Midwives

Report on Opinion - Case 97HDC7133

Complaint

The Commissioner received a complaint about the services provided to the complainant's daughter in law by three midwives. The complaint is that:

- *In April 1997, the consumer gave birth to a baby girl at her home. A local midwife, (referred to as 'the first midwife') delivered her with the assistance of two other midwives, (referred to as 'the second midwife' and 'the third midwife').*
- *After the birth of her daughter the consumer was taken out of the birthing pool and put on a settee where she haemorrhaged. While the consumer was bleeding profusely the midwives did not assist her as they were arguing about money.*
- *The consumer's husband requested a doctor be called. The midwives called an ambulance.*
- *On arrival the ambulance officers called a doctor who sent the consumer, her baby and husband to Hospital.*
- *At the Hospital, the midwives disagreed with hospital staff over whether the baby was to be admitted as a patient or a boarder. This disagreement led to a delay in the consumer receiving attention.*

Investigation

On 16 May 1997 the Commissioner received the complaint and an investigation was undertaken. Information was obtained from:

The Complainant / Consumer's mother-in-law
The Consumer
The first Provider / Midwife
The second Provider / Midwife
The third Provider / Midwife
The Consumer's husband
The Consumer's sister in law
A General Practitioner
An Ambulance Attendant

The consumer's delivery records, St John's Ambulance records and the Hospital medical records were reviewed. Independent midwifery advice was also obtained by the Commissioner.

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Midwives

Report on Opinion - Case 97HDC7133, continued

Outcome of Investigation

In late April 1997 the consumer gave birth to a baby girl at her home. In attendance were her husband, her sister-in-law, and the three midwives. The consumer's other two children were also in attendance. The first midwife was the lead maternity carer in this case.

At about 6.00pm the consumer's labour commenced. At approximately 1.00am the next day the first midwife called the second midwife to attend the consumer because she was involved with another delivery elsewhere. The second midwife proceeded to the consumer's home. The second midwife arrived at the house at approximately 2.00am. It appeared the first midwife would not arrive in time, so the second midwife called the third midwife to assist her with the delivery. The third midwife arrived at the consumer's home at approximately 10.10am. The first midwife arrived at approximately 10.20am and resumed the role of primary midwife. The baby was born at 10.51am.

The consumer's labour was managed in a birthing pool. The delivery notes indicate that the consumer remained in the birthing pool for approximately 20 minutes after the baby's birth. However, the consumer believes that she was in the pool after the birth for approximately 10 minutes. She estimated it was this long because when she took a telephone call from a friend at 11am she was not in the pool.

The first and second midwives helped the consumer from the pool. As she stepped out of the pool the consumer felt giddy and faint. She was seated on a chair by the pool and the umbilical cord was cut. The records indicate that the consumer was *"beginning to feel faint and bleeding freely".*

Initial Blood Loss

There is some conflict about the amount of blood in the pool. The first and second midwives estimate the blood loss when they helped the consumer from the pool at 300mls. The consumer's pulse rate is recorded at 80 but no other observations are recorded. The consumer was unable to say how much blood she lost but she could feel she was losing a lot of blood. She brought this to the attention of the first midwife. The consumer is unable to recall events clearly after that point in time.

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Midwives

Report on Opinion - Case 97HDC7133, continued

Outcome of Investigation, *continued*

The consumer's sister in law confirmed that the consumer kept insisting that she did not feel right during the delivery, nor while she was sitting in the pool. The first midwife advised that although the water was red with blood, the consumer's bleeding was not excessive. None of the midwives in attendance saw any clots in the water, however, the sister in law, who helped empty the pool, reported seeing many clots in the water. The first midwife advised that it is normal for blood to clot in a pool after a waterbirth and this is noticeable when the pool is drained.

Delivery of Placenta

When the consumer felt faint the midwives laid her on the settee and she started bleeding again. As the first midwife massaged the abdomen a large clot was expelled and soon after there was a gush of blood. The first midwife advised that this is usually the sign that the placenta is about to separate but this did not happen. There was a second gush of blood. The first midwife advised that this was abnormal and she knew she had to deliver the placenta without any delay.

The first midwife administered IM Syntocinon 10 units at 11.51am. She then left the room to urgently go to the toilet. She states that at that point the consumer appeared well. The third midwife delivered the placenta at 11.56am. The midwives estimated the consumer's total blood loss at 800mls and recorded her pulse rate at 90. No other observations are recorded. The consumer had a drink and began feeding the baby. The records indicate that *"[the consumer] continues to feel faint and look pale"*. Her blood loss eased and the third midwife went home. Before the third midwife left the first midwife made arrangements to pay her.

The first and second midwives and the sister in law went to the laundry to examine the placenta. The time and the condition of the placenta are not recorded but the midwives described the placenta as uneven but with no obvious signs that any of the placenta was retained. The sister in law confirmed that the midwives commented on irregularities in the placenta. The first midwife noted that the placenta was thicker than usual in places and this was the unusual factor. Both midwives thought the placenta was complete, as it appeared to be so.

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Midwives

Report on Opinion - Case 97HDC7133, continued

Outcome of Investigation, *continued*

Postpartum Haemorrhage

The consumer continued bleeding and went into shock. The first midwife attempted intravenous cannulation but was unsuccessful because the consumer's veins collapsed. The consumer's husband asked for a doctor to be called. The first midwife does not recall this request being made but did make the decision to telephone the obstetrician at the Hospital as that was her normal line of referral. Upon agreement of the first midwife's assessment and course of action, she telephoned the ambulance for transportation to hospital. The second midwife continued to talk with the consumer, massage her abdomen and helped with preparation of intravenous fluids. The second midwife reported that the consumer's fundus remained firm and it was continuously checked. There is no documentation of any of these events. No other Syntocinon or Oxytocic drug was administered.

The consumer's husband advised that his wife was bleeding continuously, had lost about two litres of blood and was very pale. The consumer's husband had some experience in estimating blood loss having worked in hospitals as an orderly. He has also attended a St John's Ambulance course. The consumer remembers saying to the midwife *"don't let me die"* because she felt she was going into shock.

At 12.44pm the Ambulance Attendant received the call on his pager and proceeded immediately to the consumer's home. His first impressions were that this was a very serious situation because the patient had lost a lot of blood.

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Midwives

Report on Opinion - Case 97HDC7133, continued

Outcome of Investigation, *continued*

When the ambulance attendant arrived he asked if the doctor had been called. He was reluctant for the consumer to travel to the Hospital, a distance of about 30 minutes by road, with no intravenous fluid replacement. The first midwife confirmed that a doctor had not been called because she wanted to get the consumer to hospital urgently and a doctor would delay matters. The ambulance attendant knew of a general practitioner who could come immediately and had experience with intravenous cannulation of patients in shock. The ambulance attendant telephoned this doctor. The ambulance arrived at 12.53pm and the driver/attendant asked for the consumer's legs to be elevated. The midwives objected to this request.

Ambulance services in the area in which the consumer lives rely on voluntary attendants who work at other occupations. This may result in delays in responding to calls and attendants who are not proficient at intravenous cannulation. The first midwife expected one of the ambulance attendants would be able to insert an intravenous line.

The general practitioner called by the ambulance attendant arrived at 1.00pm. Initially he was unable to palpate the consumer's blood pressure or pulse rate. On repeated attempts he thought her blood pressure to be possibly 80 systolic and pulse rate 125 and she was drifting in and out of consciousness. The GP found no sign that basic first aid had been attempted. The consumer was lying flat, her legs were not elevated or head lowered. He ordered that the consumer's legs be elevated. Also the intravenous solution used in the drip set-up was ringer's lactate which he thought inappropriate. The GP stated he had not seen ringer's lactate used in about twenty years. The first midwife advised that she does not carry ringer's lactate in her delivery equipment.

The GP inserted two intravenous cannulae and immediately administered 1 litre Plasmolyte with 15 units of Syntocinon and 500mls Haemocell. He ordered a further 1 litre Normal Saline with 15 units of Syntocinon and 500mls Haemocell to be administered in the ambulance during the journey to the Hospital.

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Midwives

Report on Opinion - Case 97HDC7133, continued

Outcome of Investigation, *continued*

The first and second midwives confirmed that the general practitioner asked about payment for his services because he was unfamiliar with the method of payment. The consumer's sister in law advised the Commissioner that the discussion took place as the consumer was placed in the ambulance. The general practitioner advised the discussion about payment was intended to clarify his role. He had not been notified about the birth but was called upon in a real emergency to resuscitate the consumer. He wanted to know who would take professional responsibility for her care. He advised that this was one of the worst haemorrhages he had seen and he was extremely lucky to insert the cannula at the first attempt. The GP was so concerned about this situation that he subsequently wrote to the Minister of Health in relation to these matters.

At 1.20pm, following the infusion of intravenous fluids but before leaving for the hospital, the GP recorded the consumer's blood pressure as 120/79 and pulse rate 84. At 1.28pm the Ambulance left for the Hospital. As the consumer was placed in the ambulance the consumer's husband reported that the consumer gave a choking rattling sound. He believes this was an attempt by his wife to get oxygen into her system. Moreover, he felt she was very close to a *"major collapse"*.

The consumer's husband and sister in law commented that at no time did any of the health professionals involved with the care of the consumer use gloves or have a "sharps" container for disposing of blood contaminated needles and other equipment. This was confirmed by the second midwife.

The consumer's husband travelled with his wife to the Hospital and advised that she continued to haemorrhage. The first midwife also accompanied the consumer, her husband and baby in the ambulance. The second midwife stayed behind to help clean up.

On arrival at the Hospital at 2.00pm the consumer was pale, cold and shivering. She was examined by the obstetrician who ordered 500mls Haemocell with 30 units of Syntocinon, a urinary catheter inserted, full blood count and blood cross-matched for transfusion. The consumer's haemoglobin was 64g/l and he estimated her blood loss to be greater than 1200mls.

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Midwives

Report on Opinion - Case 97HDC7133, continued

Outcome of Investigation, *continued*

The hospital midwife attempted to take the baby but the first midwife refused, saying she had discussed this with the consumer and her husband who wanted the baby kept with them. The consumer's husband advised that he had never given any such instruction and that the discussion was unnecessary. He was upset and concerned that at the time it seemed nothing was being done to help his wife. The second midwife arrived at the hospital during this conversation.

The consumer was delayed in going to theatre and the first midwife rang the theatre staff who agreed to take her to theatre as soon as possible. The consumer was in a lot of pain and continued bleeding. The first and second midwives administered hot packs to relieve the pain, but no other pain relief was given and no other observations were recorded. At 3.30pm a blood transfusion was commenced and the consumer received the first of 3.5 units of blood. The first and second midwives stayed with the consumer until she was taken to theatre at 3.57pm.

In theatre the Obstetrician removed about one litre of blood clot. An 8 centimetre piece and several smaller pieces of placental tissue were also removed from the uterus. Five units of Syntocinon was administered. He estimated the total blood loss was in excess of three litres. The blood transfusion was completed at 9.00pm.

The first midwife advised that she asked the hospital midwife not to feed the baby because the consumer wished to breast feed and artificial feeding makes breast feeding more difficult. Contrary to the first midwife's instruction the baby was fed during the night. This caused some tension between the first midwife and the hospital midwives. The consumer advised that she was unable to breast feed the baby at this time and the consumer's husband was not consulted on this matter.

The day after these events the consumer was discharged from Hospital with her baby. Her haemoglobin prior to discharge was 88 g/l.

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Midwives

Report on Opinion - Case 97HDC7133, continued

Outcome of Investigation, *continued*

The Commissioner sought advice from a midwife who noted that:

"It would be impossible to accurately estimate the blood loss in the pool. It was appropriate to get [the consumer] out of the pool to enable the midwife to deliver the placenta and better assess blood loss… Putting the baby at the breast would stimulate [the consumer's] own oxytocin production and assist with this (delivery of the placenta)*… There are two recognised managements for the third stage of labour:*

1. *Physiological – that is no prophylactic oxytocic drug is used.*
2. *Active – an oxytocic drug is given as soon as the baby is born.*

New Zealand College Of Midwives (NZCOM) Consensus Statement
The NZCOM recognises that a woman can anticipate the occurrence of a physiological third stage when it is preceded by a physiological labour and birth… It would be normal to wait up to an hour (occasionally 2), for the placenta to be delivered with a physiological 3rd stage. There is no need to interfere unless there is significant bleeding."

The first midwife confirmed that with the physiological method of delivery of the placenta she has waited up to 2 hours. She favours the physiological method because intervention is kept to a minimum and the body expels the placenta in its own time. The first midwife described heavy blood loss on two occasions before the placenta was delivered. The first signalled that the placenta was separating and was normal. However, the placenta did not separate and the second loss changed a normal physiological process into an abnormal event. The first midwife knew she had to deliver the placenta quickly.

The Commissioner's advisor noted that:

"…the care given here is appropriate and within normal practice guidelines, the placenta was delivered, putting the baby to the breast would stimulate more oxytocin".

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Midwives

Report on Opinion - Case 97HDC7133, continued

Outcome of Investigation, *continued*

She further advised:

"midwives have a responsibility to ensure that no action or omission on their part places the woman at risk. There is no record in the notes that the placenta was checked at this time as to whether it was complete or not. Checking the placenta and noting that it was incomplete may have initiated an earlier transfer to the hospital. It is the [midwives] responsibility to check the placenta or to ask another professional to do this. Sometimes it is done immediately following the birth - sometimes later (within one hour).

12:20pm, [the consumer] feeling faint and looking pale, she started bleeding again, becoming shocked.

The aim now would be to 1) control the bleeding and 2) treat the shock…

…?1235 IV attempted – failed, Ambulance called, Hospital notified…Inserting the IV line would have enabled [the first midwife] to give fluids to treat the shock and drugs to treat the haemorrhage, she was unable to treat [the consumer] at home so arranged for transfer. This care is appropriate and within expected standards…

…General recognised treatment of PPH: Massage and compress the uterus manually IV syntocinon infusion, Replace rapidly estimated blood loss, IM/IV syntometrine or ergomentrine Monitor and reassess BP, P, fundus, blood loss, Transfer for further assistance if woman's condition deteriorates, bleeding continues, pulse above 120, BP below 100/60.

….Shock treatment: lie flat, keep warm, Consider – leg elevation – Oxygen gas therapy IV fluid replacement. The two midwives should have: 1) massaged and compressed the uterus manually; 2(given a repeat dose of IM Syntometrene/Ergometrine, (Syntocinon if nothing else available); continually monitor approximately every 15 – 20 minutes [the consumer's] BP, pulse, fundus and blood loss... The midwife has easy access to appropriate emergency equipment "a repeat dose of ecbolic may have been given, fundal massage/compression may have occurred, it was just not recorded, it is often difficult in emergency situations to have time to record everything that is done."

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Midwives

Report on Opinion - Case 97HDC7133, continued

Outcome of Investigation, *continued*

As to the role of the second midwife the Commissioner's advisor informed the Commissioner:

"New Zealand College of Midwives Code of Ethics states 'Midwives take appropriate action if an act by colleagues infringes acceptable standards of care'. [The first midwife] is ultimately responsible for the care given as set out in section 51. Both midwives are accountable for their actions during the time of calling the ambulance and the ambulance arriving."

In summary, the Commissioner's advisor advised:

"...it appears that only Syntocinon was carried as at no time was any other oxytocic given. Both midwives should be encouraged to carry a variety of Ecbolics. Each birth is different and this enables the midwife to treat a postpartum haemorrhage appropriately with or without IV access. It does not appear that a repeat dose of Ecbolic was given – it should have been. I will presume that fundal massage/compression occurred at home and that frequent checks were taken of blood loss and BP/Pulse recordings. The midwife could have used a family member to assist in recording these if they were unable to – or even to apply the fundal massage if necessary. If this did not occur then the management was not within expected guidelines".

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Midwives

Report on Opinion - Case 97HDC7133, continued

Code of Health and Disability Services Consumers' Rights

RIGHT 4
Right to Services of an Appropriate Standard

2) *Every consumer has the right to have services provided that comply with legal, professional, ethical, and other relevant standards.*

…

4) Every consumer has the right to have services provided in a manner that minimises the potential harm to, and optimises the quality of life of, that consumer.

5) Every consumer has the right to co-operation among providers to ensure quality and continuity of services.

Relevant Standards

New Zealand College of Midwives (Inc) *Midwives Handbook for Practice. Scope of practice of the Midwife* states:

…This care includes preventative measures, detecting complications in the mother and child, accessing medical assistance when necessary and carrying out emergency measures…

Standard 6 states:

Midwifery actions are prioritised and implemented appropriately with no Midwifery action or omission placing the women at risk.

Criteria:

- *Demonstrates competency to act effectively in any emergency situation.*
- *Has the responsibility to refer care to the appropriate health professional when she has reached the limit of her expertise;*
- *Has easy access to appropriate emergency equipment.*

The Midwife is accountable to the woman, to herself, to the Midwifery profession and to the wider community for her practice.

Criteria:

- *Clearly documents her decisions and professional actions.*

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Midwives

Report on Opinion - Case 97HDC7133, continued

Relevant Standards, *continued*

The Ministry of Health "The Management of Post Partum Haemorrhage" guidelines state:

Initial Measures

Enlist an assistant immediately
Insert a large bore(16G) IV cannula
Submit blood specimens for cross matching and a FBC
Exclude lower genital tract injury

Treatment

Vigorous IV volume replacement
Rapid replacement of entire ***estimated blood volume lost***
Infuse a ***colloid solution*** *(eg Haemocell) or* ***Normal Saline***
As fast a possible i.e. over 5-10 minutes
Massage *& compress the uterus manually*
Infuse Syntocinon 30IU */ 500Ml Normal Saline*
Inject Syntometrine *1 ampoule IV or IM*

Ongoing Haemorrhage or Haemodynamically Unstable
Enlist support *immediately*
(Obstetrician/Anaesthetist)

Ongoing Treatment
Continue IV Volume replacement
Replace estimated blood volume lost
Infuse at double the rate of the estimated ongoing blood loss
Continue Syntocinon infusion
Repeat Syntocinon 1 ampoule
Inject Prostin/ 15M 250 (micrograms) IM into thigh or buttock

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Midwives

Report on Opinion - Case 97HDC7133, continued

Opinion: Breach, First Midwife

In my opinion the first midwife breached Rights 4(2), 4(4) and 4(5) of the Code of Health and Disability Services Consumers' Rights as follows:

Right 4(2) and Right 4(4)

The first midwife recalled three instances where the consumer bled heavily, the second of which she described as not normal. The placenta was delivered an hour after the baby's birth and the consumer continued bleeding, remained pale and faint and not fully aware of her surroundings. Intravenous access gives a more effective method of drug administration and fluid replacement in these circumstances, yet the first midwife did not attempt intravenous cannulation until the consumer was in shock. This should have been attempted earlier. I accept the first midwife's advice that she is proficient at intravenous cannulation. The first midwife advised this was only the second time in twenty years she had failed to get a line in on the first attempt. However, in my opinion the first midwife underestimated the consumer's blood loss and failed to insert an intravenous cannula as a prophylactic measure within a reasonable timeframe. In these circumstances the first midwife did not comply with professional standards and did not provide services that minimised potential harm to the consumer.

The first midwife failed to take regular recordings of the consumer's blood pressure, pulse rate or peripheral perfusion observations. Alterations in these observations are early indicators of concealed bleeding and would have alerted the first midwife to impending problems. In my opinion failure to take these fundamental observations was a breach of professional standards.

When the first midwife was unable to deliver the placenta she appropriately administered Syntocinon at 11.51am. The Ministry of Health guidelines on treatment of postpartum haemorrhage advise Syntocinon infusion and intramuscular or intravenous Syntometrine or Ergometrine. These guidelines also advise where the haemorrhage is ongoing, blood pressure, pulse, assessment of bleeding and peripheral perfusion observations and should be taken at 5 to 10 minute intervals. The first midwife failed to take appropriate observations and did not provide additional Syntocinon or other Oxytocic drugs until after the infusion was commenced over one hour later. These failures also were in breach of the Code.

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Midwives

Report on Opinion - Case 97HDC7133, continued

Opinion: Breach, First Midwife, *continued*

The general practitioner found the consumer lapsing into unconsciousness. He noted her vital signs were barely perceptible. The first midwife failed to institute the first aid measures of lowering the consumer's head and elevating her legs. As a health professional, the first midwife's failure to institute adequate first aid was a breach of professional guidelines as well as potentially endangering the consumer's life.

The scope and standards of Midwifery practice acknowledge that a midwife will need access to emergency services and hold the midwife responsible for any act or omission that places the women at risk. The first midwife attempted intravenous cannulation but was unsuccessful. She relied on the ambulance attendant who did not have the skills to insert an intravenous cannula. While the first midwife advised it was entirely appropriate for the ambulance officer to access the general practitioner's services, I note that the first midwife was prepared to send the consumer to Hospital by ambulance without fluid replacement. In my opinion, this would have placed the consumer at risk and did not meet the professional standards set by the New Zealand College of Midwives.

Right 4(5)

The first midwife has had 22 years experience as a rural midwife and knew that emergency services were 30 minutes road travel away and thus not immediately available. The first midwife did not turn her mind to the availability of professional back-up services in the area in which the consumer lived and did not call a doctor because she did not know how long it would take for a doctor to arrive.

In my opinion the first midwife, in failing to obtain local knowledge about the availability of health services, did not co-ordinate care to ensure quality services to the consumer.

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Midwives

Report on Opinion - Case 97HDC7133, continued

Opinion: No Breach, First Midwife

In my opinion the first midwife's discussion with the third midwife about payment was not a breach of the Code. Upon the third midwife leaving, the first midwife commented that she would arrange for payment. At this time the consumer's condition appeared stable.

In my opinion the first midwife's discussion with the general practitioner about payment was also not a breach of the Code. The records show that at that time the consumer had received intravenous fluid replacement and her observations were within normal limits. The consumer was about to be placed in the ambulance when the general practitioner asked about payment. The first midwife said that she would contact the general practitioner. That was the end of the conversation. There is no evidence that this delayed the consumer's journey to hospital or placed the consumer at risk.

In my opinion, the first midwife's discussion about payment with hospital midwives was not the cause of delay in taking the consumer to theatre and is not a breach of the Code. Upon her arrival at Hospital the first midwife took steps to ensure the baby was not separated from her parents. She thought this to be the wishes of the consumer and her husband. Furthermore, the first midwife telephoned the theatre to ascertain the reasons for the delay in taking the consumer to theatre.

Opinion: Breach, Second Midwife

In my opinion the second midwife breached Rights 4(2), 4(4) and 4(5) of the Code of Health and Disability Services Consumers' Rights.

The guidelines of the New Zealand College of Midwives direct a midwife to take appropriate action if an act by a colleague infringes accepted standards of care. The second midwife was not the primary midwife, however as a registered midwife she is required to observe professional standards. The second midwife did not institute adequate primary first aid care when it was clear the consumer was in shock. Moreover, she did not attempt intravenous cannulation for fluid replacement. Both these actions are advised by the Ministry of Health. In my opinion the second midwife grossly underestimated the consumer's blood loss and must share responsibility for the outcome.

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Midwives

Report on Opinion - Case 97HDC7133, continued

Opinion: Breach, Second Midwife, *continued*

The second midwife stayed with the consumer, massaging her fundus in an attempt to control the bleeding. She talked with the consumer in an attempt to keep her focused and prevent her "drifting away". The consumer continued bleeding but the second midwife failed to record her observations. Without consistent and reliable information it is difficult to assess deterioration early and the decision to take the consumer to hospital may have been delayed because of this. Earlier detection may have prevented an emergency.

Opinion: No Breach, Third Midwife

In my opinion the third midwife did not breach the Code of Health and Disability Services Consumers' Rights.

The third midwife arrived at about 10.10am. The first midwife, the lead care giver, arrived 10 minutes later and was the primary midwife. The third midwife delivered the placenta. When the consumer's condition appeared stable and the bleeding had eased the third midwife left. Before departing the third midwife did not examine the placenta which is fundamental to midwifery practice. However the third midwife left two midwives in attendance and was therefore not in breach of the Code.

In my opinion the third midwife's discussion with the first midwife about payment was not a breach of the Code. The first midwife commented that she would arrange for payment when the consumer's condition appeared stable. The first midwife was not so distracted by the discussion that the consumer was placed at risk.

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Midwives

Report on Opinion - Case 97HDC7133, continued

Actions: First Midwife

I recommend the first midwife take the following actions:

- Apologise in writing to the consumer for breaching the Code. This apology is to be sent to the Commissioner who will forward it to the consumer.
- Adopt accepted professional standards of documentation.

Actions: Second Midwife

I recommend that the second midwife take the following actions:

- Apologise in writing to the consumer for breaching the Code. This apology is to be sent to the Commissioner who will forward it to the consumer.
- Adopt accepted professional standards of documentation.
- Add disposable gloves and a sharps container to her home-birth equipment.

Director of Proceedings

I will refer this matter to the Director of Proceedings who will decide what action to take under section 45 of the Health and Disability Commissioner Act 1994.

Other Actions

A copy of this opinion will be sent to the Nursing Council of New Zealand and the New Zealand College of Midwives.