Labor & Delivery: Newborn's Cerebral Palsy Tied Directly To Nursing Negligence.

A significant case from the Superior Court, Riverside County, California, was reported on the stipulation that the names of the defendant hospital and doctor be kept confidential.

The case resulted in a $2.75 million settlement for an infant with brain injuries suffered at birth.

Fetal Heath Rate Monitoring

Fetal heart rate monitoring began upon the mother's non-emergent planned admission to the hospital's labor and delivery department.

The first monitor tracings were entirely within accepted limits, seeming to indicate the fetus was healthy and that a normal vaginal delivery could be anticipated.

A few hours after admission the monitor began to show that decelerations were occurring after the mother's uterine contractions. Fifteen minutes later it became unmistakable that the changes in the fetal heart rate after the contractions were late decelerations with diminished long term variability.

The nurses, however, did not attempt to notify the physician, who had apparently left the hospital and returned to his office.

Twenty minutes later, with the late decelerations continuing, the fetal heart rate rose from 145 to 150, then, following a severe variable deceleration, the heart rate fell to between 60 and 100 and remained in that range for seven minutes. The mother's uterus became hypertonic with contractions lasting five minutes.

Still, the nurses made no attempt to contact the physician. Nor were preparations begun in anticipation of an emergency c-section.

When the nurses did actually contact the physician, at first they did not relay to him the seriousness of the situation nor did they request that he return to the hospital immediately.

Nurse's Legal Duty to Contact Physician And Report Accurate Information

The nurses did not relay the true seriousness of the situation to the physician until more than an hour had elapsed since the nurses were first able, or should have been able, to confirm variable late decelerations from the fetal heart monitor.

By the time the physician was called this time the fetal heart rate had dropped to 60 beats per minute.

Nurses' Legal Duty to Anticipate Emergency C-Section

When the physician did arrive back at the hospital, the mother was taken promptly into an operating room for an emergency c-section.

However, due to lapses in judgment by the attending labor and delivery nurses, a pediatrician and a neonatologist had not been summoned ahead of time and did not arrive until eight minutes after delivery.

Intubation of the newborn had to be attempted by one of the nurses. The nurse erroneously inserted the endotracheal tube into the baby's stomach. Misplacement of the tube compounded the serious deprivation of oxygen the baby had already experienced in the uterus prior to delivery.

The newborn was ventilated with a bag mask and airlifted to the neonatal intensive care unit at another hospital. However, by then the damage was already done.

The child, almost seven years old at the time of the substantial out-of-court settlement, suffered from cerebral palsy, mental retardation and spastic quadriplegia.

One mitigating factor, argued on behalf of the defendant hospital and physician, was that the child would never need the projected $11 million for a lifetime of special care if he lived to a normal life expectancy, because he was not expected to survive beyond childhood. **Wert v. (Name Withheld – Confidential) Hospital, 2007 WL 901630 (Cal. Super., February 9, 2007).**