidence reveal tremendous opportunities to improve the structure, process, and outcomes of maternity care for women and babies…

Although most childbearing women and newborns in the United States are healthy and at low risk for complications, national surveys reveal that essentially all women who give birth in US hospitals experience high rates of interventions with risks of adverse effects. Optimal care avoids when possible interventions with increased risk for harm. This can be accomplished by supporting physiologic childbirth and the innate, hormonally driven processes that developed through human evolution to facilitate the period from the onset of labour through birth of the baby, the establishment of breastfeeding, and the development of attachment. With appropriate support and protection from interference, for example, labouring women can experience high levels of the endogenous pain-relieving opiate beta-endorphin and of endogenous oxytocin, which facilitates labour progress, initiates a pushing reflex, inhibits postpartum haemorrhage, and confers loving feelings. Large national prospective studies report that women receiving this type of care are much les likely to rely on pain medications, labour augmentation, forceps/vacuum extraction, episiotomy, caesarean section, and other interventions than similar women receiving usual care...

Overused Maternity Practices
Many maternity practices that were originally developed to address specific problems have come to be used liberally and even routinely in healthy women. Examples include labour induction, epidural analgesia, and caesarean sections. These interventions are experienced by a large and

growing proportion of childbearing women; are often used without consideration of alternatives; involve numerous co-interventions to monitor, prevent, or treat side effects; are associated with risk of maternal and newborn harm; and greatly increase costs. Mothers, babies, and purchasers would benefit from giving priority to effective, safe care paths and using risky interventions for well-supported indications only or when other measures are inadequate. The following practices would instead be consistent with the framework of this report: avoiding induction for convenience; using labour support, tubs, and other validated nonpharmacologic pain relief measures and stepping up to epidurals only if needed; and applying the many available measures for promoting labour progress before carrying out caesarean section for "failure to progress" … Available systematic reviews also do not support the routine use of other common maternity practices, including numerous prenatal tests and treatments, continuous electronic foetal monitoring, rupturing membranes during labour, and episiotomy.

Underused Maternity Practices

Systematic reviews also clarify that many effective maternity practices with modest or no known adverse effects are underutilized. Greater fidelity in providing these forms of care would lead to improved outcomes for many mothers and babies. In pregnancy, such care includes prenatal vitamins, smoking cessations interventions, measures for preventing preterm birth, and hands-to-belly manoeuvers to turn fetuses to a head-first position before birth. The many beneficial, underused practices around the time of birth include continuous labour support, numerous measures that increase comfort and facilitate labour progress, nonsupine positions for giving birth, delayed cord clamping, and early mother-baby skin-to-skin contact. Best available evidence also supports providing access to vaginal birth after caesarean (VBAC) for most women with a previous caesarean. Systematic reviews also identify many strategies for increasing both establishment and duration of breastfeeding and effective ways to treat postpartum depression.

Barriers to Evidence-Based Maternity Care

Efforts to increase access to evidence-based maternity care should address barriers to quality improvement. Barriers to evidence-based maternity care include the following:

- Lack of a set of robust maternity performance measures with buy-in of key stakeholders to sue them for measuring, reporting, rewarding, and improving performance
- Perverse incentives of payment systems
- Adverse effects of the malpractice system
- Primary reliance on specialists for providing maternity care to a predominantly healthy, low-risk population
- Limited reliance on best evidence in leading guidelines for maternity care
- Loss of core childbearing knowledge and skills among health professionals
- Limited attention to harms and iatrogenesis
- Challenge of translating research into practice
- Adverse effects of pressure from industry
- Inadequate informed consent processes and women's lack of preparation for making informed decisions
- Limitations of views put forth in media and popular discourse.

Efforts to improve payment systems, the liability system, consumer decision-making processes, and other factors that impact clinical decisions should identify best evidence and develop policies, programmes, and processes that align these systems with optimal care."

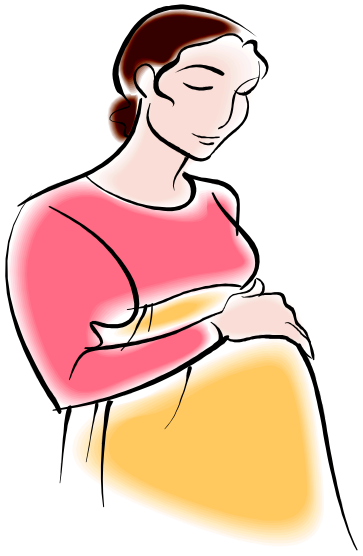
The organisations involved in compiling this report

The Milbank Memorial Fund was established in 1905 to work with decision makers in the public and private sectors to carry out nonpartisan analysis, study, and research on significant issues on health policy.

The Reforming States Group was organised in 1992 and is a voluntary association of leaders in health policy in the legislative and executive branches of government, from all fifty of the states in the USA, and from Canada, England, Scotland, and Australia.

Established in 1918, Childbirth Connection (formerly Maternity Center Association) is a national not-for-profit voice for the needs and interests of childbearing families. Its mission is to improve the quality of maternity care through research, education, advocacy, and policy.

- A copy of the 55-page report "*Evidence-Based Maternity Care"* is available at www.milbank.org/reports/0809MaternityCare/0809MaternityCare.html



BISPHENOL A, BABY BOTTLES & BREAST CANCER

This following article appeared in Issue 78 of Upfront*, the newsletter of the Breast Cancer Network NZ. It was written by Sue Claridge and is reprinted with permission*.

Despite the denials of any possible harm from the plastics industry, some governments are starting to take action against endocrine disrupting chemicals, such as Bisphenol A and phthalates, in everyday plastic items and are applying the precautionary principal, especially when it comes to the most vulnerable members of society – our babies.

Having already banned some phthalates* in cosmetics and toys, in January 2005 the European Parliament's public health committee called for banning nearly all phthalates in household goods and medical devices.

In 2005, a bill was put before the Californian Legislature that would have banned toys, pacifiers, baby bottles and teethers that contained Bisphenol A (BPA) or phthalates. The bill sparked considerable debate and was defeated in January 19, 2006, after sparking a scientific debate and intense lobbying by the plastics industry. The failure of the bill came only three days before the Israeli Ministry of Health warned that parents should throw away old or cracked baby bottles, and worn pacifiers and teething rings because of the BPA leaching into baby formula or being ingested directly from worn plastic.

Finally in September 2007, the California legislature passed a bill that requires that all child care products and children's toys sold in California are free of phthalates. Governor Arnold Schwarzeneggar said "We must take this action to protect our children," as he signed what became known as the Toxic Toys Bill. "These chemicals threaten the health and safety of our children at critical stages of their development."

BPA and plastic hit the international news headlines again December 2007 and January 2008 when a number of retailers in Canada (including one of Canada's largest outdoor gear retailers, the 2.7 million-member Mountain Equipment Co-op) pulled plastic bottles from their shelves over concerns that BPA may make polycarbonate bottles a health hazard. The popular Nalgene bottles were among those removed from shelves.

At the time, BPA was under review as part of the Canadian federal government's Chemicals Management Plan, and the Ontario government had recently announced an expert panel would review toxic chemicals, including BPA.

BPA forms the polycarbonate plastic used in a wide variety of everyday items including baby bottles and sippy cups, food can linings, dental sealants and sports water bottles as well as many food containers and clear polycarbonate "glasses." ** Research has shown that BPA leaches from intact polycarbonate products as well as from worn or damaged plastics.

The impact starts as early as in the womb: the authors of research published in the journal *Endocrinology* (2005) wrote that their studies "suggest that perinatal exposure to BPA in particular, and to oestrogens in general, may increase susceptibility to breast cancer." The impacts of BPA on human health, in particular breast cancer, from as early as in the womb have been the subject of previous articles in *Upfront* (Insidious Oestrogens, *Upfront* 67; The Impacts of a Chemical Soup, *Upfront* 76).

In April 2008, the Canadian government announced that it plans to ban the import and sale of polycarbonate baby bottles containing BPA in mid June, making Canada the first country in the world to limit exposure to the controversial chemical. Canadian Health Minister Tony Clement said that Health Canada's assessment shows that in most instances, negative health effects occur at levels [of exposure] much greater than those to which Canadians are exposed. "[But] this is not the case for newborns and infants," he said. "We have concluded that early development is sensitive to the effects of bisphenol A. Although our science tells us that exposure levels to newborns and infants are below levels that cause effects, we believe the current safety margin needs to be higher."

In response to the Canadian announcement New York company Nalgene Outdoor Products – manufacturers of the Nalgene water bottles which were the subject of the December retailers' withdrawal – announced that it would stop producing the containers because they are made with BPA.

In stark contrast to the move by Canada to ban BPA, and California's banning of phthalates, the New Zealand agency responsible for overseeing the safety of anything to do with food and drink – the New Zealand Food Safety Authority – steadfastly refuse to entertain the idea that there may be harms associated with the use of products containing BPA and phthalates. Despite significant and increasing evident to contrary, the NZFSA states on their website (accessed on May 22, 2008) that "To date, the available scientific data (which includes life-time feeding studies in animals) indicates that bisphenol A does not cause cancer." They go on to say that "NZFSA does not believe that parents and caregivers who use polycarbonate baby bottles following manufacturers' instructions are placing infants at risk."

However, the Breast Cancer Network's Stop Cancer Where it Starts project recommends that parents use glass baby bottles and avoid reusing plastics made with BPA, in line with advice from researchers such as Dr Maricel Maffini from Tufts University in Boston.

In a follow up article in the December 2008/January 2009 issue of "Upfront" Sue Claridge reports that the continued use of BPA in plastics that are used in food containers and packaging is coming under increasing criticism from scientists who are also leveling criticism at the FDA. She writes:

"On the 16th of September 2008 the FDA announced, in a draft assessment of the safety of BPA in food contact applications, that current levels of BPA used in food packaging do no appear to cause health problems. On the same day the *Journal of the American Medical Association* (JAMA) published online the results of a study which found that exposure to the BPA in food packaging may be putting millions at an increased risk for cardiovascular disorders, diabetes and liver abnormalities.

While the specific concern of many researchers revolves around the oestrogenic activity of BPA and its role in the development of breast cancer and male genital tract deformities among other effects, it is ironic that the link between BPA and "some of the most significant and economically burdensome human diseases" came on the day that the FDA announced that "an adequate margin of safety exists for BPA at current levels of exposure from food contact uses."

The FDA announcement also comes only months after its neighbour, Canada, banned the use of BPA in baby bottles and the liner in cans of baby formula. As governments and regulator agencies in the developed world (the EU, Japan, Canada, California) begin to take a harder line on the use of endocrine disrupting chemicals such as BPA and phthalates, particularly in items used by babies

and children, it is hard to understand the FDA's rationale. That is, until one discovers the FDA excluded all but two of the many independent studies published on the effects of BPA, and that the only two studies that were relied upon in the assessment were industry funded.

So why would the FDA ignore a huge volume of research in favour of two industry-funded rodent studies? The plastics industry is a huge, multi-billion dollar industry worldwide and a powerful lobby group. They have also consistently denied that their products cause any harm. For example, the New Zealand plastics industry association website (www.plastics.org.nz) still insist that BPD can't possibly be harmful and that our exposure to BPA from plastics is below the level deemed to be safe by the FDA…

What the New Zealand plastics industry association also fail to point out on their website, after using the FDA report to support their case that BPA levels are safe, is that the FDA report has come in for considerable criticism since it was released and that the FDA Science Board Subcommittee on bisphenol A have released a report of their own which is highly critical of the original FDA report."

* Pronounced tha-lates, phthalates are endocrine disrupting chemicals used as plastecisers to keep some plastics soft and pliable.

** Polycarbonate plastics have the recycling number 7.

For further information, contact admin@bcn.org.nz

NEW METHOD OF FOETAL MONITORING

Developing a less invasive way of monitoring foetal heartbeats is the basis of research being undertaken by Victoria University's School of Engineering and Computer Science.

Senior Lecturer Paul Teal says his aim is to find a more passive method of determining the heartbeat of infants in the womb than the active method currently used by physicians and midwives.

“A popular method used in New Zealand is the SonicAid, which is a Doppler device that puts an ultrasound pulse into the mother. You can tell what the heart is doing from the change in frequency of the reflected sound.”

Paul says most clinicians believe that Doppler ultrasound is perfectly safe, but anecdotal evidence suggests many mothers don’t like this method, as it actively puts energy into their bodies, and many midwives report that babies aren’t too keen on it either.

“So I’ve been looking at a passive way to measure the foetal heart rate. You can do this either by putting electrodes on the mother and then detecting the Electric Cardiogram (ECG) signal, or by listening with microphones, which is what my research has focused on. This is more like using the Pinard – the foetal stethoscope that midwives used before the invention of Doppler ultrasound, but much more reliable and easy to use.”

Paul, who previously worked at Industrial Research Limited (IRL) in Gracefield, has been collaborating with his former colleagues to develop a method of using microphones to separate out the mixture of signals emitted from the womb by using a technique called Blind Source Separation.

“This isolates the foetal heart rate from the mother’s heart rate, and the background noise. It’s also a more passive method of monitoring that doesn’t negatively impact upon either the mother or the baby.”

Paul says he and his IRL counterparts are now working closely with Wellington midwives to collect data from mothers using this less invasive method.

“We’ve proved the method works in the last few weeks of pregnancy, but we’re hopeful that eventually we will be able to use it from when a foetus is 18 weeks. Doppler ultrasound can work from about 12-14 weeks, but the important stages are later in the pregnancy.”

Published 14 January 2009

HEALTH AND DISABILITY COMMISSIONER
Summary Of Reports
November 2008 To February 2009

Case 07HDC04325 – Released 25 November 2008

Overview
Baby A was born at Palmerston North Hospital on 2 July 2003 in apparently normal condition, and transferred to a maternity unit for postnatal care. On 5 July, the baby developed hypoglycaemia and sustained significant neurological damage as a result. The report considers the adequacy of care provided to Baby A by the midwifery staff of the maternity unit, and MidCentral District Health Board, from 3 to 5 July 2003.

Complaint and investigation (as per page 1 of the report)
On 19 March 2007, the Health and Disability Commissioner (HDC) received a letter from Mrs and Mr A requesting an investigation into the services provided to their son, Baby A, at a maternity unit in July 2003.

On 15 August, the Commissioner commenced an investigation, and identified the following issues:

- *Whether Baby A was provided with an appropriate standard of care on by Midwife B, C, D and E during his postnatal stay at the maternity unit.*

Opinion: Breach — Midwives B, D, C, and E

- Midwife B, D and E breached Right 4(2) of the Code.
- Midwife C breached Right 4(1) of the Code and also breached Right 4(2) of the Code.

Opinion: Breach — MidCentral District Health Board
Direct and Vicarious liability

Documentation and care planning continue to be a consistent theme of cases investigated by the HDC, however there is one aspect of this case that would resonate with many families:

"My feelings at that time were that he wasn't feeding well as I kept telling them. All the midwives kept 'reassuring' me as the notes reflect. As [HDC advisor] Jacqui Anderson has observed, if their reassurances to me had been based on self questioning of their own practice in relation to the worried mother's baby's condition, then they may have been alerted to a need to pay closer attention to that baby. And once again, could that have meant a far better outcome for [Baby A]? ... Is there perhaps an assumption amongst midwives that new mothers can be worrisome and overly paranoid? A reminder that not all new mothers are like this and a respect for a mother's innate instinct about her newborn might be called for here. I knew that something was wrong with my baby — my husband and my mother will confirm that I said this several times — but no one was listening."

As part of his opinion, the Commissioner notes*: "Providers should always treat consumers with respect and listen carefully to their concerns. This case is a reminder of why this is so important."* I couldn't agree more!

Case 07HDC15908 – Released 17 February 2009

Overview
Mrs A had a normal pregnancy and went into spontaneous labour at 43 + 1 weeks after being closely monitored by her LMC. After transferring into the hospital in early labour for pain relief an epidural was sited without the recommended 20 minute continuous CTG taking place prior to its insertion, instead a Doppler was utilised and the baby's heart rate was considered to be satisfactory. Once the epidural was sited, continuous monitoring via the CTG commenced and some early decelerations were noted, however these

quickly settled. Shortly after this syntocinon was commenced. Late afternoon the Obstetrician who was asked to review, felt that the CTG looked "pathological" since early in the day and after a foetal scalp Baby A was birthed by forceps. Unfortunately Baby A was born without a pulse or heartbeat; the cord was wrapped tightly around his neck three times.

Complaint and investigation
On 5 September 2007 the Health and Disability Commissioner (HDC) received a complaint from Mr and Mrs A about the services provided to Mrs A and their son, Baby A. The following issues were identified for investigation:

- *The appropriateness of the care provided to Mrs A and Baby A by midwife Ms B.*
- *The appropriateness of the care provided to Mrs A and Baby A by a District Health Board in 2007.*

An investigation was commenced on 14 November 2007. A key focus of the review was around the primary and secondary interface and obstetric consultation and oversight.

Opinion: Breach — Midwife B; Rights 4(2) and 4(5)
Opinion: No Breach — District Health Board

Case 07HDC14036 – Released 17 February 2009

Overview
Mrs A's first baby was due in mid 2007. Mrs A had an uneventful pregnancy. Lead Maternity Carer (LMC) Ms D booked Mrs A for an induction delivery at a public hospital ten days after her due date. However, assessment by locum midwife Ms E indicated that Mrs A was in early labour and induction was not required. Ms E did not listen to the fetal heartbeat. Mr and Mrs A returned to hospital the following morning but the fetal heart could not be heard and their baby had died. The family elected to proceed with a natural delivery and Baby A was delivered later that day. Ms D attended the delivery in conjunction with hospital staff. The family became concerned about the level of professionalism and competence Ms D demonstrated during the day and requested that hospital staff manage the delivery. This report primarily considers the issue of whether mother and baby were adequately assessed by midwife Ms E, and whether LMC Ms D provided appropriate care during the delivery.

Complaint and investigation
On 6 August 2007, the Commissioner received a complaint from Mr and Mrs A about the services provided by midwives Ms D and Ms E. The following issues were identified for investigation:

- *The appropriateness of the care midwife Ms D provided to Mrs A in relation to the labour and birth of Baby A. The adequacy of the information and communication midwife Ms D provided to Mrs A in relation to the labour and birth of Baby A.*
- *The appropriateness and adequacy of the care midwife Ms E provided to Mrs A.*

An investigation was commenced on 18 December 2007. As with the case above, a key focus of the review was around the primary and secondary interface and obstetric consultation and oversight

Opinion: Breach — Ms D; Rights 4(2) and 5(2)
Opinion: Breach — Ms E; Right 4(2)

To review the full reports, please visit the HDC website: www.hdc.org.nz

UPCOMING CONFERENCES

SANDS Conference 2009

"A little life, not a little loss"

Date: Friday 7th & Saturday 8th August 2009 **Venue:** Waipuna Hotel & Conference Centre, Auckland

Fees: $110 one day/$150 Sands Parents full conference/$170 full conference

Hosted by SANDS Auckland Central, the biennial national SANDS conference is a forum for health/caring professionals and bereaved parents/families to come together, to share information & experiences of baby loss. The conference will be an educational programme seeking to raise awareness and promote understanding of baby loss. It will be an excellent opportunity to share knowledge and to listen and meet with others who may share similar jobs/experiences. The aim is to promote a better understanding of the short and long term effects of grief following the loss of a baby. For preliminary information & registration details contact Claire or Tania at SANDS Auckland Central.

New Zealand Lactation Consultants Association
WALKING TOUR

Breastfeeding: Walking together on the path to good health
Whangai U. Hikoi tahi tatou I runga i te huarahi oranga

Auckland 23 March 2009 *The Conference Centre; AUT Tech Park*
Wellington 25 March 2009 *Terrace Conference Centre*
Christchurch 27 March 2009 *Russley Golf Course*

ONLINE REGISTRATION
www.workz4u.co.nz/events