Taking care in after-hours calls
(98HDC15681, 25 July 2000)

General practitioner ~ Meningococcal septicaemia ~ Professional standards ~ Information about procedures following death ~ Infection control ~ Rights 4(2), 6(1)(e)

An 18-month-old Maori boy was taken to a locum GP with diarrhoea, vomiting and a slight fever of two days' duration. In the preceding two weeks the locum had seen many children with a gastroenteric illness that was going around the town and that seemed to be helped by a course of metronidazole. She advised the grandmother about fluids, explained that she should return if the boy's condition worsened or he was not taking fluids, and prescribed a course of metronidazole.

Three days later the grandmother noticed that the child was a little lethargic and irritable, and was not taking his bottle or eating. She telephoned her usual GP, who was on call, at 10pm on a Sunday evening, told him that the child had a fever, and asked for advice. The GP had not been involved in treating the child's earlier vomiting and diarrhoea, and had no knowledge of that consultation. He checked over the phone that no rash was present and suggested the child be given Pamol.

The grandmother called the GP again at 10.30pm and advised that the child was vomiting. The GP ascertained that the fever had lessened and his impression was of a child with a non-specific febrile illness, probably viral. He advised the grandmother to call again if she was worried. She phoned a third time at 3am and said that her grandson had developed a rash and had purple lips. The GP asked to see the child straight away and diagnosed meningococcal meningitis and possible septicaemia. The child died later that morning. A post-mortem was carried out, with a final diagnosis of meningococcal septicaemia and rotavirus infection leading to dehydration.

The Director of Public Health advised that "any child presenting with a febrile illness, diarrhoea and vomiting needs to be examined to rule out a number of other diagnoses that may require antibiotic treatment, including meningococcal meningitis. If the child is reported by the family to have these symptoms, and to be 'very unwell', they should be seen immediately and examined for signs of meningococcal meningitis. These diagnoses cannot be ruled out over the telephone."

The GP argued that the child was described by his grandmother as being "generally unwell" and that no specific symptoms were described. He said that "in this rural vicinity, and in keeping with the time of year, there were many children with gastroenteric and flu-like illnesses". He stated that he is very experienced at taking telephone calls out of hours about illness, and has a low threshold for detecting concern in relation to patients' illnesses. He did not detect a high level of concern from the grandmother in her first two telephone calls.

There had been deficiencies in the GP's telephone consultation. He did not obtain a full clinical history and was therefore unaware that the child had been seen three days previously with diarrhoea, vomiting and a fever. Without this history he was unable to determine whether the child was indeed experiencing a gastroenteric or flu-like illness or whether the symptoms were suggestive of more serious illness. He was not in a position to determine whether even a gastroenteric illness should have been treated with a greater degree of concern.

The GP advised that as a result of the child's death he had changed his practice and now sees any child showing flu-like or diarrhoea and vomiting symptoms whose parents call him for advice.

Following the child's death the GP was obliged to notify the Police, as he was unable to sign a death certificate because the cause of death was unknown. However, he failed to do so or to explain to the whanau that until the Coroner had decided whether a post-mortem was necessary the body could not be taken home. In addition, it was incumbent on the GP to inform the whanau that he suspected that meningitis, a notifiable infectious disease, was the cause of the child's death and that immediate precautions were necessary. The GP was held to have breached of Rights 4(2) and 6(1)(e).