Severe hypoglycaemic episode after deteriorating condition missed (07HDC04325, 13 October 2008)

Midwife ~ Maternity Unit ~ District Health Board ~ Hypoglycaemia ~ Rights 4(1), 4(2), 4(5)

Parents complained about the care provided to their baby at a maternity unit. The baby was born at full term with no complications, was a good weight for his age and received satisfactory Apgar scores. He was latching on and breastfeeding by the time he was transferred from hospital to the maternity unit. During his stay he was cared for by four midwives. Two days after his birth, he was noted to have developed jaundice. His bilirubin levels were tested and he was placed under phototherapy lights. Although he fed regularly during the day he became sleepy and uninterested in feeding later that night. By the next morning his temperature had dropped, he was reluctant to feed, and he had developed jittery movements — all signs of developing hypoglycaemia. He was transferred by ambulance to hospital, and later diagnosed with neonatal hypoglycaemia of unknown cause with neurological sequelae: epilepsy, developmental delay, behavioural problems and visual impairment. He is significantly disabled.

It was held that all of the midwives failed to adequately document the baby's care, and did not meet professional midwifery standards. This included the preparation of care plans, documentation of the length and quality of the baby's feeds and documentation of bowel movements. This lack of documentation may have affected his continuity of care, as subtle changes in his feeding pattern and behaviour were not able to be passed on to subsequent team members caring for him. Accordingly, each of the midwives breached Right 4(2).

It was also held that the documentation systems in use at the maternity unit fell below the standard expected and put patients at risk. Accordingly, the DHB breached Right 4(1). The inadequate documentation system prevented effective co-operation among providers to ensure quality and continuity of services. Accordingly, the DHB breached Right 4(5) of the Code. The DHB failed to take reasonably practicable steps to prevent the four midwives from breaching Right 4(2) and was held vicariously liable for their breaches.