

**Health Practitioners Disciplinary Tribunal**  
*The Director of Proceedings v Dale – 2 November 2005*

On 10 October 2005, the Health Practitioners Disciplinary Tribunal heard a charge of professional misconduct in respect of care provided by Ms Naomi (aka Sally) Dale to Mr Neil Bedford. Of the seven particulars, five were proven and were upheld, and each of these was sufficiently serious to be upheld as professional misconduct on an individual basis.

**Facts**

Mr Bedford suffered from Parkinson's disease, hypertension and postural hypotension, and was an insulin-dependent diabetic. Since 1998 he had lived at a rest home, during which time he had also experienced transient ischaemic attacks (TIAs).

Mr Bedford's blood glucose levels were taken twice daily and his insulin was administered at 8am each day. During the period of 17–21 September, Mr Bedford's blood glucose levels decreased. The morning recordings for that period ranged from 4.3mmol/L to 2.3mmol/L. (A blood glucose of less than 4.0mmol/L is considered too low and in need of immediate raising.) The night recordings also dropped from an average of around 7.0–10.0mmol/L to approximately 5.0mmol/L.

The Tribunal found that during the few days immediately prior to Mr Bedford's death, Nurse Dale failed to adequately assess, monitor, evaluate and respond to Mr Bedford's changing blood glucose levels.

On 20 September 2003, at 7.45pm, Mr Bedford suffered a fit, which differed from his usual TIAs. The senior caregiver rang Nurse Dale, described the fit to her, and told her that Mr Bedford's blood glucose level had been 2.7mmol/L at tea-time. Nurse Dale instructed the caregiver to check Mr Bedford's blood glucose again, take his blood pressure, and then call her back.

At approximately 8pm the caregiver rang Nurse Dale and advised her that Mr Bedford's blood glucose level was now 2.5mmol/L. Nurse Dale advised the caregiver to give Mr Bedford some Milo and put up his bed rails to stop him falling out of bed. Mr Bedford appeared to settle and there was no further contact between the caregiver and Nurse Dale that evening.

The Tribunal upheld as professional misconduct Ms Dale's failure to provide appropriate instructions for assessment, monitoring and feedback over this period.

At 7am and 8am on the morning of 21 September 2003, the caregiver on the morning shift measured Mr Bedford's blood glucose, which was 3.2mmol/L on both occasions. She then gave Mr Bedford his usual 20 units of insulin, thinking that this would increase his blood glucose level. At the time there was a policy in place at the rest home with regard to the subcutaneous administration of insulin, but it did not specify in what circumstances insulin should be withheld.

At 9.30am the caregiver checked on Mr Bedford and found him to be a bit pale. She also observed that he was not really responding to her. She took his blood pressure, which was 160/110. She rang Nurse Dale and explained that Mr Bedford "wasn't really with it" and that his blood glucose was 3.2mmol/L. She advised Nurse Dale that she had given Mr Bedford his regular dose of insulin at 8am and that "he hadn't picked up".

Nurse Dale advised the caregiver to check Mr Bedford's level of consciousness by touching his eyelash to see if it twitched. She said that if it twitched he was conscious, and that if he responded in this way the caregiver should then give him some sugar. Nurse Dale advised the caregiver to then check Mr Bedford's blood glucose and to call back if she was not happy.

Ms Dale again failed to provide appropriate instructions for assessment, monitoring and feedback in response to this telephone call. This failure was upheld as professional misconduct.

The caregiver followed Nurse Dale's instructions and observed Mr Bedford twitch when she touched his eyelash. On that basis she proceeded to give Mr Bedford a drink of Milo.

At 9.50am the caregiver re-checked Mr Bedford's blood glucose and found it was 1.1mmol/L. She rang Nurse Dale a second time, advised her of the reading and asked whether she should call an ambulance. Nurse Dale did not reply to the question, instead asking her to take blood glucose readings every 15 minutes.

The Tribunal was satisfied that Nurse Dale failed to arrange for an ambulance to be called in a timely manner.

Following the telephone call at 9.50am, the caregiver took at least two further blood glucose readings. The last reading was recorded in the notes as 2.0mmol/L. The caregiver then rang Ms Dale for a third time, advised her of the result, and told her that Mr Bedford was not really responding. Nurse Dale asked her to ring an ambulance, which was done immediately.

On arrival, the ambulance officer began treating Mr Bedford for hypoglycaemia by administering glucose intravenously. Mr Bedford was in a critical condition and was taken to Tokoroa Hospital before being flown to the intensive care unit of Waikato Hospital, where he was placed on a ventilator.

Mr Bedford did not respond to treatment, and the decision was made by his family to take him off the ventilator. He died on 24 September 2003.

The Tribunal found that Ms Dale had failed to provide adequate and appropriate training to caregivers in respect of monitoring and responding to changing blood glucose levels, recognising the signs of consciousness, and the administration of insulin, and that this amounted to professional misconduct.

### **Penalty**

The Tribunal issued a written decision on 2 November 2005 and ordered that Ms Dale practise only under the supervision of a registered nurse approved by the Nursing Council of New Zealand. She was also ordered to contribute \$10,000 to the costs of the hearing and prosecution.

*Link to HPDT decision:*

[www.hpdt.org.nz/portals/0/Nur0509dfindings.pdf](http://www.hpdt.org.nz/portals/0/Nur0509dfindings.pdf)

*Link to Commissioner's decision:*

[www.hdc.org.nz/files/pageopinions/03hdc14664nurse.pdf](http://www.hdc.org.nz/files/pageopinions/03hdc14664nurse.pdf)