HEALTH & DISABILITY COMMISSIONER
TE TOIHAU HAUORA, HAUĀTANGA

Post birth care of baby boy breaches the Code
22HDC00236

In a report published today, Deputy Health and Disability Commissioner Rose Wall has found Health NZ Te Toka Tumai Auckland breached the Code of Health and Disability Services Consumers' Rights (the Code) for failures in the care of a baby boy in his first hours post-delivery.

The baby, born at Auckland hospital at full term gestation, required transfer to the Neonatal Intensive Care Unit (NICU). At 10.5 hours post birth he was assessed as having mild hypoxic ischaemic encephalopathy[1] (HIE) with some features of moderate HIE. Months later he was diagnosed with cerebral palsy.

At the time of the incident, national guidelines outlined that standard practice was to manage babies at high risk of HIE after birth by conducting an initial neurological assessment, followed by subsequent 'serial' observations every hour for six hours.

In this case, the initial Baby Newborn Record, which includes neurological testing, was only partially completed and there was no documentation of neurological assessment in the admission note to the NICU.

The junior registrar who attended the birth and accompanied the infant to NICU should have completed this documentation. She told HDC that neurological checks would likely have been performed as part of managing other procedures and that, due to a heavy and complex clinical workload that day, there had not been an opportunity to review paperwork.

Ms Wall accepted that the initial neurological examination was likely done, and made an adverse comment about the registrar's incomplete documentation, noting the importance of ensuring a full and complete picture of the baby's health be available for all others responsible for his care from that point on.

Ms Wall found that the required subsequent hourly monitoring did not occur.

"On review of the available information, it is apparent that this baby did not receive any further specific neurological assessment or serial monitoring in line with his risk, as required under the national guidelines," said Ms Wall.

Although the registrar was responsible for the baby's care, Ms Wall considered the failure was attributable to Health NZ at an organisational level.

Ms Wall said Health NZ had a duty to ensure that the services the baby received complied with legal, professional, ethical and other relevant standards. She found Health NZ breached the Code for failing to provide an appropriate standard of care | Tautikanga.

The breach covered several shortcomings in care:

- The registrar was not provided with encephalopathy training in a timely manner.

[1] Disturbed neurological function in the earliest days of life.

- The orientation booklet did not include information about neonatal encephalopathy, or refer to specific guidelines to guide practice.
- There were no internal policies and procedures in place to ensure that babies at high risk of HIE were managed and monitored using serial Sarnat scoring, in accordance with national guidance on neonatal encephalopathy in place at the time.

"I am critical that Health NZ did not have in place sufficient policies and procedures to support its staff adequately regarding the baby's neurological assessments and monitoring," Ms Wall said.

Since the events, HNZ has made changes, including the development of Auckland-specific protocols and processes and an Auckland guideline for managing babies at risk of encephalopathy, along with changes to orientation and training (including changes to the orientation booklet).

Taking into account the changes already made, Ms Wall made several further recommendations for Health NZ and the registrar.

21 October 2024

Editor's notes

Please only use the photo provided with this media release. For any questions about the photo, please contact the communications team.

The full report of this case can be viewed on HDC's website - see HDC's 'Latest Decisions'.

Names have been removed from the report to protect privacy of the individuals involved in this case.

The Commissioner will usually name group providers and public hospitals found in breach of the Code unless it would not be in the public interest or would unfairly compromise the privacy interests of an individual provider or a consumer. More information for the media, including HDC's naming policy and why we don't comment on complaints, can be found on our website here.

HDC promotes and protects the rights of people using health and disability services as set out in the Code of Health and Disability Services Consumers' Rights (the Code).

In 2022/23 HDC made 592 quality improvement recommendations to individual complaints and we have a high compliance rate of around 96%.

Health and disability service users can now access an animated video to help them understand their health and disability service rights under the Code.

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