ZEST Safety Incident Response Policy

Effective date: 12 January 2026

Estimated refresh date: 11 January 2029

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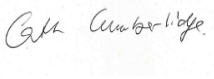
Author	**Catherine Cumberlidge**	**Lead Midwife for Safety and Quality Governance**		**8 January 2026**
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Purpose

This Patient Safety Incident Response Policy has been developed for ZEST Midwives Ltd (hereafter referred to as ZEST). The glossary below defines key terms used throughout this policy to ensure clarity, consistency and shared understanding across all colleagues, ZEST registrants and partners. This policy supports the requirements of the Patient Safety Incident Response Framework (PSIRF) and sets out ZEST's approach to developing and maintaining effective systems and processes for responding to safety events for the purpose of learning and improving patient safety.

ZEST is an organisation that offers a range of registration packages for UK registered NMC midwives including newly qualified midwives, MaMas (Mother and Midwife Assistant), birth workers, student midwives, and complimentary therapists. Registration packages include access to exclusive indemnity insurance for independent maternity practice, advocacy and support from fully qualified and experienced Professional Midwifery Advocates (PMAs), and exclusive Mandatory Practical Training called 'Safe and Skilled at Home,' (Community Birth Challenges: A Multi-Disciplinary Team Approach)© alongside a whole host of other training and benefits including Safeguarding (level 3) and other optional training.

ZEST is led by highly skilled and experienced practitioners and midwives. ZEST's Director of Midwifery, Tracy Thomas, has more than 25 years' experience across home, community and hospital maternity settings, including senior leadership roles within both independent services and the NHS. Working alongside this expertise is Katy Shay, Director of Health and Wellbeing with 25 years' experience running an established homeopathy practice and extensive expertise in holistic approaches to health and wellbeing care, including yoga, nutrition, relaxation, mindfulness and sound-based therapies. She is also an experienced doula and has supported many births over the last 20 years in both community settings and NHS hospitals.

In addition, ZEST's senior leadership team benefits from a Lead Midwife for Safety, Compliance and Quality, Catherine Cumberlidge, with over 18 years' experience in midwifery practice and 11 years in senior quality and clinical governance leadership across maternity and neonatal services. She has completed extensive training in learning from patient safety incidents (in excess of 30 days), maintains current knowledge of best practice in learning responses, and has significant practical experience in both leading and providing independent oversight of learning responses in line with national patient safety standards. This includes using the Perinatal Mortality Review Tool (PMRT) and close collaborative working with the Health Services Safety Investigations Body (HSSIB).

The senior leadership team also includes Dr Beverley Jervis, a midwife with over 20 years midwifery experience. She is experienced in cross discipline training, national and international collaborative

working and leadership in enhancing midwifery practice. Dr Jervis is also a Professional Midwifery Advocate (PMA).

There are two further highly experienced midwives in the senior leadership team who are Professional Midwifery Advocates (PMAs), Robyn Thomas and Emma Reynolds. Robyn is ZEST's Consultant Midwife; she supports the ZEST community and offers professional support & advocacy. Robyn co-facilitates ZEST training and offers unique guidance and access to ZEST systems and processes. Emma is ZEST's Head of Midwifery and has 17 years' experience as a midwife, working in roles including hospital settings, striving for personalised maternity care, the community setting advocating for continuity of care and home births, and as a Consultant Midwife. Both Robyn and Emma lead on the Trigger Notification (TN) process for the organisation (See page 7). Communications are expertly led by a non-clinical member of the senior team who has responsibility for communications, and supports effective information sharing, engagement and transparency across the organisation. Altogether, the senior leadership team makes up the Kindness, Quality and Safety Collaborative (KQSC) (see page 7).

The PSIRF advocates a co-ordinated and data-driven response to safety events. It embeds safety event responses within a wider system of improvement and prompts a significant cultural shift towards systematic safety management. Language is very important. The PSIRF has the word 'patients' as a mainstay throughout its documents. Independent midwives, who are registered with ZEST, provide maternity care to women and birthing people who are experiencing a normal life event and are, therefore, not categorised as 'patients' but as 'clients'. Consequently, the word 'patient' is avoided in ZEST PSIRF documents.

ZEST's policy supports development and maintenance of an effective safety event response system that integrates the four key aims of the PSIRF:

- compassionate engagement and involvement of those affected by safety events
- application of a range of system-based approaches to learning from safety events
- considered and proportionate responses to safety events and safety issues
- supportive oversight focused on strengthening response system functioning and improvement.

Glossary of Terms

- Birthing women and people - Individuals who are pregnant, birthing or postnatal, recognising diverse identities and experiences.
- Clients - the women and birthing people who choose to receive their maternity care from ZEST registered independent midwives.
- Family - The people chosen by the birthing woman/person to be involved in their care and decision-making.
- Colleague - Anyone employed or contracted with ZEST.
- Registrant Midwives and Registrant MaMas. Independent midwives and MaMas who are registered with ZEST.
- Safety event - An event or circumstance that could have or did lead to unintended or unexpected harm and that meets the definition of a patient safety incident in PSIRF guidance.
- Learning response - The appropriate method for exploring an incident (e.g., After-Action Review, MDT Reflective Review, Patient Safety Incident Investigation).
- Duty of Candour - The statutory requirement for openness and honesty when care does not go as planned (applicable across the UK, with differently named frameworks in each nation).
- Continuity of carer - A model of maternity care in which midwives provide relationship-based care across pregnancy, birth and the postnatal period.
- Stakeholders - Individuals or organisations who influence, or are affected by, ZEST (e.g., NHS trusts, Integrated Care Boards, families).

Scope

This Patient Safety Incident Response Framework (PSIRF) policy applies to all maternity services provided by independent UK registered NMC midwives, MaMas, birth workers and complementary therapists, who are registered with ZEST. Maternity services include antenatal, intrapartum and postnatal care delivered in families' homes, community settings, or other non-NHS environments, via the Continuity of Carer model.

In independent midwifery, safety is shaped by the quality of relationships, professional judgement, and how care is coordinated around the birthing woman or person. Therefore, it is important that safety responses under this policy follow a systems-based approach, because safety, experience and outcomes for birthing women and people and babies are shaped by relationships, decision-making, coordination and context, rather than by isolated actions. Maternity care is inherently complex and relational, often involving continuity of carer, shared decision-making, care across home, community and hospital settings, and interfaces with multiple services. A systems-based approach recognises that outcomes are influenced by how these elements interact.

The policy applies to all ZEST's KQSC, colleagues, contractors, associates, midwives, MaMas and birth workers who are involved in the planning, delivery, coordination or governance of maternity care. This policy covers safety events involving birthing women and people, babies, families, ZEST colleagues, registrant midwives and MaMas, including safety events arising from clinical care, communication, coordination, information sharing, equipment, environment, safeguarding, and interface with other services and NHS partners. Specifically, ZEST's PSIRF policy covers the following key areas of maternity care, people, and practice:

✓ Antenatal, intrapartum and postnatal care
✓ Birthing women and people, babies and families
✓ Home and community settings
✓ All colleagues and practitioners involved in care or governance
✓ Interface with NHS services
✓ Clinical and non-clinical safety events
✓ Equity, inclusion and psychological safety
✓ Proportionate application of PSIRF principles

While ZEST is not an NHS provider, this policy adopts the principles and expectations of NHS England's Patient Safety Incident Response Framework, proportionately applied to independent maternity services, and is aligned with relevant regulatory, contractual and professional requirements; for example, the NMC code, Data Protection regulations, and Safeguarding Legislation.

For all safety events, ZEST will apply the “Being Fair Tool” to support a just culture (NHS England 2025), ensuring that safety events are investigated proportionately, with a focus on learning and system improvement rather than individual blame, and with the experiences of birthing women and people, and families at the centre. Furthermore, there is no remit to apportion blame or determine liability, preventability or cause of death in a response conducted for the purpose of learning and improvement. Other processes, such as claims handling, professional standards investigations, coronial inquests and criminal investigations, exist for that purpose. The principle aims of each of these responses differ from those of a PSIRF safety response and are outside the scope of this policy.

Information from a PSIRF safety response process can be shared with those leading other types of responses, but other processes should not influence the remit of a PSIRF safety response.

Our patient safety culture

ZEST Kindness Quality and Safety Collaborative (KQSC)

The ZEST KQSC manifesto, developed in 2024, influences how ZEST’s senior leadership team supports and empowers midwives and birth workers while enhancing the birth experiences of families. It includes steps to promote sustainable professional practice for midwives and birth workers through continuity of care and individualised support. The manifesto is reinforced by the principles of support and autonomy, achieved through a community of advocacy that connects and strengthens the organisation’s network of midwives and birth workers. Fundamental to ZEST’s KQSC manifesto is the relationships it makes with partners in the NHS, the Nursing and Midwifery Council, insurers, midwives, birth workers and the birth families that are cared for. This provides a model that ensures cohesive working relationships, embraces diversity and upholds professional accountability to preserve safe practice.

ZEST Trigger Notification Process

ZEST has a unique reporting Trigger Notification process for when birthing women and people wish for specific care plans, such as being supported to birth at home pre-37 weeks or beyond 42 weeks of pregnancy, or who wish to be supported at home to birth twins. There are also trigger notifications for maternity incidents; these include transfers into hospital from a planned homebirth, any obstetric or neonatal emergency, delays in care or in relation to a client’s complaint. A high reporting culture is encouraged with follow up on all Trigger Notifications with one of the Professional Midwifery Advocates (PMA) who work in the ZEST senior leadership team.

All Trigger Notifications are responded to in line with PSIRF principles with emphasis on the SEIPS (System Engineering in Patient Safety) to avoid a punitive, blame culture. All four nations of the United Kingdom have moved towards a fair, learning-focussed approach to Just Culture. Wales has a clear, government backed Just Culture approach called ‘Speaking up Safely’, Scotland embeds these principles through staff governance and safety programmes, Northern Ireland emphasises listening to staff and England has the Being Fair Tool.

ZEST safety partners

ZEST's Kindness Quality and Safety Collaborative (KQSC) Board includes birthing people, whose insights and experiences are valued in shaping, advising, and informing ZEST on matters that are important to those using maternity services.

Addressing health inequalities

ZEST's KQSC Board includes birthing women and people whose perspectives and lived experiences help to influence and inform ZEST's approach to safety, learning, and improvement. This ensures that considerations of equality, inclusion, and diversity remain central to decision-making and oversight of patient safety incident response.

ZEST is committed to ensuring that its patient safety incident response processes actively support health equality and contribute to reducing inequalities in maternity care. This commitment is embedded within our governance arrangements, including KQSC Board oversight and the meaningful involvement of birthing people with diverse lived experiences. As part of PSIRF implementation, ZEST will consider patterns in safety events related to ethnicity, ensuring that our PSIRF documentation captures and responds to these findings.

Engaging and involving patients, families and staff following a patient safety incident

The PSIRF recognises that learning and improvement following a safety event can only be achieved if supportive systems and processes are in place. It supports the development of an effective safety event response system that prioritises compassionate engagement and involvement of those affected by safety events (including birthing women and people, their families, midwives, MaMas, and birth workers). This involves working with those affected by safety events to understand and answer any questions they have in relation to the safety event and signpost them to support as required.

Midwifery is built on trust, continuity, and relationship-based care. Engagement with those affected by safety events strengthens that foundation by:

- Upholding professional integrity
- Protecting the birthing person's right to know
- Promoting a culture of learning, not blame
- Aligning with the NMC Code and best practice standards

Being open and honest is more than a legal obligation; it reflects the core values at the heart of midwifery practice. All providers of maternity care must act with honesty and transparency when care outcomes are adverse. In independent midwifery practice, the midwives who work with ZEST are no exception and are expected to adhere fully to duty of candour principles. In England, this is set out under Regulation 20 of the Health and Social Care Act 2008 (Duty of Candour); in Wales, under the Health and Social Care (Quality and Engagement) (Wales) Act 2020; and in Scotland and Northern Ireland, equivalent duties ensure honesty and transparency with birthing people and their families.

When a PSIRF learning response is required, a member of the senior leadership team will act as the family engagement lead, offering accessible guidance and support and ensuring that the family has a clear point of contact throughout the process.

Patient safety incident response planning

PSIRF supports organisations to respond to safety events and issues in a way that maximises learning and improvement, rather than basing responses on arbitrary and subjective definitions of harm. Beyond nationally set requirements, organisations can explore safety events relevant to their context and the populations they serve rather than only those that meet a certain defined threshold.

This ZEST PSIRF policy recognises the distinct context of independent maternity services, including continuity of carer models, home and community-based birth settings, lone working, and close working with NHS maternity, neonatal, ambulance and safeguarding services. Within these settings, our safety event response planning takes consideration to safety events that may include events resulting in physical, psychological or emotional harm, or where there is a risk of harm, loss of trust or inequitable experience for birthing women or people and their families:

- Clinical harm or near misses affecting birthing women, people and/or babies
- Delayed escalation or transfer of care
- Communication failures with NHS partners
- Safeguarding concerns
- Information governance incidents
- Equipment or environment issues in home settings
- Discrimination, bias or inequitable care
- Psychological harm, loss of trust, or trauma

With respect to the relational and interpersonal context of maternity care, it is critical that a proportionate approach is taken to safety event responses.

ZEST Safety Incident Response Plan

Our plan sets out how ZEST intends to respond to safety events over a period of 12 to 18 months. The plan is not a permanent set of rules that cannot be changed. We will remain flexible and consider the specific circumstances in which each safety event occurred and the needs of those affected, as well as the plan.

ZEST's safety incident response plan is a 'living document' that will be reviewed and updated as it is applied to respond to safety events within our services. The plan will be reviewed every 12 to 18 months to ensure it reflects current practice and emerging learning; as our portfolio of maternity services evolves, the types and patterns of safety events we encounter are likely to change. This review period will also provide an opportunity to re-engage with stakeholders, including families, birth workers, and partners, to discuss and agree any changes made in the previous cycle.

Updated plans will be published on our website, replacing previous versions. In addition, a more comprehensive planning exercise will be undertaken every two years, or more frequently if required, to ensure our efforts remain proportionate between learning and improvement. This in-depth review will include assessing our response capacity, mapping our services across the UK, and analysing a broad range of organisational data, including maternity safety incident investigation reports, improvement plans, complaints, claims, colleague feedback, inequalities data, and reporting metrics, alongside engagement with key stakeholders.

Resources and training to support patient safety incident response

Within the senior leadership team at ZEST, there are six clinical colleagues, all with experience of reviewing safety events. The Lead Midwife for Safety, Compliance and Quality has the 30 required days of patient safety training, this includes Patient Safety Syllabus levels one and two and maintains up-to-date practice with PSIRF safety responses. All of the six clinical senior leadership team members have received PSIRF training bespoke to maternity services and the two PMA's take a System Engineering in Patient Safety (SEIPS) approach to all safety events, aligning with the policy and ZEST's PSIRF plan. There are no capacity issues to support the midwives and birth workers in the review of safety events.

Responding to Safety Events

Safety Event Reporting Arrangements

All ZEST colleagues and registered midwives are responsible for recording and reporting potential or actual safety events as Trigger Notifications as per our incident reporting policy. The person making the report will record the level of harm they believe birthing people, babies or families have experienced, using the harm criteria outlined in Appendix one. Each trigger notification will be reviewed and triaged by a PMA who will follow up with a meeting with the reporter.

Corresponding to our trigger notification process, the safety event will be reviewed with feedback to the reporter and closure if applicable. ZEST's senior leadership team has oversight of all trigger notifications to ensure that safety events are responded to in a proportionate and timely way. This will include consideration of Duty of Candour. In addition to the trigger notification process where all safety events receive a review with a PMA, events where the opportunity to learning and improvement would be of greatest value, will be led by a member of the team, as a learning response leads who has completed level 1 (essentials of patient safety for all staff) and level 2 (access to practice) of the patient safety syllabus.

Patient safety incident response decision-making

For a serious safety event, there is an immediate incident triage, taking place as soon as possible after a safety event occurs. This is to identify the key events and understand where there is a need for further investigation. If the incident has resulted in Moderate harm or above, a Rapid Incident Review (RIR) is required to be completed within 72 hours. A decision is then made if further review using a PSIRF safety response is required.

If a PSIRF safety response is required, ZEST uses one of NHS England's PSIRF templates, that has been adapted for use in ZEST and using language that is appropriate to maternity and neonatal incidents. There is consistent reference to NHS England's Being Fair Tool as a fair approach to midwives and birth workers who are involved in safety events.

With a close overview of all safety events, ZEST's senior leadership team maintain robust processes for the horizon-scanning of any emergent issues or trends of sfety events, with the distinct practical knowledge that a trend of low harm incidents will subsequently result in harm. Risk management at ZEST includes a proactive approach to emerging risk, using proportionate response methodology, for example, thematic review. Any emergent issues that were not included in our PSIRF plan will be considered for future iterations.

Responding to cross-system incidents/issues

ZEST has built strong working relationships with key stakeholders; these include NHS partners throughout the UK, and with the NMC, to safeguard consistent approaches to the fair treatment of midwives, advocate for proportionate responses to safety events, and compassionate engagement with those affected by them.
Safety events must be reported through:

- ZEST Trigger Notification (for ZEST registered midwife)
- The Trust's own reporting system (e.g., Datix, InPhase, or Ulysses)

Any escalation will follow the PSIRF in a collaborative manner.

Timeframes for learning responses

Learning responses will be undertaken in a timely and proportionate way, recognising the complexity and sensitivity of maternity care and the importance of meaningful engagement with birthing women and people, families, and colleagues.
Initial consideration of a reported safety event will take place as soon as reasonably practicable to determine the appropriate learning response. Where a PSIRF safety response is required, timescales will be agreed at the outset, that takes consideration to the nature of the event, the needs and preferences of those affected, and the availability of the relevant information required to complete the response.

Learning responses will prioritise quality and depth of learning over haste to complete the review. Where timescales need to be extended, this will be communicated clearly to all those involved, with ongoing updates provided. Any actions identified to reduce immediate risk will be implemented promptly and do not require completion of the learning response to begin.

Indicative timeframes for PSIRF learning responses

After Action Review (AAR) – Will be completed within two to four weeks of the safety event, where learning can be gained through timely reflection with those involved.
Multidisciplinary Team Reflective Review (MDT) – Will be completed within four to eight weeks, recognising that there will be a need to involve colleagues across professional boundaries and care settings.

Patient Safety Incident Investigation (PSII) – Will be completed within three to six months, allowing sufficient time for meaningful systems-based learning and the development of safety actions, engagement with families, midwives, and colleagues, and consideration of equity and inclusion.

Safety action development and monitoring improvement

Safety actions resulting from PSIRF learning responses will be system and process-focused, proportionate and co-developed with midwives and, whenever appropriate, birthing women and people. Improvement will be monitored through ZEST governance arrangements, including through discussion at the KQSC, to evaluate and monitor the impact of safety actions and learning over time.

Safety improvement plans

ZEST safety improvement plans will bring together learning from PSIRF learning responses, safety events, any concerns raised, and wider quality intelligence to champion coordinated and sustained improvements in maternity care. In the context of independent maternity services, safety improvement planning will be proportionate, flexible and responsive to the nature of care that is provided across home and community settings.

ZEST will adopt a flexible style to safety improvement planning, that recognises that different types of learning will require different responses. This may include:

- A ZEST Community-wide maternity safety improvement plan, that summarises priority improvement themes and actions that have resulted from PSIRF learning responses, safety data, feedback from birthing people and families, and engagement with midwives, birth workers, and NHS colleagues.
- Targeted safety improvement plans that come into focus when learning indicates a localised or recurrent risk.
- Thematic safety improvement plans developed where learning from individual incidents, or a trend of low-harm incidents, when assessed together, highlight shared or interconnected system issues requiring a coordinated action.

The decision to develop a safety improvement plan will not be based on numerical thresholds or the volume of learning responses completed. Instead, it will be informed by the depth and consistency of learning, patterns or themes identified, equity considerations, stakeholder engagement and insight, and the potential to achieve meaningful improvement.

Safety improvement priorities will be shaped by:

- ZEST's maternity safety incident profile and trends over time
- Learning from PSIRF responses, including After Action Reviews, multidisciplinary team reflective reviews and investigations
- Feedback from birthing women and people, families, midwives, and colleagues
- Consideration of inclusion, equity and psychological safety
- Alignment with regulatory expectations and professional standards

Oversight roles and responsibilities

Effective oversight ensures that ZEST's learning response processes are consistent, proportionate and founded in a learning-focused approach to maternity care. This oversight also provides assurance to ZEST's senior leadership team, the KQSC, registrant midwives and MaMas, and NHS partners that learning responses are carried out competently and in line with national expectations.

The Lead Midwife for Safety, Compliance and Quality supports ZEST's senior leadership team with the design, delivery and continuous development of ZEST's Patient Safety Incident Response Framework Policy and Plan. This role provides professional and accountable leadership and assurance across all learning responses. The post-holder has completed more than 30 days of recognised patient safety training, including the NHS Patient Safety Syllabus Levels 1 and 2, and meets NHS England's requirements for individuals leading and overseeing learning responses. They are responsible for:

- ensuring PSIRF processes are implemented consistently across ZEST,
- determining the proportionality and type of learning response required,
- overseeing all learning responses to incidents within maternity care,
- ensuring findings translate into meaningful safety improvement work,
- working with colleagues, registrant midwives and MaMas and NHS partners to maintain an open, transparent and learning-focused culture,
- ensuring Duty of Candour requirements (for England and devolved nations) are met.

ZEST's senior midwives collectively support oversight of maternity safety responses. Each is an experienced midwife who has led, contributed to or quality-assured learning responses in previous roles within the NHS and/or private maternity services. Their responsibilities include:

- contributing to decision-making around the most appropriate learning response,
- acting as learning response leads where appropriate to their expertise,
- supporting proportionate, system-based approaches to understanding safety events,
- providing oversight of actions and improvement activities arising from learning responses,
- ensuring that learning is shared with midwives, MaMas, birth workers and external partners,
- supporting registrant midwives and MaMas, and colleagues through psychologically safe review processes.

For any incident requiring a PSIRF learning response, a member of the senior leadership team will act as the family engagement lead. This role ensures that:

- birthing women, people and their families have a clear point of contact,
- communication remains timely, compassionate and transparent,
- Duty of Candour responsibilities are met,
- families are supported to contribute meaningfully to the learning process if they wish,
- their questions are answered and updates are provided throughout the response.

All registrant midwives, MaMas and birth workers practising with ZEST have a shared responsibility to support a learning-focused culture. Their responsibilities include:

- promptly reporting all safety events via ZEST's Trigger Notification process,
- participating openly in reflective learning processes,
- supporting families with empathy and transparency,
- contributing to improvement actions where relevant,
- upholding professional standards and ZEST's expectations of candour.

The KQSC Board and Senior Leadership Team provide organisational oversight and strategic assurance. Their responsibilities include:

- approving the PSIRF policy and plan,
- monitoring themes and improvement outcomes from learning responses,
- ensuring appropriate resources, capacity and leadership are in place,
- supporting a culture of openness and equity,
- maintaining oversight of risks, including those escalated through ZEST's risk register.

Complaints and appeals

ZEST is committed to transparency, openness, and learning from all safety events. Birthing women and people, their families, midwives and/or NHS colleagues who have concerns about the ZEST's response to a safety incident are encouraged to raise these through our formal complaints and appeals process.

Details of how to make a complaint or appeal a decision are available in our Compliments and Complaints Policy. The policy outlines:

- How to raise a concern or appeal a decision about a safety response.
- The timeframe in which concerns will be acknowledged and addressed.
- How complaints and appeals will be investigated, including the opportunity to discuss the issue with relevant colleagues.

- How outcomes, learning, and any resulting improvements will be communicated.

All complaints are treated sensitively and seriously, handled confidentially, and provide an opportunity for learning and system improvement. ZEST's values all forms of feedback, including complaints, as essential sources of learning. The experiences shared by birthing women and people, their families and our midwifery community help us continually enhance the safety and quality of our maternity services.

Appendix One – Definitions of Harm in Maternity and Neonatal Incidents

Moderate Harm

Maternal

Postpartum haemorrhage requiring hospital admission and blood transfusion with full recovery within one month

Fourth degree tear

Maternal infection following birth requiring admission, IV antibiotics and extended hospital stay

Neonatal

Unplanned admission to NICU for short-term respiratory support or infection management

Hypoglycaemia requiring admission, IV glucose but without neurological impact.

Psychological

Significant distress caused by inadequate communication, lack of consent or perceived neglect – especially if it leads to anxiety, trauma symptoms, or delayed bonding.

Severe Harm

Maternal

Uterine rupture leading to emergency hysterectomy and loss of fertility.

Severe postpartum haemorrhage resulting in multi-organ failure or intensive care admission.

Sepsis due to delayed recognition or treatment, resulting in long-term health consequences.

Eclampsia or stroke during pregnancy or labour, with lasting physical or cognitive impairment.

Neonatal

Hypoxic-Ischaemic Encephalopathy (HIE) due to delayed recognition of fetal distress, resulting in cerebral palsy or other neurological disabilities.

Shoulder dystocia with brachial plexus injury leading to permanent loss of arm function.

Stillbirth or neonatal death following preventable delays in care or mismanagement.

Psychological

Birth trauma resulting in post-traumatic stress disorder (PTSD), especially when linked to poor communication, lack of consent, or perceived neglect.