Taranaki Healthcare, Dr A, Mrs B, Dr C, Dr D, Dr E, Dr F

Opinion - Case 98HDC13685

Complaint

Mr Arthur Whittaker complained to the Commissioner about services provided to his son, Tommy Whittaker (deceased), by Taranaki Healthcare Limited. The complaint is summarised as follows:

- *Mr Tommy Whittaker did not receive services of an appropriate standard from the time of his presentation at Taranaki Hospital Accident and Emergency Department on 15 November 1997 until his transfer to Wellington Hospital on 16 November 1997.*

Investigation Process

The Commissioner received Mr Whittaker's complaint on 2 April 1998 and an investigation was commenced on 11 June 1998. Information was obtained from:

Mr Arthur Whittaker	Complainant / Consumer's father
Dr A	Provider / House Surgeon
Mrs B	Provider / Nurse
Dr C	Provider / Consultant General Surgeon
Dr D	Provider / Anaesthetist
Dr E	Provider / Anaesthetist
Dr F	Provider / Surgical Registrar
Taranaki Healthcare	Provider / Public Hospital

Copies of Mr Tommy Whittaker's medical records were obtained from Taranaki Healthcare and Capital Coast Health.

Inquest
The Commissioner received independent advice from an emergency medicine practitioner and a registered nurse.

Taranaki Healthcare, Dr A, Mrs B, Dr C, Dr D, Dr E, Dr F

Opinion - Case 98HDC13685, continued

Preamble

Mr Whittaker's tragic death has been the subject of a number of external and internal investigations by various agencies. I have obtained and carefully reviewed:

- the Coroner's report and Inquest transcript;
- the Police records of the investigation into Mr Whittaker's fall and death, including expert reports from a neurosurgeon, and a, neurological and spinal surgeon;
- the reports and conclusions generated by Taranaki Healthcare's internal investigation into Mr Whittaker's death; and
- a report written by a consultant neurosurgeon, into Mr Whittaker's care (a report commissioned by the Whittaker family).

I have included in my opinion those excerpts from the inquiries that I consider directly relevant to my investigation.

Information Gathered During Investigation

Fall

At approximately 12.35am on 15 November 1997 Mr Tommy Whittaker fell from a shop canopy onto a footpath outside the City Centre Complex in New Plymouth. The Coroner, described the City Centre Building as a multi-storeyed complex. A glass canopy covers its main entrance with curves running from the top of the building to a height of about five metres from the pavement in front of the complex. On either side of the glass canopy are steep concrete sloping ramps that are part of the main structure. Mr Whittaker and his friend had climbed onto the roof of the City Centre Building and Mr Whittaker attempted to slide down the canopy towards the street. Instead of sliding down the canopy Mr Whittaker slid towards the side of the structure, fell off the edge and landed on the concrete pavement face down.

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Taranaki Healthcare, Dr A, Mrs B, Dr C, Dr D, Dr E, Dr F

Opinion - Case 98HDC13685, continued

Information Gathered During Investigation *continued*

In a statement given under oath to the Coroner, Mr Whittaker's friend described an evening of drinking from 5.30pm or 6.00pm with three of his friends, one of whom was Mr Whittaker. The group went to a local nightclub around 11.00pm, and soon after both the friend and Mr Whittaker left. Mr Whittaker's friend stated:

> "*Tommy said, to me, 'C'mon let's go to Centre City. I'll show you how to slide down the windows.'*
>
> *Tommy had told me he had slid down the covered entrance way to Centre City on Gill Street once before and we had talked about this before.*
>
> *Earlier on that night we had driven past City Centre and Tommy pointed out where he had slid down.*
>
> *We walked over towards the Centre City building and up the ramp beside State Insurance where we climbed a wire fence.*
>
> *We then climbed up a couple of roofs and then walked along the main roof, which is level with the dome entrance.*
>
> *Tommy had a stubby in his pocket and we both skulled it.*
>
> *I'd say we had drunk about a couple of dozen stubbies each at max. We were both very pissed and stoned. We had been smoking some pot (Marijuana) on and off during the night.*
>
> *I watched Tommy climb onto a small wall and shuffle over to the slide. By that I mean the curved entrance.*
>
> *He was going to slide down first and show me how to do it and then come back up, at which time we were both going to do it.*
>
> *I saw Tommy climb onto the glass dome where he laid down on his stomach. He started sliding down feet first, but then began sliding towards the side of the dome.*

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Taranaki Healthcare, Dr A, Mrs B, Dr C, Dr D, Dr E, Dr F

Opinion - Case 98HDC13685, continued

Information Gathered During Investigation *continued*

I saw Tommy fall off the side and onto the pavement below. I yelled at him to see if he was okay, but he didn't respond, so I ran down to where he was to see if he was alright.

He talked to me. I can't remember what he said. I think he was calling my name.

I saw a lot of blood around his head and knew it was serious, so I ran across the gardens to the corner outside the Post Office.

I told two people what had happened and rang for an ambulance from the phone box.

I then ran back to where Tommy was and saw the two people I had told comforting him.

I was talking to Tommy and stayed with him when the Police and ambulance arrived."

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Taranaki Healthcare, Dr A, Mrs B, Dr C, Dr D, Dr E, Dr F

Opinion - Case 98HDC13685, continued

Information Gathered During Investigation *continued*

A security alarm company activity report filled out by a security guard, stated:

> "*On Friday 15.11.97 at approximately 0025* [12.25am] *I arrived at the Centre City Complex to carry out patrol duties whilst patrolling on the very top car park of the complex I was driving towards the glass windows of Pak 'n' Save, in the direction of Gill St. It was then that the headlights of the Patrol Vehicle gave me view of a person disappearing over the side of the complex. I thought I was imagining things. When I heard a loud crash only seconds after the jump, which sounded the alarm system I quickly drove to the edge of the building. As I peered over the edge of the building I saw a body lying in a pool of blood at the bottom of the building outside the Farmers entrance. At the time of the activation* [the] *time* [was] *approximately 0032* [12.32am]. *It was only seconds after* [an employee] *from monitoring informed me of the activation. This is company procedure even if monitoring staff are aware that the guard is in the vicinity. I informed* [an employee] *of what had taken place. I immediately respond*[ed] *to disarm the alarm system, time 0034* [12.34am]. *When I had exit*[ed] *the complex on the Gill St side 2 members of the public were at the scene comforting the victim. On viewing the situation I contact*[ed] [an employee] *to get professional assistance. I locked the doors to the building that I had exit*[ed] *from and went to get the Patrol Vehicle. On arriving back to the scene, Police were there, at a rough guess it would have been 5 minutes after the Police had arrived, that the Ambulance appeared on the scene. I found out that the victim's name is Tom Whittaker …. His injuries looked serious, knowing there wasn't anything more I could do I left the scene in the hands of the professionals and continue*[d] *with the Patrol duties. I left Centre City at approximately 0056* [12.56am]."

Police records show that a call was received at 12.36am on 15 November 1997 from a security alarm company to report that the "*guard has found someone seriously injured who seems to have fallen off the top of the building*" at the City Centre complex. Two constables were sent immediately to attend the incident.

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Taranaki Healthcare, Dr A, Mrs B, Dr C, Dr D, Dr E, Dr F

Opinion - Case 98HDC13685, continued

Information Gathered During Investigation *continued*

In a statement given under oath to the Coroner, one of the constables said he arrived at the scene of the accident at about 12.36am. He spoke to Mr Whittaker's friend who told him that Mr Whittaker had fallen from the side of the glass canopy and described how the incident occurred.

The constable's report on the incident stated:

> *"This report relates to Thomas Arthur Whittaker, 19 yrs old, ….*
>
> *At 0036hrs* [12.36am] *on Saturday the 15th of November 1997, Police Control were contacted by* [a security alarm company] *with regards to a glass break activation at Centre City Complex on the Gill Street entrance.*
>
> *The alarm company stated that one of their guards had found someone seriously injured who appeared to have fallen off the top of the Centre City building.*
>
> *In company with* [a policeman] *I attended the scene and observed a male Maori youth lying face down on the pavement below the Farmers Entrance of the building on Gill Street.*
>
> *I observed that there was a large quantity of blood in and around the youth's head and immediately requested urgent attendance of an ambulance crew.*
>
> *A female member of the public and her husband … were also at the scene rendering first aid ….*
>
> [The female member of the public] *was talking to the youth reassuring him and preventing him from moving and causing himself further injury.*
>
> …
>
> *Also at the scene was the injured youth's friend* […] *who was co-operative and who stated that he had been with the injured youth all day drinking and that they had both consumed a large amount of alcohol.*

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Taranaki Healthcare, Dr A, Mrs B, Dr C, Dr D, Dr E, Dr F

Opinion - Case 98HDC13685, continued

Information Gathered During Investigation *continued*

He also stated that his friend had wanted to show him how he could slide down the glass covered entrance way of the Farmers entrance to the building.

Both youths had walked to the top of the Centre City Carpark at which point the injured youth had climbed out onto the glass entrance cover.

He slid down the first hump but then fell to the concrete pavement below a distance of approximately 20 metres.

The injured youth's friend then ran to the bottom of the carpark and across the road shouting for help.

It is at this point that the [two members of the public] *assisted.*

The injured youth [Mr Whittaker] *was talking during my attendance at the scene and appeared to be in a great deal of pain. He was talking to his friend and from what he was saying details of the occurrence were confirmed.*

I do not in any way believe that there are any suspicious circumstances regarding this Incident. In my opinion it is a prank that has gone very wrong.

When the ambulance arrived at the scene I assisted in applying splints and collars to the youth and placing him in the ambulance."

In a later report (undated) the constable recorded that:

"*On arrival of the ambulance staff* [they] *were assisted by Police to place the deceased* [Mr Whittaker] *into the ambulance prior to his conveyance to Taranaki Base Hospital.*

The deceased appeared to have sustained massive head injuries and broken bones in his left hand and arm."

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Taranaki Healthcare, Dr A, Mrs B, Dr C, Dr D, Dr E, Dr F

Opinion - Case 98HDC13685, continued

Information Gathered During Investigation *continued*

Taranaki Healthcare stated that Taranaki Base Hospital received an emergency 111 call at 12.30am on Saturday 15 November 1997 and an ambulance was despatched at 12.31am, arriving at the scene at 12.35am. (According to the security guard Mr Whittaker had not fallen off the building at the time when the ambulance was said to have been called and dispatched.)

A police constable spoke to the ambulance officer at the scene. The Constable subsequently stated to the Coroner:

> "*On arrival of the ambulance I spoke to the male ambulance officer and informed him that Mr Whittaker appeared to have injuries to his head and arm.*
>
> *I pointed to the top of the City Centre building and explained that this was the place Mr Whittaker had fallen from.*
>
> *I assisted in placing Mr Whittaker in a splint and neck brace prior to putting him on a stretcher for conveyance to hospital.*
>
> *During the whole time I was dealing with the incident Mr Whittaker was conscious and talking about the pain in his hand and arm.*
>
> *Mr Whittaker had obvious injuries to his left hand and arm which looked broken and to his head which had been bleeding heavily.*"

In cross-examination during the Inquest the constable said that Mr Whittaker's friend had been "*quite clear*" when explaining how the accident occurred, which left the constable in no doubt as to what had happened. The constable said he conveyed his understanding of the accident to the ambulance officer in the same way as described during the Inquest, and pointed out to the ambulance officer where he believed that Mr Whittaker had fallen from. The constable said he would describe the incident "*as a slide and a fall. He* [Mr Whittaker] *slid down part of the first canopy and then fell quite some distance to the pavement below.*" The constable estimated that Mr Whittaker would have free fallen at least 15 metres from the point on the canopy where Mr Whittaker's friend had indicated.

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Taranaki Healthcare, Dr A, Mrs B, Dr C, Dr D, Dr E, Dr F

Opinion - Case 98HDC13685, continued

Information Gathered During Investigation *continued*

Mr Whittaker's friend said to the Coroner:

> "*When the ambulance officers arrived I pointed out to them where Tommy had fallen from.*
>
> *I knew that Tommy had fallen quite a distance and that he had landed on his head.*
>
> *I then went with Tommy to the hospital where I called some friends who got hold of his Mum.*"

In cross-examination during the Inquest Mr Whittaker's friend said he was sure that he had made it clear to the ambulance officers that Mr Whittaker had first slid and then free fallen. Mr Whittaker's friend did not recall talking to a doctor or nurse at the hospital, but acknowledged that this could have been due to his own intoxicated state.

A volunteer ambulance officer and the ambulance officer examined Mr Whittaker and carried out a full patient assessment. The ambulance records state:

> "*History: Patient slid down a very steep sloping wall on Centre City. Height 10-12 metres. Patient landed prone onto concrete. He was not knocked out. Friends state that patient has consumed 12+ stubbies. On examination: Patient found lying prone. Conscious, unco-operative but with good memory of events. Pulse 88; BP* [blood pressure] *90 palpation; Resp* [respiration] *20. Left pupil normal size reacting. Right pupil closed due to haematoma* [blood clot]. *Multiple lacerations and bruising to face. ? fracture right wrist. Treatment: Cervical collar applied. Patient log rolled and scooped. Oxygen. En route no change.*"

In a statement given under oath to the coroner, the ambulance officer said:

> "*The patient was conscious and lying prone on the footpath.*
>
> *We did a full patient assessment. The patient appeared to have facial and head lacerations and a fractured right lower arm.*

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Taranaki Healthcare, Dr A, Mrs B, Dr C, Dr D, Dr E, Dr F

Opinion – Case 98HDC13685, continued

Information Gathered During Investigation *continued*

He had good limb baselines, which means he had good feeling and movement and capillary refill in both arms and legs.

The patient was conscious, unco-operative and smelt heavily of alcohol.

I spoke to the patient's friend who told me that the patient had not been unconscious immediately after the fall and estimated that the patient had consumed approximately 12 or more stubbies since finishing work the evening before.

From questioning the patient's friend I was under the impression that they had climbed onto the roof of the City Centre building and slid down the steep sloping wall to the north of the entrance.

From the patient assessment it did not appear that the patient had suffered neck or spinal injuries, but because of the mechanism of injury we treated the patient as having potential spine and neck injuries in addition to the head and arm injuries.

To this end we applied a cervical collar, log rolled the patient onto his back with the aid of the Police Officers present.

The patient was then scooped to minimise all movement, placed on the ambulance stretcher in the ambulance.

In the ambulance we put the patient on high flow oxygen via a Hudson mask. We then transported the patient to hospital.

From the time we started attending to the patient throughout our contact the patient was unco-operative, resisting treatment, moving around trying to get up and wanting to go home.

We departed the scene at 0100hrs [1.00am] *and arrived at Taranaki Base Emergency Department at 0105hrs* [1.05am]."

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Taranaki Healthcare, Dr A, Mrs B, Dr C, Dr D, Dr E, Dr F

Opinion - Case 98HDC13685, continued

Information Gathered During Investigation *continued*

The ambulance staff did not assess Mr Whittaker's Glasgow Coma Scale ("GCS"). The GCS is a measurement of neurological function. It is used in cases of head injury to detect the presence or absence of brain involvement. The ambulance attendant notified Taranaki Hospital Emergency Department about Mr Whittaker's accident and that he would be transported to the Hospital. The staff ambulance officers classified Mr Whittaker as a status two, which meant that he was stable with the potential to become unstable.

In his evidence to the Coroner, the Medical Director of the Emergency Department at Taranaki Base Hospital, stated:

> "*Mr Whittaker was scene triaged by paramedic as Status 2 (old ambulance call codes).*
>
> *This is indicating a patient with a stable but potentially unstable condition.*
>
> *This had surprised Mrs B and other staff members who had suspected and were preparing to receive a patient with unstable injuries.*
>
> *This was based on the preliminary communication from ambulance control that a crew had been dispatched to a fall off Centre City.*
>
> *This call did not then result in a trauma call activation that would have brought additional senior and technical assistance.*"

Arrival at Taranaki Base Hospital

Mr Whittaker arrived at Taranaki Base Hospital Emergency Department at 1.07am, 15 November 1997, accompanied by his friend. At the hospital he was assessed by Dr A and Mrs B.

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Taranaki Healthcare, Dr A, Mrs B, Dr C, Dr D, Dr E, Dr F

Opinion - Case 98HDC13685, continued

Information Gathered During Investigation *continued*

Dr A was a first year house surgeon when she treated Mr Whittaker. Dr A explained during cross-examination at the Coroner's Inquest that there were eight first year house surgeons employed by Taranaki Hospital at that time, and all of them were rostered on night duty after only six weeks at the hospital. When on night duty the house surgeons covered all areas of the hospital wards and A&E, with the exception of obstetrics and gynaecology. The house surgeon on duty was the only doctor awake but had on-call backup from an additional house surgeon and/or the medical or surgical registrar on-call. Dr A gave evidence that she and a number of the first year house surgeons had concerns about the rostering, supervision and sole charge of A&E by first year house surgeons. Dr A said that these issues were raised with the Medical Director of Taranaki Hospital at the time. The Medical Director told Dr A that Taranaki Base Hospital needed to roster first year house surgeons at nights, as otherwise the more senior staff would have been overloaded, and that Taranaki's situation was no different than that of other similar hospitals. However, he stated Taranaki's practice could alter in the future as it may look at employing casualty officers to cover A&E.

The Manager Intensive Care Unit and Nursing Resources, advised the Commissioner that he searched the files held in the Emergency Department Nurse Manager's office and in the files of the Clinical Services Director and found no correspondence or internal memoranda relating to that time to confirm Dr A's claim. However, the Acting Director of Emergency Services advised that, in July 1997 prior to the complaint, Taranaki Healthcare identified that staffing of the Emergency Department by doctors ranging in experience from inexperienced medical officers to experienced medical staff was an area for improvement. Taranaki negotiated a contract for a senior medical officer to do this specific duty. This contract commenced in January 1998.

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Taranaki Healthcare, Dr A, Mrs B, Dr C, Dr D, Dr E, Dr F

Opinion - Case 98HDC13685, continued

Information Gathered During Investigation *continued*

Between 8.00am and 4.00pm on Friday 14 November 1997 Dr A was rostered on a medical ward and was also on call for acute medical admissions at Taranaki Base Hospital. From 10.30pm that night to 8.30am the next day (15 November) she was on night duty. Dr A's statement continued:

> "*I started work at Taranaki Base Hospital at 10.30pm on what was an extremely busy night. From 12.00am on, I was the only doctor awake and on duty in the whole hospital, although there were Registrars and a backup house surgeon I could wake up if needed. In addition to covering A&E, I was also responsible for all difficulties with patients in all the other wards. I recall that night as being typified by my pager going off continuously and running from ward to ward and back to A&E.*
>
> *During my roster, I received advice from the nurses of the imminent arrival of a Status 2 patient. I was in the middle of treating other patients at the time. The nurses let me know so we could meet the patient as soon as he was wheeled into our resuscitation room.*"

Registered nurse, Mrs B, was on duty at Taranaki Base Hospital Emergency Department on 15 November 1997. In her response to the Commissioner, Mrs B stated she qualified as a registered general and obstetric nurse in 1966, then did not work as a nurse from 1967 until 1987. Mrs B returned to work as a nurse in an alcohol and drug rehabilitation facility for four years, then worked at Taranaki Hospital's Emergency Department from 1991 until 1999. In her statement to the Commissioner Mrs B said:

> "*THE NIGHT OF 15 NOVEMBER 1997*
>
> *This was a Friday night, and was the first night of that shift. I started work at 22.45 hours* [10.45pm] *and began my duties by checking the department. That is to say the equipment trolleys, linen, resuscitation equipment and oxygen. I then received a handover from the nurses who were just finishing the previous shift. I was on duty with [nurse] who is another experienced senior staff nurse who normally only works on night shifts.*

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Taranaki Healthcare, Dr A, Mrs B, Dr C, Dr D, Dr E, Dr F

Opinion - Case 98HDC13685, continued

Information Gathered During Investigation *continued*

It was not particularly busy at the start of the shift, although it did turn out to be one of the many busy shifts I have done, although by no means the worst.

Sometime after 12.30am we received a telephone call telling us to expect the arrival of a man who had fallen off the Centre City building. At about the same time we were warned of the arrival of a child from Hawera, we called the paediatric team in to care for that child so that we could deal with the arrival of Tommy Whittaker.

We were surprised that Tommy Whittaker was telephoned through as a Status 2. Status 2 means that a patient is unstable.

The information we had about Tommy Whittaker was that he had fallen off the Centre City building, which suggested very serious injury. [The other nurse on duty], Dr A and I went to the resuscitation room to await. There were no other patients in casualty at that stage although the arrival of the paediatric patient I mentioned was imminent.

Tommy Whittaker arrived on a trolley with an ambulance officer, paramedic, and with [Mr Whittaker's friend]. I first saw Tommy Whittaker at approximately 0105/0110 [1.05am/1.10am].

It was obvious from the smell that Tommy Whittaker had been drinking; I assumed his friend was in a similar state. What I didn't know at the time was that both of them had been also smoking marijuana. [Mr Whittker's friend] appeared drunk and just stood staring. I thought he was in a state of shock.

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Taranaki Healthcare, Dr A, Mrs B, Dr C, Dr D, Dr E, Dr F

Opinion - Case 98HDC13685, continued

Information Gathered During Investigation *continued*

Contrary to the message we had received earlier, the ambulance officer told us that the accident to Mr Whittaker had occurred by him sliding down a steep sloping wall and going smack onto his face. His injuries were consistent with this. On the admission form, [the other nurse on duty] wrote that Tommy Whittaker had slid some 10 metres, based on what she heard from the ambulance staff. I was insistent about asking where the accident had actually happened because I could not visualise a ramp at Centre City of the sort described, but [the ambulance officer] was firm that he had slid down the ramp and not fallen.

Tommy Whittaker was transferred onto our resuscitation trolley.

He was conscious and was not co-operative. He was trying to throw himself off the trolley as he wished to go home.

The casualty bell was rung and [the other nurse on duty] went to see what was happening. She came back and spoke to Dr A about a possible meningitis case and Dr A left. I continued to deal with Tommy Whittaker, having the assistance of .... the ambulance officer."

In her statement to the Coroner, Dr A recalled that Mr Whittaker was brought in by ambulance:

"*The ambulance officers gave me a brief history. They advised me and the nurses that he hadn't fallen, and that he had slid approximately 10-12 metres down a ramp like structure at the Centre City Complex. I couldn't picture exactly where they meant and was surprised by what they were saying. I was surprised because I had previously received information that he had fallen. As a result, I questioned the ambulance officers as to whether he had fallen or not and was told that he didn't fall, he slid down.*

The casualty officer nurse also asked the same question again, and received the same answer. We both also questioned further as to where he had slid off as neither of us could picture where this ramp was located.

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Taranaki Healthcare, Dr A, Mrs B, Dr C, Dr D, Dr E, Dr F

Opinion - Case 98HDC13685, continued

Information Gathered During Investigation *continued*

The ambulance officers also told us that Whittaker had been intoxicated prior to the event, that he was found lying prone, that he had not been knocked out and there had been no loss of consciousness. The fact that he had not been knocked out and there had been no loss of consciousness were very important factors that I kept uppermost in my mind during the later course of my duty hours.

I did a quick initial assessment of Whittaker, the result of which were as follows: Airway: clear; Breathing: normal; Circulation: intact with good perfusion [passage of fluid through tissue]*, no evidence of active bleeding; GCS: 14/15 – eyes closed on arrival. L eye opened to voice, then remained open. Patient orientated, able to give Hx* [history] *of event, appropriate answers, c/o* [complains of] *pain right wrist, nil elsewhere. Right periorbital haematoma and laceration, suggesting presence of head injury. Markedly deformed right wrist suggesting presence of #* [fracture]*/dislocation. Stable at present with potential to become unstable."*

Mr Whittaker's Emergency Department casualty record stated:

"*Arrival;, 15/11/97*
Time: 0107 [1.07am] *hours.*
Triage: stat;[immediately]
Doctor: stat;
Code Two."

Dr A recorded the following in Mr Whittaker's records:

" *Slid off Centre City, landed on right arm. Not knocked out. Prone when found. Complains of sore right forearm, sore face. Not sore elsewhere. Last ate 5 hours ago – beer, crackers. GCS 14/15. Eye 3 to 4.*"

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Taranaki Healthcare, Dr A, Mrs B, Dr C, Dr D, Dr E, Dr F

Opinion - Case 98HDC13685, continued

Information Gathered During Investigation *continued*

Mrs B continued to record in Mr Whittaker's notes:

"*Dislocated right hand, fractured on x-ray. Vomiting dark blood. Observations stable – hand perfused, sensation ✓. Discussed with registrar [Dr F] – back slab, review mane* [morning]. *IV line ✓, bloods ✓. Mother present.*"

Two sets of vital signs were recorded on the ED sheet as follows:

"Times	*BP*	*HR*	*Resp*	*Oximetry*	*L Pupil*	*R Pupil*	*GCS*
0230	*145/71*	*67*	*24*	*99*	+	-	-
0110	*110/60*	*73*	*24*	*99*	+	-	-

Temperature: 35.6 ℃. No known allergies. Admitted 0200hrs."

In cross-examination during the Inquest Dr A said she had initially recorded 15/15 for the GCS. She realised later this was a mistake as Mr Whittaker had in fact had his eyes closed on arrival, giving a score of 14/15.

Because the Emergency Department was so busy, the ambulance officer stayed with Mr Whittaker for about one hour. In his statement to the Coroner the ambulance officer said that, although he acknowledged he had misunderstood just how the accident had occurred, "*just looking at the mechanism of injury, it was obvious he* [Mr Whittaker] *had potential for head injuries*". The ambulance officer did not observe Mr Whittaker make any jerky limb movements during the hour he spent in the resuscitation room after arriving with Mr Whittaker.

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Taranaki Healthcare, Dr A, Mrs B, Dr C, Dr D, Dr E, Dr F

Opinion - Case 98HDC13685, continued

Information Gathered During Investigation *continued*

Dr A advised that after she first examined Mr Whittaker on his arrival at A&E she was called away. Dr A said:

> *"I was then summoned urgently out of resuscitation by another casualty nurse to see a child who was febrile and vomiting with a petechial rash. I asked Mrs B to page the Registrar, Dr F, because at that time I was not experienced in dealing with trauma patients. He was the only person of officially senior level that I could contact and I knew that I needed advice and guidance from someone more senior and experienced than myself. I attended to the child and while doing so a nurse asked me to attend another patient who was also in a potentially life-threatening situation."*

Mrs B stated:

> *"At around this time the A&E department filled up with acutely sick people. There was a lot of noise. I recall that one university undergraduate arrived having overdosed. There was also a lady who was very drunk and had been assaulted with cuts to her face, was extremely noisy, screaming and abusive and another person with acute chest pains, as well as the four year old from Hawera.*
>
> *At about this time Tommy vomited copiously. I was very careful to hold his head during this, maintaining c-spine traction, because I didn't know whether his fall had caused him any injury to his spine and neck. [The ambulance officer] assisted me with suction as I was very concerned to ensure that he did not aspirate his own vomit. He was still trying to get off the bed in the manner described earlier.*
>
> *The ambulance staff had placed a hard collar on him to protect his neck before transit to hospital.*
>
> *Once he had vomited he settled and we were able to get details about him from [Mr Whittaker's friend]. As a result I telephoned for his father but was not successful and I got [Mr Whittaker's friend] to ring Tommy's mother. By this time it was 01.40.*

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Taranaki Healthcare, Dr A, Mrs B, Dr C, Dr D, Dr E, Dr F

Opinion - Case 98HDC13685, continued

Information Gathered During Investigation *continued*

He had vomited up old blood and alcohol and I put towels down because the place was literally awash, as you can imagine.

Tommy Whittaker vomited intermittently for about 20 minutes. In between bouts I was taking his observations. I asked the ambulance officer, ... to write the observations on a blotter as I went through them, as my priority was to stay with Tommy at this point. I paged the registrar and the radiologist and requested an orderly to help me so that I could continue my observations. The orderly did come shortly afterwards, which released [the ambulance officer] to go on about his duties. Tommy was quieter by this time, having finished vomiting.

I had tried to get assistance from the Casualty Department during one of Tommy Whittaker's quiet moments, but they were so busy that they could not assist me. Indeed, they had called in the back-up house surgeon. The duty resource nurse then came into Resus and said she was trying to organise some help for me.

Mr Whittaker's eyes were open and he spoke to me (said 'you're nice') as I wiped his face. He was compliant with treatment at this stage and was still while I cannulated and took blood samples from him. With his left hand he kept holding on to my left hand.

Dr A then arrived to do a full assessment. Also the pool nurses arrived to assist me during that assessment. I couldn't write my own observations down because Mr Whittaker was still trying to get off the bed, and lifting his obviously dislocated right hand up to the cut above his right eye. I was still gloved, with vomit and blood on my apron and gloves. The pool nurses assisted me by noting my observations from the blotter, continuing those which .... the ambulance officer had started. I noted that Dr A suggested doing an alcohol level and although a sample was taken for that purpose, it was never analysed by the lab."

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Taranaki Healthcare, Dr A, Mrs B, Dr C, Dr D, Dr E, Dr F

Opinion - Case 98HDC13685, continued

Information Gathered During Investigation *continued*

In her statement to the Commissioner Mrs B said:

> "*I should explain that the registrar had been summoned by phone because of the dislocated wrist which Tommy Whittaker had, and the possibility that he might have a head or spine injury.*
>
> *The first two times I paged the registrar through the operators, he did not respond, and on the third occasion the operator said they would try to put a phone call through to his home.*"

After seeing to the two other patients, Dr A returned to Mr Whittaker. Dr A's statement to the Coroner continued:

> "*I handed the child over to the Paediatric team, gave instructions for the second patient, then returned immediately to resuscitation. The casualty nurse told me that she had called for Dr F, as I had requested, to attend to Whittaker. She was in the process of taking blood and inserting an IV line. Whittaker did not like this and was trying to get off the bed. He was clearly very drunk and I had to help the nurses by holding him on to the bed so that the IV line could be inserted. I then proceeded to do a full assessment on Whittaker.*
>
> *Some history was obtained from Whittaker and some from his friend who had witnessed the whole episode. Whittaker said he had been drinking beer earlier in the evening and was at Centre City with his mates. He had slid down and landed face down on his right arm and also hurt his right eye. He said he had not been knocked out. He was certain of this and it was confirmed by his friend who had been watching.*
>
> *Whittaker complained about pain in his right wrist, especially when he tried to move it. When asked if he had hurt himself anywhere else he said his right eye was a bit sore. He said he hadn't been hurt anywhere else. I questioned him specifically about pain or discomfort in all other areas – head, neck, chest, abdomen, pelvis, left arm, legs, back. He denied any pain or ache in these areas.*

Continued on next page

Taranaki Healthcare, Dr A, Mrs B, Dr C, Dr D, Dr E, Dr F

Opinion - Case 98HDC13685, continued

Information Gathered During Investigation *continued*

While I was taking the history the other casualty nurse asked if she could page the back-up house surgeon as A&E was filling up fast. I agreed and she paged him to come in."

Mrs B stated that Mr Whittaker's mother arrived at some point during the assessment. Mr Whittaker's mother, Mrs Diane Whittaker, gave a statement under oath to the Coroner stating:

"*At about 1.00am on Saturday, 15 November 1997 I received a telephone call from Tommy's friend ... who told me Tommy was at Taranaki Base Hospital in intensive care.*

I rang my eldest daughter Robina who told me she had also received a phone call and that she understood it was not serious and that Tommy may have a broken wrist.

I quickly got dressed and raced over to the hospital where I was shown into A&E to see Tommy.

A female house surgeon and a couple of nurses were attending to Tommy.

Tommy had just been sick and I was upset to see him in the state he was.

I saw that Tommy had a large cut above his right eye and his right wrist was severely broken. He was burbling and making no sense and I had never seen him like that before.

The staff who were tending to Tommy's wrist got someone from the x-ray department to come down.

At this time a person whom I have never met before named [Mr Whittaker's friend] was also standing next to Tommy.

[Mr Whittaker's friend] appeared to be affected by alcohol and to be rather vague and upset.

Continued on next page

Taranaki Healthcare, Dr A, Mrs B, Dr C, Dr D, Dr E, Dr F

Opinion - Case 98HDC13685, continued

Information Gathered During Investigation *continued*

Not long after my arrival I said to the house surgeon 'Are you sure his head's alright?'.

I was concerned about the head injury judging from Tommy's appearance, the cut over his head and the fact that he had fallen from such a height.

The house surgeon said to me that they had checked his head and I saw that Tommy had a neckbrace on.

Tommy vomited for a third time before his right arm was put in plaster."

In cross-examination during the Inquest Mrs Whittaker clarified that she did not in fact know that Mr Whittaker had fallen from a height at the time she was in the Emergency Department. In cross-examination during the Inquest Dr A said she passed on Dr F's reassurance to Mrs Whittaker and informed her that Mr Whittaker would be monitored overnight for any change.

Mrs B told the Coroner that on the third attempt she tried to contact Dr F, he responded, but Mrs B did not know whether he had been reached at home or within the hospital. Taranaki Healthcare was unable to provide a record of these telephone calls.

Continued on next page

Taranaki Healthcare, Dr A, Mrs B, Dr C, Dr D, Dr E, Dr F

Opinion - Case 98HDC13685, continued

Information Gathered During Investigation *continued*

Dr A stated:

"*Dr F had still not arrived or answered his call so I rang the operator and asked them to page him again. I was paging him because in particular I needed him to:*

a) Listen to the description of the patient's presentation and tell me what further investigations if any I should carry out and what matters if any I should be particularly concerned about. This included:

i) I wanted to know exactly how concerned I should be about his periorbital haematoma and if we needed to take any additional action with regard to that, ie further [investigation] *monitoring or treatment.*

ii) I wanted instructions with regard to the right wrist – whether he needed manipulation or theatre that night, and if not, what the registrar wanted us to do until the morning.

iii) I wanted advice regarding the patient's vomiting blood, whether it was likely to be due to something simple such as swallowing blood from epistaxis which then irritated the stomach leading to vomiting, or whether it was more likely to herald something more sinister such as more serious head injury or abdominal trauma.

iv) I wanted to be sure I hadn't missed anything I should have done, to give the registrar the opportunity to add anything that should be done and to hear the registrar's opinion of the seriousness of the case.

Continued on next page

Taranaki Healthcare, Dr A, Mrs B, Dr C, Dr D, Dr E, Dr F

Opinion - Case 98HDC13685, continued

Information Gathered During Investigation *continued*

While awaiting his answer I ordered x-rays. In Taranaki Base Hospital there is no radiographer on site at night. To get any x-rays done a radiographer has to be called in from home. Medical staff have instructions to ask only for urgent x-rays at night. Non-urgent x-rays wait until 8.20am when staff arrive at work. Initially I wanted x-rays of Whittaker's right wrist and chest. I thought about cervical spine or skull x-rays, but they did not seem to be warranted clinically and I thought I could add them before the radiographer went home if the registrar, Dr F, wanted them.

As Dr F still had not answered either of our two calls, the casualty nurse tried to get him again. This time he answered. She handed the phone to me. I told Dr F everything contained in the notes. I had the notes in front of me and [went] *through Whittaker's history from the notes. I told Dr F everything because I didn't feel I had sufficient knowledge to know what he might or might not consider was important. The time was approximately 2.00am. I told him that I was ringing about a 19 year old male, Tommy Whittaker, who was brought in as a Status 2 by ambulance after sliding 10-12 metres off a ramp-like structure at Centre City. He had taken alcohol prior to the event. He had been found lying prone. He was not knocked out. On examination the main findings were a large periorbital haematoma of his right eye, laceration of his right eyebrow and marked displacement of right wrist (?) fracture or dislocation. His GCS was 14/15 (not opening eyes spontaneously), he was restless and had vomited some old blood which I felt he had swallowed. His neck, chest, abdomen and other limbs appeared to be satisfactory. I told Dr F that x-rays of his wrist and chest were currently being developed and would be ready when he got here. I asked particularly about the periorbital haematoma, the vomiting and his wrist. Dr F replied that he did not need to come in, that there was nothing further we needed to do tonight. He gave instructions to keep the wrist immobilised until morning, keep the patient nil by mouth and the team would see him in the morning and probably take him to theatre then. I questioned him: 'You're not coming in?' and he replied 'No'.*

Continued on next page

Taranaki Healthcare, Dr A, Mrs B, Dr C, Dr D, Dr E, Dr F

Opinion – Case 98HDC13685, continued

Information Gathered During Investigation *continued*

When talking to Dr F first he listened to what I had to say. Then he asked some questions. He asked how far Whittaker had fallen. I said I was unsure. I told him though that it sounded like he had slid about 10 metres but emphasised that I was not sure how far he had fallen. I had already told him about the periorbital haematoma, the laceration to the right eyebrow and his displaced right wrist. His question about other injuries caused me to give him a rundown of the rest of my examination. Dr F asked me if the circulation and sensation to his right hand was okay, and I informed him that it was. We discussed the fact that the patient had vomited blood. Dr F was of the opinion this was due to a nose bleed and he was not concerned. It was at this point in the discussion that he said he did not need to come in. I then asked if there was anything else I should be doing. I was told to immobilise the wrist in a backslab and keep him nil by mouth and to get the nurses to do circulation observations on his right hand. He told me there was nothing else we needed to do that night and that he would review him in the morning and take him to theatre then. He did not seem concerned at all, which reassured me.

My expectation when I rang Dr F was that he would come in and review Whittaker himself. I, however, had to accept his clinical judgement that his attendance wasn't necessary. However, when he didn't seem to feel that the patient's condition warranted his attendance I expected him to highlight anything that I had left out, give instructions for any further investigations or treatment that was required, tell me if I needed to in particular carry out further investigations of his periorbital haematoma as there was still a possibility of arranging such investigations as an x-ray, finally I expected him to remain available if there were any further problems."

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Taranaki Healthcare, Dr A, Mrs B, Dr C, Dr D, Dr E, Dr F

Opinion – Case 98HDC13685, continued

Information Gathered During Investigation *continued*

Dr F gave evidence to the Coroner that he was not aware of any difficulties with his pager the night of 15 November 1997, and was not called to the hospital until 7.20am. Dr F was unable to recall when he was contacted by Dr A at around 2.00am, whether he responded to his pager or to a telephone call, but thinks it was more likely a telephone call. Other than possibly at 2.00am, Dr F's pager did not go off from the time he left the operating theatre until he was called by telephone at 7.20am. When asked if his pager was turned on, Dr F replied:

> "*I can't be completely sure, I never turn my pager off, but it is not unheard of for the switch to be knocked against something and turned to either buzz or off state.*"

Dr F said in a statement given under oath to the Coroner:

> "*I was the on call registrar at Taranaki Base Hospital on 16* [15] *November 1997.*
>
> *On call surgical registrars are required to be obtainable within ten minutes, while on call. I always stayed on the hospital grounds while I was on call at the room in the quarters available for this. The Friday night call, at this time, commenced at 4.00pm following the normal working day, and ended at 8.00am the following morning. Unless attending patients, I was in the on call room for the duration of the morning of 16* [15] *November 1997 and available on my pager.*

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Taranaki Healthcare, Dr A, Mrs B, Dr C, Dr D, Dr E, Dr F

Opinion – Case 98HDC13685, continued

Information Gathered During Investigation *continued*

I was contacted at around 2.00am whilst in the on call room by the night house surgeon, Dr A. I was advised by Dr A that a young man had been admitted who had apparently been drinking and had fallen, perhaps from some scaffolding. He was awake, alert and complained of an injured wrist. X-rays showed that there was a fracture to the distal radius which would require manipulation. I asked how far he had fallen and this was unclear. I also asked whether he had any other injuries. I do not recall being told that there was an associated dislocation of the wrist. If I had been informed of a dislocation I would have advised the house surgeon to reduce this immediately. I was not told of a head injury. I advised that the wrist should be placed in a back slab and that I would review the man first thing in the morning with a view to manipulating the wrist. Dr A did not ask me to attend the patient; I certainly would have if requested."

Dr F clarified during cross-examination that he was asleep in the on-call room when he was contacted at 2.00am; he was unsure whether he was contacted by a phone call or via his pager. Dr F made no notes of the content of the conversation. Dr F stated that Dr A told him that Mr Whittaker had bruising around his right eye. Dr F stated that his statement to the Coroner that he was not told of a head injury was correct as he was told by Dr A of bruising to the head. Dr F stated that bruising is layman's speech for periorbital haematoma.

Dr A disputed Dr F's statement that she had not told him that Mr Whittaker had a head injury. She stated:

"*… I told him what I had found, that he had the large periorbital haematoma and the laceration, how that I understood he had slid, that he hadn't been knocked out, that there was no loss of consciousness and his current GCS score.*"

In her statement to the Coroner, Dr A said that she did not think Mr Whittaker had a head injury, but rather a "*potential head injury*" and was therefore monitoring Mr Whittaker's GCS. Dr A explained that she did not consider the fact she did not write 'head injury' on the admission form as being significant, because she had noted the periorbital haematoma which was indicative of a head injury.

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Taranaki Healthcare, Dr A, Mrs B, Dr C, Dr D, Dr E, Dr F

Opinion – Case 98HDC13685, continued

Information Gathered During Investigation *continued*

Dr A stated that although she recorded only that Mr Whittaker had slid, she verbally told Dr F it was not clear whether Mr Whittaker had fallen or slid, because of the conflicting accounts she had received from the call taken by nursing staff and the report given by the ambulance officer.

At the Inquest Dr A said she asked Dr F whether head x-rays should be taken, and that Dr F had replied that there "*was nothing more we needed to do*". Dr A said that she would not have been able to order a CT scan following her initial assessment as Mr Whittaker's presentation did not meet the hospital criteria for a CT scan at that time, and only the registrar had authority to call in a radiologist after hours. Dr A said that she would have called the registrar if Mr Whittaker's GCS dropped to 12/15 and would have considered calling him if Mr Whittaker's GCS dropped to 13/15, with a view to obtaining a CT scan.

Taranaki Healthcare provided the Commissioner with its protocol for ordering a CT scan. In his evidence to the Coroner the Medical Director of the Emergency Department, stated:

> "*Mr Whittaker was not considered for CT scan on arrival in the resuscitation room.*
>
> *Based on the concurrent and the revised CT scan criteria, there was no evidence that Mr Whittaker's neurological state on admission or within the immediate post resuscitation period would have made a CT scan mandatory.*
>
> *In hindsight however, this examination would have been prudent.*
>
> *It may have indicated evidence of skull fracture, cerebral contusions and developing extradural haematoma.*
>
> *It is however also possible that if this examination was undertaken early it may not have revealed the mass lesion.*"

Continued on next page

Taranaki Healthcare, Dr A, Mrs B, Dr C, Dr D, Dr E, Dr F

Opinion – Case 98HDC13685, continued

Information Gathered During Investigation *continued*

Mrs B advised the Commissioner that:

> "*The house surgeon wrote brief notes at that time, then later when she left resus (0230-0245), made admission notes. I believe I formally admitted Mr Whittaker to the hospital on the computer during the house surgeon's assessment. We needed sticky labels off the printer for x-rays and bloods with his NHI number on. Also, the radiologist arrived about that time. It was while I was with the radiologist in the resuscitation room that the registrar rang back in answer to my page. I heard Dr A talking to the registrar, although I couldn't clearly hear what was discussed. I estimate that their conversation lasted from 3 to 5 minutes.*
>
> *After the call, Dr A told me that the registrar was not going to come in and that the patient's wrist was to be put in a back slab overnight and reset in the morning. I put the back slab on at this time. I was surprised that the registrar was not coming in because it was normal for a registrar to do so where there was an obvious dislocation of any limb and where we were not sure of the sort of head injury Mr Whittaker may have suffered. This was the first time I had ever seen a dislocation left over night. Because the dislocated hand was not to be reset until the morning, I put a thick plaster cast on his hand to completely immobilise it. He had good circulation in his hand.*"

Dr A said that when Dr F informed her he was not coming in, she queried him, but did not insist, and that she felt considerably reassured after the conversation with Dr F. Mrs B said that she questioned Dr A about Dr F's decision not to attend and she and Dr A discussed this. Mrs B stated to the Coroner:

> "*I didn't consider ringing the consultant because it seemed that the house surgeon had had extensive discussion with the registrar on the phone.*"

Mrs B said she did not hear what Dr A had said to the registrar as Dr A is very quietly spoken and Mrs B was busy attending to Mr Whittaker.

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Taranaki Healthcare, Dr A, Mrs B, Dr C, Dr D, Dr E, Dr F

Opinion – Case 98HDC13685, continued

Information Gathered During Investigation *continued*

Dr A stated:

> "*I advised the casualty nurse that the registrar wasn't coming in, did not seem concerned and wanted the wrist immobilised until morning. The nurses applied a backslab to his right wrist while I sutured the laceration on his eyebrow under local anaesthetic (5 sutures with 4-0 suture). We called a couple of nurses and an orderly to help out. They helped us keep Whittaker still while we did the suturing and backslab.*"

When Dr A sutured Mr Whittaker's eye laceration she observed that he was groaning but did not note that he was verbalising inappropriately, and described his arm and leg movements as "*purposeful*" to stop her from suturing.

Mrs Whittaker told the Coroner:

> "*After his arm was in plaster he was waving it around and was agitated and moaning. I held Tommy's arm to help the nurses do their work.*
>
> *The nurses weren't particularly concerned about the jerking of his arm – they were dressing his other wounds.*
>
> *Then his right leg began thrashing around as well. At this stage they began cleaning him up and took his top off and I noticed there seemed to be bleeding around the back of his head.*
>
> *Again I asked them if they were sure his head was alright. Either the house surgeon or one of the nurses said that it was fine.*
>
> *They assured me that the blood was all just from the cut on the head.*"

Continued on next page

Taranaki Healthcare, Dr A, Mrs B, Dr C, Dr D, Dr E, Dr F

Opinion – Case 98HDC13685, continued

Information Gathered During Investigation *continued*

Dr A continued:

> "*I rechecked Whittaker again – GCS and pupil reaction still unchanged. I wrote up his notes, told the nurses to transfer him to the ward side of A&E, to do hourly neuro obs and call me if there was any deterioration.*
>
> *While I was assessing Whittaker my pager went off frequently and the wards started writing lists of jobs for me to do. I checked on the back-up house surgeon to see how he was getting on.*
>
> *I saw the rest of the casualty patients then had to go to Ward 17 to deal with a violent patient who had attacked two staff at the hospital.*
>
> *After attending to that patient, I had to return to all the other wards to do the jobs that were waiting.*"

In cross-examination during the inquest Dr A explained that it was not appropriate to call in either the medical or surgical registrars on call to help out with the general 'busyness' of the night. The back up house surgeon was called to assist in this role for one and a half to two hours until all the acute urgent patients had been seen. Dr A said she was aware that the back up house surgeon had already worked 16 hours that day.

Dr A continued:

> "*I expected that every hour Whittaker would be woken up and an assessment would be carried out of his GCS, scored out of 15, that his pupils would be checked, that his pulse, blood pressure and* [oxygen saturation] *would be measured. I expected to be called and notified if there was any change in any of these parameters.*"

Dr A left Mr Whittaker at around 2.20am, and gave evidence that she was unaware of a GCS score taken by nursing staff ten minutes later of 12/15.

Continued on next page

Taranaki Healthcare, Dr A, Mrs B, Dr C, Dr D, Dr E, Dr F

Opinion – Case 98HDC13685, continued

Information Gathered During Investigation *continued*

Mrs B stated to the Commissioner:

> *"The house surgeon stitched the cut above Mr Whittaker's eyebrow, after she had finished his complete assessment, (face, spine, x-rays and GCS).*
>
> *As I indicated earlier, two pool nurses were assisting at this time, one of them writing all observations done on the blotter. On reflection it is likely that the particular nurse who was doing that did not have experience in the A&E Department, hence the observations concerning Tommy's neurological position were written on to the green Patient Observation Chart, instead of the grey edged Neurological Observation Chart, and therefore some observations were omitted. The GCS of 14 at 0230 was not noted. Also my informal quarter hourly observations were not recorded.*
>
> *…*
>
> *I took over care of Mr Whittaker when Dr A left at approximately 02.40.*
>
> *I had done the Glasgow Coma Scale Neurological observations in my head on arrival and at approximately 02.30, which I found to be in the range 12/13. After he had vomited, that went up to 14. A higher score was prevented by his right eye not being able to open due to bruising and swelling.*
>
> *Dr A had gone to write up copious notes which she was still writing when I moved Mr Whittaker to the ward side of A&E at 0330."*

Continued on next page

Taranaki Healthcare, Dr A, Mrs B, Dr C, Dr D, Dr E, Dr F

Opinion – Case 98HDC13685, continued

Information Gathered During Investigation *continued*

Dr A recorded the following in Mr Whittaker's medical notes:

"*GCS 14/15 – not opening eyes spontaneously.*
Orientated x3, able to answer questions appropriately, also groaning at times.
Restless at times – trying to get off bed when procedures attempted (IV line, bloods, BP reading, suturing) and needing restraint at times.
Smelt of alcohol.
Right periorbital haematoma (right eyelid swollen shut and bruised).
Laceration right eyebrow.
Dried blood around nose, no CSF leakage.
No discharge from ears (CSF or blood).
No lacerations seen inside mouth.
No lumps detected on palpating skull.
Right wrist was markedly deformed, displaced and tender.
Radial pulse present, good capillary refill.
Sensation present and unimpaired.

Few abrasions present elsewhere, ie knee.
Left arm, both legs, cardiorespiratory, abdomen, pelvis all satisfactory.
Neck completely non-tender (had never been sore and had been moving neck around with no restriction, restraint or pain before hard collar applied).

During the neurological part of the examination I found the left eye reacting to light and was 6mm, FROM: sensation/power/co-ordination grossly normal.

During the examination Tommy had felt sick and vomited up some dark blood and alcohol. He had a few subsequent small vomits of dark blood, then stopped. Vomiting was not projectile. I rechecked him, his abdomen was non-tender, soft, no rebound or guarding. I felt he had swallowed blood from a nosebleed, this irritated his stomach and he then vomited it up."

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Taranaki Healthcare, Dr A, Mrs B, Dr C, Dr D, Dr E, Dr F

Opinion – Case 98HDC13685, continued

Information Gathered During Investigation *continued*

Dr A compiled the following problem list and findings:

"***Interdisciplinary Assessment Form:***

Problem List:

Active		***Inactive***
1.	*Fracture right forearm*	*Asthma*
2.	*Laceration right eyebrow*	
3.	*Periorbital bruising right eye*	
4.	*Fracture rib*	

History of Presenting Complaint: Slid down steep sloping wall on Centre City approximately 10-12 metres height about midnight. Not knocked out. Landed prone on concrete. Good memory of events. Complains of pain right wrist and face – cannot move wrist. Head/neck not sore. Abdomen/chest/legs okay. Last ate approximately 10pm – crackers and beer.

Past Medical History: asthma as child – returned about 1 year ago. Not using ventolin inhaler recently. No diabetes, epilepsy, heart disease, hypertension or tuberculosis.

Medications: ventolin inhaler prn [as required]. *No known allergies.*

Social History: lives with mother.

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Taranaki Healthcare, Dr A, Mrs B, Dr C, Dr D, Dr E, Dr F

Opinion – Case 98HDC13685, continued

Information Gathered During Investigation *continued*

On examination: ***conscious, alert GCS 15/15.*** *Left pupil equal and reacting to light and accommodation. Cardiovascular: pulse 88/min strong, regular; BP 94/50. Heart sounds dual, nil added, no oedema, peripheral pulse palpable. Respiratory: trachea midline, percussion resonant, breath sounds vesicular, nil added, good air entry. Abdomen: soft, non-tender, no rebound, no guarding, no organegoly, no masses, bowel sounds active. Legs power, coordination, sensation, pulses normal bilaterally. Neck non tender, no abnormalities described. Right arm – marked deformity right wrist and swelling, also tender. Pulse strong. Capillary refill good. Sensation intact all distributions. No movement due to pain. Left arm: no abnormalities, power/sensation/co-ordination/pulses normal. Face: periorbital bruising right eye, laceration right eyebrow, slightly jagged. Bleeding from nose now stopped. No CSF leakage. Mouth: no laceration seen, teeth appear okay. Ears: no CSF leak or haemorrhage.*

Began vomiting blood then ceased.

Impression: ? dislocation ? fracture right wrist:

Laceration right eye; periorbital bruising right eye

Plan:

- *PA/lat right distal forearm/wrist*
- *Chest x-ray*
- *Nil by mouth*
- *Analgesia as needed*
- *Bloods/iv line*
- *Suture right eyebrow*
- *Immobilise wrist*
- *Hourly neuro observations please – call if deteriorate.*
- *Casualty nurse called surgical registrar [Dr F] – discussed with [Dr F] – keep in backslab tonight; team to review mane.*
- *Approximately 4-5cm laceration over right eyebrow, slightly jagged edges; sutured with 4/0 monofil – 5 sutures required.*"

Continued on next page

Taranaki Healthcare, Dr A, Mrs B, Dr C, Dr D, Dr E, Dr F

Opinion – Case 98HDC13685, continued

Information Gathered During Investigation *continued*

Mrs B stated at the Inquest that she transferred Mr Whittaker to the admitting ward of the Emergency Department and began a neurological observation chart for him. Mrs B advised the Commissioner that:

> "*I do not recall Dr A asking me personally to do the neurological observations. There was a lot of noise coming from casualty. It was unnecessary for me to hear that instruction, because I am aware of the protocol operating in the A&E Department for head injuries, namely that the observations are done 1 hourly.*
>
> *However, in my training at Stratford between 1987-1991, I was in the practice of doing 15 minute checks in cases of patients whose injury had not been fully established from the history and about which there were concerns. Tommy Whittaker gave me cause for such concern and although I do not normally record these interim checks (it would be impossible to do so with all the other duties one has in the A&E Department), I did those checks between the time that the house surgeon left right until 0530 at which time I became concerned about him. I try and make these checks every 15 minutes, but other duties pressing on me in the A&E Department at various times mean that the time between the checks can vary from between 10 to 20 minutes."*

Mrs Whittaker stated at the Inquest:

> "*Tommy was then taken to the 'recovery room' (part of the A&E section) and by now it was about 3.00am.*
>
> *I stayed with him in the recovery room and tried to keep his arm and leg stable. He was burbling and groaning.*
>
> *It did not seem to be really an attempt to speak.*
>
> *For whatever reason he was very 'out of it'.*
>
> *His leg and arm still kept thrashing up and down and I asked the nurses if this was normal – she suggested it was due to Tommy's alcohol intake.*

Continued on next page

Taranaki Healthcare, Dr A, Mrs B, Dr C, Dr D, Dr E, Dr F

Opinion – Case 98HDC13685, continued

Information Gathered During Investigation *continued*

At one stage Tommy's leg got caught up in the stainless steel sides of the bed."

Mrs B did not observe any jerky limb movements made by Mr Whittaker, and during cross-examination at the Inquest described his unco-operative behaviour as:

> "*… he continually took his broken wrist up to his sore eye, the whole time he was in resus. He continually tried to get off the bed. Until he had had a large vomit, several large vomits actually, so that he settled after that.*
>
> …
>
> *And I remember his thrashing around ….*
>
> …
>
> *I was scared he was going to hurt himself. Mrs Whittaker asked me why he was doing that and I looked at him and I knew the doctor had checked him out and I thought it was the alcohol.*"

Mrs B acknowledged that "*thrashing about and the general unco-operativeness can also be signs of concussion*". In cross-examination during the Inquest Mrs B agreed with Mrs Whittaker's description of her son as "*burbling and groaning*".

The relieving nurse and the duty resource nurse cleaned the resuscitation area for Mrs B after Tommy had been transferred to the ward side of A&E. The duty resource nurse spent about one hour with Mrs B and Mr Whittaker but was called away as intruders were reported in a closed ward.

Continued on next page

Taranaki Healthcare, Dr A, Mrs B, Dr C, Dr D, Dr E, Dr F

Opinion – Case 98HDC13685, continued

Information Gathered During Investigation *continued*

Mrs B advised the Commissioner:

> "*The interim checks I did for Tommy Whittaker, as is my normal practice with such patients, particularly where alcohol is concerned, is to get them to respond to my commands by squeezing my hand and opening their eyes; in Tommy's case his left eye (his right was still closed). When they are drunk they often will not make an appropriate verbal response. The tests I did were quite robust due to his state and the pressure of work.*
>
> *I was particularly concerned with Tommy Whittaker because of the complication of alcohol which has a marked effect upon the GCS scores that can be obtained from such patients. My experience of using GCS scoring in relation to severely inebriated patients, as was the case with Tommy Whittaker, was that the GCS score can change from minute to minute. They can go from sleep to talking and back to sleep again within minutes. It is not unusual in some severely inebriated patients to get a GCS score as low as 3, which would indicate that a patient is either dead or approaching death, and 6 can indicate a comatose situation ie no eyes open, no verbal response, withdrawal to touch. When I worked in the alcohol and drug centre we would often have to nurse them on a mattress or the floor so that they would not hurt themselves and just observe them.*
>
> *Consequently, although I did the formal neurological observations in relation to him, my interim checks were much more important for establishing whether he was stable, and indeed gave the lie to the formal GCS totals which we now see on his Neurological Observation chart and Patient Observation chart.*"

Mrs B stated that she would not consider a reduction in GCS alone enough to signify a notifiable deterioration. Because of the complicating factors of alcohol and drugs, she would look at the general picture, including blood pressure, pulse rate, pupil reaction, and verbal response before determining if Mr Whittaker was deteriorating.

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Taranaki Healthcare, Dr A, Mrs B, Dr C, Dr D, Dr E, Dr F

Opinion – Case 98HDC13685, continued

Information Gathered During Investigation *continued*

In cross-examination during the Inquest Mrs B said that during her time as a registered nurse in A&E, she took Glasgow Coma Score (GCS) readings "*often*". She was confident in her ability to take Glasgow Coma scores when patients had not drunk any alcohol, but found it "*scary*" when patients had drunk alcohol.

Mrs B continued in her statement to the Commissioner:

> "…
>
> *After the house surgeon left at 0240* [2.40am] *I remained in the resus room with he and his mother, who had arrived very shortly after she was telephoned. Together we changed him into a clean gown and then we moved him over to the ward side at approximately 0330. At around 0345 I took repeated neurological observations as I was recording them. I also transposed my earlier observations from the blotter to the Neurological Observation Chart. I filled in the Neurological Observations Chart as these observations are required for all head injury patients and Mr Whittaker was within this category. The general Patient Observation Chart, which is green, is not normally used for head injury patients as it has no space for a full GCS and the Neurological Observations Chart has places to record more general information (temperature, blood pressure and pulse) as well as the GCS scores.*
>
> *It was at this time* [3.45am] *that I noticed that the ward nurse who had never worked in A&E before had written observations on the green Patient Observations Chart. I transferred these to the Neurological Chart. Because I was transferring the recordings, I note that some areas of the Neurological Observation Chart, such as the totalling of the GCS had not been filled in. I did not realise that I had not totalled the scores, as is my usual practice. For some observations of his injured eye, I have written 'c' which is the accepted symbol for the eye which is not able to be open. I made efforts to prise his eye open but, prior to falling asleep, he reacted physically and would not allow me to pursue this.*

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Taranaki Healthcare, Dr A, Mrs B, Dr C, Dr D, Dr E, Dr F

Opinion – Case 98HDC13685, continued

Information Gathered During Investigation *continued*

A good example of the imprecision of the GCS scoring is that the GCS score, if totalled for 0345, would be 9/15. The reality was that I had done one of my other interim checks within 5 minutes after these observations. He had spoken to me, indicating he felt sick, which would immediately improve his GCS score significantly. This is why my interim checking throughout the time that he was in the A&E, was able to establish that he was stable and not deteriorating between 0230 and 0530. It was only subsequent to that time that deterioration occurred.

Support for my belief at the time that he had not deteriorated is Dr A's GCS scoring at that time of 14/15. This also underlines the extreme variation that there can be in GCS scoring in someone who is suffering from the effects of alcohol."

Mrs B advised the Commissioner that:

"*Because Mr Whittaker was still retching at approximately 0355, I gave him cyclezine to relieve his nausea (after discussion with Dr A). I encouraged his mother to go home as she was exhausted and afraid for Tommy as her eldest son had gone through a similar life threatening situation due to alcohol. She went home at this time at around 0430.*

At around that time Tommy Whittaker who had been moaning stopped moving around and appeared to sleep. This was the result I expected as he was resting, no longer needing to vomit; typical of someone who had received an antiemetic.

As his oxygen stats were stable at 97%, and his colour was good, I removed the Hudson mask as I did not want him to vomit into it and aspirate if I was called away into casualty."

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Taranaki Healthcare, Dr A, Mrs B, Dr C, Dr D, Dr E, Dr F

Opinion – Case 98HDC13685, continued

Information Gathered During Investigation *continued*

Mrs B confirmed that when she discussed an anti-emetic medication with Dr A for Mr Whittaker at about 3.55am she did not mention any deterioration in his GCS or general condition, as she did not consider he had deteriorated. Dr A stated to the Coroner that the first time she knew Mr Whittaker's GCS was ever as low as 12/15 was at 6.30am. (The A&E record states that the anti-emetic, cyclizine, was given to Mr Whittaker at 3.30am.)

Mrs Whittaker advised the Coroner:

> "*I stayed with Tommy until about 4.00am or a little after. By then he appeared to have gone to sleep but before that happened I asked the nurse again whether he was concussed.*
>
> *I asked that question because of what I knew about the situation – the fact he had had a fall, the cut on his head and the bleeding and the way his legs and arms were thrashing about plus his burbling.*
>
> *The nurses assured me that he wasn't concussed but she did seem concerned about him and not terribly sure of herself in saying that.*
>
> *However I left at about 4.00am or so somewhat reassured by what she had said.*
>
> *I certainly would not have gone home if she had said that he might be concussed and that she would seek further advice about that.*
>
> *I was told that they would do an operation on his wrist in the morning but because I was very tired and that was not too serious I decided to go home and get some sleep. I wanted to be there before he went to surgery.*"

Mrs B's statement to the Coroner continued:

> "*At approximately 4.15am I would have eaten a snack in the department. The pool nurse was in casualty at this time.*
>
> *[T]he other nurse, also did some observations for me, probably the ones recorded at 4.30am.*

Continued on next page

Taranaki Healthcare, Dr A, Mrs B, Dr C, Dr D, Dr E, Dr F

Opinion – Case 98HDC13685, continued

Information Gathered During Investigation *continued*

I may have transposed her observations onto the neurological chart for her.

After 4.30am I must have worked with other patients. I went back to check Mr Whittaker when I was able."

Recording Mr Whittaker's observations

Two sets of observations were kept on Mr Whittaker, a patient observation chart (green in colour) and a neurological observation chart. The patient observation chart showed:

Time	*BP*	*Pulse*	*Resps*	*Rousability*	*Oxygen Sats*
0230	*145/70*	*65*	*22*	*To voice*	
0345	*150/100*	*82*	*22*	*To voice*	*97% on air*
0430	*160/80*	*80*	*22*	*To voice*	
0515	*182/90 (dynamap)*	*65 & 78*	*18*	*To voice*	*98%*
	Manual 156/78				

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Taranaki Healthcare, Dr A, Mrs B, Dr C, Dr D, Dr E, Dr F

Opinion – Case 98HDC13685, continued

Information Gathered During Investigation *continued*

The neurological observation chart showed:

Time	*BP*	*PR*	*RR*
0100 on admission	*110/60*	*66*	*21*
0230	*145/70*	*80*	*22*
0345	*150/100*	*67*	*22*
0430	*160/80*	*78*	*218*
0530	*155/78 (manual)*	*78*	*20*
0730	*175/77*	*85*	*24*
0745	*175/85*	*85*	*28*
0800	*190/100*	*100*	-
0810	*212/155*	*165*	-

The GCS categories and scores given on the Taranaki Base Hospital neurological observation sheet are as follows:

Eyes open	4	Spontaneously
	3	To speech
	2	To pain
	1	None
Best verbal response	5	Orientated
	4	Confused
	3	Inappropriate Words
	2	Inappropriate Sounds
	1	None
Best motor response	6	Obeys commands
	5	Localises pain
	4	Withdraws
	3	Flexion to pain
	2	Extension to pain
	1	None

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Taranaki Healthcare, Dr A, Mrs B, Dr C, Dr D, Dr E, Dr F

Opinion - Case 98HDC13685, continued

Information Gathered During Investigation *continued*

The GCS scores for eyes open, best verbal response, and best motor response were filled out on the neurological observations chart. However, the scores were not totalled. If they had been totalled the results would have been as follows:

Time	GCS
0100 on admission	*12/15*
0230	*12/15*
0345	*9/15*
0430	*6/15*
0530	*6/15*
0730	*3/15*
0745	*3/15*
0800	*3/15*
0810	*3/15*

Dr A disputed at the Inquest the 'on admission' GCS recorded by Mrs B on the neurological observation sheet of 12/15. Dr A said that Mr Whittaker's score was higher than that recorded as Mr Whittaker "*definitely was obeying commands and answering*" (which would give a score of 14/15).

Mrs B also kept a chart to monitor the colour, warmth, movement, and sensation of Mr Whittaker's injured wrist overnight. The chart contained the following observations:

Time	Colour	Warmth	Movement	Sensation
0130	pink	warm	moving fingers	patient states he has sensation
0230	pink	warm	good	✔
0330	✔	✔	✔	patient sleeping
0430	✔	✔	✔	non-compliant
0530	✔	✔	✔	asleep
0630	✔	✔		asleep

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Taranaki Healthcare, Dr A, Mrs B, Dr C, Dr D, Dr E, Dr F

Opinion - Case 98HDC13685, continued

Information Gathered During Investigation *continued*

In cross-examination during the Inquest Mrs B provided further evidence regarding the observations taken on Mr Whittaker. Mrs B clarified that she had taken the GCS on admission at 1.00am which totalled 12/15 and then taken another GCS 20-25 minutes later of 14/15 which was not recorded. Mrs B could not recall if she or another nurse took the GCS which was also 12/15 recorded at 2.30am, the GCS of 9/15 recorded at 3.45am, or the GCS of 6/15 recorded at 4.30am. Mrs B said that at 3.45am the recordings were not marked on the neurological observation sheet, but on blotter paper and the green patient observation chart, and she transposed the recordings onto the neurological observation sheet at 3.45am shortly after the GCS was assessed. Mrs B said that although she did not total the scores on the sheet, she was totalling them in her head.

When questioned during cross-examination at the Inquest about the deterioration in GCS from 12/15 at 2.30am to 9/15 at 3.45am, Mrs B responded:

> "*… Can I just explain to you the difficulty of the GCS. I just want to show you one thing here. The 0345 where it says inappropriate sounds, within five minutes of that he had told me yes, he felt sick. That doesn't become an inappropriate sound then, and that's the difficulty.*
>
> …
>
> *You can't then say he is orientated, he was still using inappropriate words, but he answered appropriately and that's the difficulty where alcohol is involved.*"

Mrs B said that she did not count the drop from 12/15 at 2.30am to 9/15 at 3.45am as deterioration in neurological function because Mr Whittaker's "*inappropriate sounds*" were followed five minutes later by "*a definite yes*".

Mrs Whittaker stated to the Commissioner that at 3.45am she was beside Tommy and he never spoke at all.

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Taranaki Healthcare, Dr A, Mrs B, Dr C, Dr D, Dr E, Dr F

Opinion - Case 98HDC13685, continued

Information Gathered During Investigation *continued*

When asked about the GCS taken at 4.30am of 6/15, although she could not confirm whether she had assessed this score herself, Mrs B interpreted the findings as follows:

> "*… at 4.30am Tommy settled and I thought he was sleeping.*"

When asked to confirm that a GCS of 6/15 indicates a comatose state Mrs B responded:

> "*… well, that's if it's true that he did withdraw. He may have been asleep and just not woken up aggressively enough.*"

In cross-examination during the Inquest Mrs B stated that she did not realise that Mr Whittaker was in a comatose state at 5.30am, despite a GCS reading of 6/15, and called Dr A only to inform her about the increase in blood pressure she had detected on the dynamap. On the green patient observation sheet a dynamap reading of approximately 182/90 is recorded. No such entry is made on the neurological observation sheet.

Mrs B stated that from the time Mr Whittaker was transferred to the ward side of A&E until 5.30am she informally monitored him about every 20 minutes in addition to the hourly neurological observations she or another staff member recorded, and she based her judgements of Mr Whittaker's overall condition on this informal monitoring.

Mrs B recalled in a statement to the Commissioner that:

> "*At 0530 I went to take the formal neurological observations of Tommy Whittaker. His left eye, which had not been closed by bruising, but had been open and responsive throughout to testing, now had a pupil response that was faintly sluggish. In addition, using the electronic Dynamap blood pressure machine, I found his blood pressure was raised. These two factors combined did not accord with the observations I had made of him throughout the night and I immediately telephoned for the house surgeon to attend and replaced the Hudson mask. I re-checked the left pupil 3 to 4 times and it reacted briskly.*

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Taranaki Healthcare, Dr A, Mrs B, Dr C, Dr D, Dr E, Dr F

Opinion - Case 98HDC13685, continued

Information Gathered During Investigation *continued*

Dr A came very shortly afterwards and the outcome of our discussion was that a complete reassessment should be done.

Dr A came and took the blood pressure manually using a standard blood pressure cuff. The reason for this is that it is well known that Dynamaps can be inaccurate. I recorded the result of that test on the Neurological Observation chart at 0530. I noted 'manual' on the record to ensure that the nursing shift following mine had a manual base recording.

We checked everything together, she validating my findings. It is recorded by the house surgeon that 'he told me to go away'. It was during this testing that the house surgeon made a GCS scoring of 14. For the first time, she managed to check both eyes, which reacted briskly. The sluggish pupil response had abated.

As far as I recall, I thought Dr A had seen the Neurological Observation chart at that time because it was beside her. I was very concerned about the patient. I can't recall exactly what we discussed although I do recall making a comment to the house surgeon that I believe that Mr Whittaker may have been developing a concussion.

Mr Whittaker was responding to voice. His pupil size was approximately 6.5. I spoke to him and shook him, to which he reacted by muttering and turning his head. Dr A checked his right eye and saw it as having a pupil size of 6 with reaction which was equal to her assessment of the left eye and told me that the left eye responded quicker to light once she had opened the right eye. All this testing and reassessment would have been completed by 0610.

I went to the office to document these findings. Dr A came in and told me that Mr Whittaker had told her to 'go away'. The bell sounded and further casualties arrived with which I assisted. I was not able to complete the documentation because of the bell going off."

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Taranaki Healthcare, Dr A, Mrs B, Dr C, Dr D, Dr E, Dr F

Opinion - Case 98HDC13685, continued

Information Gathered During Investigation *continued*

Dr A's evidence under oath continued:

"*The next I heard about Whittaker was at about 5.30am when the casualty nurse, Mrs B, telephoned to say that his BP reading was high and was I concerned. I was concerned because if he had a rising BP and decreasing pulse, that could indicate serious brain injury. I asked Mrs B if the reading had been taken manually and she said it had been taken on the dynamap machine. Often on the wards the dynamaps can give incorrect readings, so I came to do a manual BP and check his pulse. I took a manual BP – it was approximately 156/74, pulse, 70. Mrs B showed me his green obs sheet (the usual one we use for pulse, blood pressure and temperature) and this reading was very similar to his other recordings since about 2.00am. Therefore on checking the BP, I found his BP was unchanged. The green obs sheet is not the formal one used for neurological observation, but has a space at the bottom to tick if the patient is responding to voice, etc. When I checked it, I saw that it was ticked that Whittaker was responding to voice. Mrs B then mentioned that his pupil was more sluggish. We both looked at his left pupil again and it did seem more sluggish and was about 6.5 (previously 6). Because of this I checked his GCS. I shook his shoulder and shouted in his ear a couple of times to wake him. After that he opened his left eye to command, squeezed my hand and told me to 'go away' or 'leave me alone', I cannot remember the exact words, just his meaning. I discovered the nurse had only been checking the left pupil as the right eyelid was swollen shut. I opened his right eye so I could see greater than half the pupil, it was 6 and reacting. I rechecked the left pupil, it was now 6 and reacting better.*

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Taranaki Healthcare, Dr A, Mrs B, Dr C, Dr D, Dr E, Dr F

Opinion - Case 98HDC13685, continued

Information Gathered During Investigation *continued*

As Whittaker's condition was unchanged from the time when I had last spoken to Dr F I didn't try to re-contact him. I also did not look at the full neurological observations the nurses had done on the formal neurological observation sheet. The reason I did not was that the nurse had not been concerned about the patient's GCS. In addition, I had just checked the GCS and found it to be 14/15, i.e. unchanged. For this reason I was not alerted to investigate further. Because my findings were of an unchanged situation from when I had last spoken to the registrar, I did not write this down in the notes."

In cross-examination during the inquest Dr A said that the GCS score she took at around 5.30am was a full neurological check of Mr Whittaker with a score of 14/15, which she did not write down. Dr A explained that she obtained the score in the following way:

"*… When I shouted at him once he didn't answer, so I shook his left shoulder, shouted into his ear. … [H]e opened his eyes to speech which is a three. He told me to either go away or leave him alone, which in training at Dunedin we were told was considered appropriate which was a five on the verbal, and he obeyed commands which gives him a six on the motor. … I asked him to squeeze my hand.*"

However Mr Whittaker's neurological observation chart at 5.30am scores his GCS as 6/15 (comatose). Dr A said Mr Whittaker was not comatose when she saw him at 5.30am and pointed out that her GCS taken at this time was consistent with the note on the green patient observation chart at 5.15am that Mr Whittaker was rousable to voice.

"*… I don't know what the story is with that GCS* [5.30am] *but I know my own GCS, and that was 14/15, and in scoring GCS you give the best response.*"

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Taranaki Healthcare, Dr A, Mrs B, Dr C, Dr D, Dr E, Dr F

Opinion - Case 98HDC13685, continued

Information Gathered During Investigation *continued*

Dr A explained why she did not contact Dr F between 5.30am and 6.00am when she noted Mr Whittaker's sluggish pupil reaction:

> "… *I considered* [contacting Dr F], *that is why I performed my GCS which I performed just after 5.30am, that was normal compared to what he had been on admission, when I then re-checked the pupils after finishing the GCS, it had returned to normal and was reacting briskly and seeing as it had returned to normal, I did not contact the registrar*."

Dr A said that admission blood pressures often change later as they are due to factors such as shock and distress. Dr A considered that there was a "*slight increase*" in blood pressure from 2.30am to 7.30am shown on the Neurological Observation Chart which would not have prompted her to call Dr F had she seen the neurological observation sheet around 5.30am – 6.00am.

Dr A explained that the only observation chart she saw the night of 15 November 1997 was the green patient observation sheet. Dr A accepted that GCS charts are important and in hindsight she wished she had looked at Mr Whittaker's chart the night of 15 November 1997. However she added:

> "… [Investigators] *also need to bear in mind that I was in charge of about, I guess, 250 patients, at Taranaki Base, all of whom were sick, which is why they were in hospital, all of whom had an observation chart, which was important to that patient, and as the one doctor on call for the whole hospital, it is not possible for me to go through every chart.*"

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Taranaki Healthcare, Dr A, Mrs B, Dr C, Dr D, Dr E, Dr F

Opinion - Case 98HDC13685, continued

Information Gathered During Investigation *continued*

Dr A gave evidence to the Coroner that there was a discrepancy between the GCS readings recorded on the neurological observation chart and Mr Whittaker being scored consistently as rousable to voice on the patient observation chart. Dr A said that although there was an apparent deterioration in the GCS scores on the neurological observation sheet, no such deterioration was apparent on the green patient observation sheet, which she saw. There is in fact a trend of a rising blood pressure apparent on the patient observation form. Dr A acknowledged that the rousability score on the green patient observation chart did not provide a full GCS score as no verbal response component was included, but said it provided a quick check. Dr A stated:

> "*… you don't determine the total score by simply looking at the green sheet, but it is the quick way of noting deterioration and although you don't get the total score from the green sheet, what has been ticked on the green sheet, if that is the correct GCS, necessitates a higher total than was done on the white sheet.*"

Dr A also said:

> "*… I know full neurological observations are done on the white sheet* [neurological observation sheet]. *Why I looked at the green sheet was because I had been called for blood pressure, was because it's the usual blood pressure sheet which was what I was called for, but I glanced down and saw he was rousable to voice.*"

Mrs B recorded on the back of the ED sheet as follows:

> "*Clinical Notes:*
>
> *0530hrs: Sleeping deeply, difficult to rouse, observations stable. Left pupil more sluggish. Hand warm, good perfusion.*"

Continued on next page

Taranaki Healthcare, Dr A, Mrs B, Dr C, Dr D, Dr E, Dr F

Opinion - Case 98HDC13685, continued

Information Gathered During Investigation *continued*

Dr A continued:

> "*After seeing Whittaker on this occasion, I continued attending to other patients and the needs of the wards. I describe the night as remaining frantically busy. I remained concerned about Whittaker and although attending the needs of other patients, my mind kept trying to think of a reason for the pupil being sluggish even though it had improved. I spoke to one of the casualty nurses about it to see if she had any advice. Her response was that she did not know what to make of it either, but we agreed that otherwise he seemed alright.*
>
> *Because I had a lingering concern, I went back to see Whittaker at 6.30am. I shook his shoulders again and shouted in his ear. He didn't respond. I then used my pen to press on the nail beds of his left hand. He responded by opening his left eye to command. He moved his left arm. I didn't ask him to move his right arm as it was broken. He muttered something to me. I then checked his pupils, they were still reacting though sluggishly.*"

In cross-examination during the Inquest Dr A said at around 6.30am – 6.40am she found Mr Whittaker's GCS had deteriorated, although she did not formally add the score or record it. Dr A decided to contact Dr F:

> "*… when I checked him* [Mr Whittaker] *and found his GCS had deteriorated. … 6.30am was when I went to the patient to do the GCS, it can take a while to perform a proper GCS examination, especially when the patient is not responding to voice because obviously you then have to go on and check if they are responding to pain, so it would actually have been after 6.30am when I got my GCS result, to call the registrar, closer to 6.40am or somewhere in between. … I didn't actually add it up at that time, I only noted he was only responding to pain, instead of adding it up I tried to get the registrar right away, because I knew it had deteriorated. … [H]is eyes opened to pain, which was 2. He muttered something, I can't remember now if it was inappropriate sound or words, so verbal would have been 2 or 3. And he withdrew to pain, so probably about 8.*"

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Taranaki Healthcare, Dr A, Mrs B, Dr C, Dr D, Dr E, Dr F

Opinion - Case 98HDC13685, continued

Information Gathered During Investigation *continued*

Dr A explained that she was "*very concerned*" after she found Mr Whittaker's GCS had deteriorated but was not in a panic. When Dr F did not respond to her pager calls, she did not consider contacting Dr C, the consultant surgeon, with her concerns about Mr Whittaker as she "*wasn't aware at that time that we could actually do that*". In eleven and a half months of working at Taranaki Base Hospital Dr A did not recall ever having been told she could contact a consultant directly, and explained that the need had never arisen as registrars usually responded to pagers straight away. Dr C said during the inquest that he made a point of telling his house surgeons that when they started a "*run*".

Mrs B stated to the Commissioner:

> "*At 0630 I went from Casualty to repeat the neurological observations on Mr Whittaker. I saw Dr A kneeling down beside Mr Whittaker, already doing the neurological observations and I returned to Casualty.*
>
> *I again went back to the office to check that Dr A had recorded the observations at 0640, because I know that when the Department is busy, recording of observations may be overlooked. I always try and check that documentation has been recorded. She had not been able to record the observations because of the pressure upon her. She had her hand on the telephone, presumably waiting for the registrar to call her back, having tried to raise him through the operator.*
>
> *I immediately went to Mr Whittaker to do more observations. I could not get him to respond to voice (but he was responsive to pain), saw that he was incontinent of urine and checked the left pupil, which had minimal response but still reacted.*
>
> *By the time I'd looked around Dr A had gone. I assumed that the registrar must be on his way in and if I had known that he was not, I would have called the consultant in as I have done in the past.*

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Taranaki Healthcare, Dr A, Mrs B, Dr C, Dr D, Dr E, Dr F

Opinion - Case 98HDC13685, continued

Information Gathered During Investigation *continued*

…

By now it was nearly 0700 and the morning staff were arriving. They were told of the situation. (I didn't know the neuro observation hadn't been recorded from 0530 until the next night when I went to see him in ICU.)

I gave my hand over about Mr Whittaker to the morning staff. I recall telling them that he slid down a ramp and was now only responding to pain. That his Glasgow Coma Score was down. One of the morning staff suggested he might have a meningeal bleed. I did not say that the registrar had not been called because I believed that he had. I did not know at that stage that Dr A had herself gone looking for the registrar as later transpired to be the case."

Dr A stated:

"*As WHITTAKER's condition had deteriorated from when I had last spoken to Dr F, I felt very concerned and decided to page him myself. I paged him myself rather than going through the operator as sometimes they page the wrong person. I know this from my own experience. There was no answer in 5-10 minutes so I paged him again. It was very unusual not to get an answer from Dr F. Every other time I have paged the registrar at night he or she has answered immediately. I was using the only method I know of to get advice from a senior colleague.*"

In cross-examination at the Inquest, Dr A stated that she chose to page Dr F herself rather than through the operator, as early that morning she had had problems contacting him through the operators, and knew from experience that the operators sometimes put calls through to the wrong pager number. Dr A stated that the department had a list of pager numbers. On this occasion she noted that there were two numbers by Dr F's name and she called both numbers. Dr A called three times on the unfamiliar pager number and at least four on the pager number she was familiar with.

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Taranaki Healthcare, Dr A, Mrs B, Dr C, Dr D, Dr E, Dr F

Opinion - Case 98HDC13685, continued

Information Gathered During Investigation *continued*

Dr A continued:

> "*By this time it was getting close to 7.00am. Because Dr F was hard working, I thought it quite likely that he could already be in at the hospital, this being typical of his work habits. I thought I might have better luck getting hold of him if I checked around the hospital so I quickly checked RMO rooms on the 5th floor, then checked the cafeteria. He wasn't in either place. By this stage I was at a loss to know what to do next. I was constantly being summoned to the phone by my pager going off or trying to find the surgical registrar. He hadn't answered his pager and I didn't know how to locate him. I think that I paged him again at this time though cannot be absolutely certain.*
>
> *I returned to the A&E. New nursing staff were arriving and they were in the middle of the change-over.*
>
> *I returned to check Whittaker. He had dilated pupils, very sluggish, and by this stage was not responding to pain when I checked him. One of the new nurses, when learning of my difficulties in contacting Dr F, suggested to me that the operators have a list of phone numbers and can sometimes get the registrar at home. The nurse agreed to contact the operator to try this avenue for getting hold of Dr F. While she was doing this, I quickly checked Whittaker's current status so I could give an up to date report to the registrar.*"

Dr A said the last GCS assessment she took on Mr Whittaker was the one taken prior to speaking to Dr F on the telephone and she did not record it, but stated it showed further deterioration. This GCS was not as thorough as her previous one, and was taken for the purpose of having up to date information to pass on to Dr F.

Dr A continued:

> "*The nurse was able to contact Dr F by phone and I spoke to him.*

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Taranaki Healthcare, Dr A, Mrs B, Dr C, Dr D, Dr E, Dr F

Opinion - Case 98HDC13685, continued

Information Gathered During Investigation *continued*

I explained I was ringing about the patient that we had discussed earlier and brought him up to date with his present symptoms. Dr F agreed to come straight in."

Dr A's notes read:

"*0630 hours: pupil decreased responsiveness; still responding to pain. Tried to page registrar – no answer. Contacted registrar at home about 0720 hours. Pupil still decreased responsive, now not responding to pain. Registrar coming immediately. For CT scan.*"

Dr A continued:

"*Dr F arrived at approximately 7.15 to 7.20am. He saw Whittaker as he walked in and then called me into the office to get a full report. I spent the minimum amount of time possible explaining things to him so he could attend to Whittaker, who was now unresponsive.*

Dr F took over care of Whittaker and made arrangements to get hold of the surgeon, the radiologist and the anaesthetist."

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Taranaki Healthcare, Dr A, Mrs B, Dr C, Dr D, Dr E, Dr F

Opinion - Case 98HDC13685, continued

Information Gathered During Investigation *continued*

Dr F advised the Coroner:

> "*I was not paged further until 7.20am that morning. I was still at the on call room in the hospital grounds. I was told that the same man was now unresponsive with 'sluggish' pupils. I went immediately to the emergency department and reviewed the patient at 0725am. Mr Whittaker was unresponsive to voice or painful stimuli. He had a large bruise to the right side of his forehead and swelling of the lids around the right eye. His pupils were bilaterally fixed and dilated. On review of his chart, the Glasgow Coma Scale had been recorded and showed an obvious decline in the morning, around 3 – 4am. After assessing the patient I immediately asked the telephonists to page the radiologist on call, this was around 7.30am, to arrange a CT scan of the brain. There was about a five minute delay before speaking with this person. Whilst waiting for the radiologist I contacted the surgeon on call, [Dr C] to inform him of the events and the seriousness of the situation. He advised me to arrange theatre to follow the CT scan and to shave the patient's head. After talking with the radiologist and informing him of the need for an immediate CT scan I contacted the CT radiographer who told me that she would leave immediately and call for the patient when they were ready. This took some 10 to 20 minutes or so.*"

On 15 November 1997 at 7.50am Dr F recorded in Mr Whittaker's records:

> "*19 year old boy with decreased level of consciousness/unresponsive; decreased reaction pupils.*
> *History from casualty officer: brought in last night apparently intoxicated. Fall 10-12 metres (Nature of fall). No loss of consciousness. Complained of pain in his right wrist. Last night initially appropriate although drunk. During night progressively less reactive. On examination now: GCS 3-5/15. Large periorbital haematoma. Pupils bilaterally large, dilated, unresponsive. X-ray: fracture dislocation right wrist.*
>
> *Impression:* *1. significant head injury – probably coning.*
> *2. fracture dislocation right wrist.*

Continued on next page

Taranaki Healthcare, Dr A, Mrs B, Dr C, Dr D, Dr E, Dr F

Opinion - Case 98HDC13685, continued

Information Gathered During Investigation *continued*

Plan: CT"

The ED clinical record sheet continued in two other staff members' hand-writing:

"*0700hrs:* *Assessed – nil response to pain; pupils not reacting, dilated. Observations as charted; GCS = 3. House Surgeon & Registrar informed.*

0740hrs: *Patient unconscious. Not responding. GCS 3. BP & HR increased as per neurological observations chart. Mother notified. Head shaved in preparation for ? burr holes. Mannitol commenced.*

0815 hrs: *Patient transferred with Registrar and RN escort. Condition remains unchanged. BP & HR continue to rise.*"

The radiologist was contacted at home at 7.30 am with an urgent request that she come to the hospital to carry out a CT scan. The radiographer arrived at approximately 8.00am and the scan began at 8.30am and was completed at 8.45am.

Dr F continued:

"*The CT scan showed a large right frontal extradural haematoma with significant mass affect. Mr Whittaker was then taken to the theatre where a large extradural haematoma was evacuated.*

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Taranaki Healthcare, Dr A, Mrs B, Dr C, Dr D, Dr E, Dr F

Opinion - Case 98HDC13685, continued

Information Gathered During Investigation *continued*

I have been advised that there were major difficulties in contacting me during the course of the morning. I cannot understand how this occurred. My pager was on, and operational. I was, as usual, in the on call room for the registered medical officer, and remained there unless I was attending patients. I cannot explain the difficulty in locating me. I did not return home at any time during that night, and was located on the hospital premises when required at 7.20am. If for some reason I, as registrar on call, was not contactable on a pager at night, the hospital operators could have located me in the on call room.

When I reviewed the patient at 7.25am, I was aware of the serious condition that he was in. That was why we asked for an urgent CT scan and urgent surgery. [Dr C] requested the CT brain scan before the operation and this identified the exact location of the bleed."

Dr A stated:

"*The surgeon, [Dr C], arrived and I explained the history to him in the same terms that I had explained it to Dr F. We moved Whittaker on to another bed and he half-opened his left eye and groaned when we did this to him. He was taken for an urgent CT scan at 8.40am.*"

Mrs Whittaker's evidence under oath continued:

"*I got a call I think about 7.45am from the hospital. The nurse asked me to come up to the hospital and would not say why.*

I think I arrived at about 8.00am or not long after that.

I spoke to a male doctor. He said there had been complications and made some references to a semi-induced coma. He said they needed to do a CAT scan. I was shocked by this.

They showed me the results of the scan which indicated a mass on the brain and extensive swelling. They said it was life-threatening and they needed my consent to operate on him, which I gave.

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Taranaki Healthcare, Dr A, Mrs B, Dr C, Dr D, Dr E, Dr F

Opinion - Case 98HDC13685, continued

Information Gathered During Investigation *continued*

He had the operation and I was told it was successful in draining the blood clot but they were still concerned about swelling and that it could get worse over the next 36 hours or so.

They did another scan after the operation which showed that the clot had been successfully drained."

Dr E advised the Commissioner:

"*I was the On Call Anaesthetist to Taranaki Base Hospital on Friday 14-Nov-97 from 5.00 pm to 8.00 am on Saturday 15-11-97.*

I was informed of this patient at about 7.30 am on Saturday 15-11-97. Immediately I went to the hospital. At that time he was in the CT room and the scanning was over. I saw him in CT room and accompanied him to the operating theatre.

In the operating theatre the Anaesthetist on call [Dr D] was already present. I helped in the start of the anaesthetic and then left the operating theatre.

The late Mr Whittaker was admitted to the ICU after the operation on Saturday and I was not on call when he was admitted."

Dr D advised the Commissioner:

"*I was the consultant anaesthetist on call for Theatre and the Intensive Care Unit at Taranaki Base Hospital from 0800 hours* [8.00am] *on 15 November 1997.*

I was called by [Dr E], the anaesthetist on call prior to me, who had looked after Tommy Whittaker in the CT scan unit for a brain scan and during the subsequent transfer to theatre for drainage of the large right frontal extradural haematoma by [Dr C].

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Taranaki Healthcare, Dr A, Mrs B, Dr C, Dr D, Dr E, Dr F

Opinion - Case 98HDC13685, continued

Information Gathered During Investigation *continued*

Dr E had set up for the anaesthetic and was preparing to initiate anaesthesia when I arrived. Dr E presented the details of the case to me and after a hand-over period, went off duty.

The surgery and anaesthesia proceeded uneventfully and at 1015 hours [10.15am] *the patient was transferred to the ICU."*

The surgery commenced at 9.00am and was completed at 10.08am. Dr C's operation note recorded:

"***RIGHT ANTERIOR BURR HOLE***
CT had shown a large anteriorly placed extradural haematoma extending to the midline over the frontal sinuses.

A vertical incision was made after infiltrating the soft tissues with Xylocaine and Adrenaline. A burr hole was performed and this was later enlarged inferiorly and anteriorly.

A large amount of clot corresponding approximately to the amount seen on the CT scan was recovered. The anterior branch of the middle meningeal artery was seen to be bleeding freely and was controlled in the end quite easily with diathermy.

Bleeding vessels in the temporalis muscle were controlled and the wound was closed over a Redivac drain. Temporalis fascia was closed with continuous chromic and skin with continuous nylon.

At the end of the procedure the patient had his right wrist manipulated under anaesthetic with the image intensifier by the Orthopaedic registrar and was transferred to the unit for ventilation."

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Taranaki Healthcare, Dr A, Mrs B, Dr C, Dr D, Dr E, Dr F

Opinion - Case 98HDC13685, continued

Information Gathered During Investigation *continued*

Dr F noted in the medical records:

"*15.11.97 10am:*

Operative Note: *1. Craniotomy, evacuation right anterior haematoma and haemostasis,*
2. Manipulation under anaesthetic fracture dislocation right distal radius.

Surgeon: *1. [Dr C]; assistant [Dr F];*
2. [another person]

Anaesthetist: [Dr E] / [Dr D]

Post Op:
1. ICU for artificial ventilation
2. mannitol
3. head up
4. cervical spine x-ray in ICU
5. discussed with [Dr C] – D/W neurosurgeons unless complications

1015hrs [10.15am]*: Note: As surgical registrar on call I was told about a man with a fractured wrist. I do not know what time this was. No mention was made of head injury and the ? mechanism to my knowledge.*
1030hrs [10.30am]*: Extensive discussion with family. Poor outlook outlined, chance of recovery (partial).*"

Mr Whittaker was transferred to Intensive Care Unit (ICU) at 11.00am, where his blood pressure became low (54 systolic at 12.00pm). Dr D stated:

"*In the ICU the patient was placed on full ICU monitoring, neurological observations, fluid restriction, Mannitol infusion, bed head elevation, orogastric tube and ventilation to try to improve the blood flow to the brain and reduce brain swelling. A urinary catheter, central venous line and arterial line were inserted to assist in management of the patient. Blood, x-ray and ECG investigations were done.*

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Taranaki Healthcare, Dr A, Mrs B, Dr C, Dr D, Dr E, Dr F

Opinion - Case 98HDC13685, continued

Information Gathered During Investigation *continued*

After discussion with [Dr C] it was decided to urgently transfer him to a tertiary hospital neurosurgical intensive care unit for optimal care. The surgical team then arranged for transfer to the Wellington neurosurgical unit."

At 3.00pm Dr C arranged to transfer Mr Whittaker to Wellington Hospital Neuro-ICU and discussed this with his family.

Dr D continued:

"*Advice from the Wellington unit was for a repeat CT scan. This was done at 1420 hours* [2.20pm] *and this showed drainage of the frontal extradural haematoma but persistent swelling of the brain.*

To maintain optimal blood flow to the brain and to reduce brain swelling, the blood pressure was maintained between 110 to 170 systolic. Shortly after his arrival in the ICU his blood pressure fell. To correct this the sedation was withdrawn, Dopamine infusion started and a fluid challenge given as he was passing very large amounts of urine. These measures restored his blood pressure to satisfactory levels and he continued to pass large amounts of urine. His Glasgow coma scale was 3/15 and his pupils dilated with minimal reaction to light.

The helicopter arrived at 1800 hours [6.00pm] *but it was decided by the Wellington Neurosurgical team and the Taranaki paediatricians to be used to transport another emergency neurosurgical case to Wellington. The helicopter was to then have returned immediately but regrettably the weather closed in and it was not able to return until the morning of the 16 November 1997 to transfer the patient to Wellington.*

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Taranaki Healthcare, Dr A, Mrs B, Dr C, Dr D, Dr E, Dr F

Opinion - Case 98HDC13685, continued

Information Gathered During Investigation *continued*

Over this period the patient continued to be fully monitored and ventilated in the ICU. There was no improvement in his condition. His pupils remained dilated with minimal reaction to light and a Glasgow Coma Scale 3/15. Large amounts of ionatrope infusions were required to support the blood pressure. He continued to pass large amounts of urine, was in negative fluid balance and as his CVP was low fluids were given to improve the CVP and his blood pressure. The urine and blood osmolality showed inappropriate antidiuretic hormone secretion associated with brain injury. The patient's condition was discussed with the Wellington neurosurgeons who advised treatment with vasopressin. This resulted in improvement in his urine output and blood pressure until he was transferred to the Wellington unit.

On a number of occasions I spoke with Mr Arthur Whittaker to inform him on his son's condition, the management and the transfer to Wellington. I spoke of the severity of the injury, the prognosis as well as giving some hope of a favourable outcome and that we were doing all we could to achieve it."

Mr Whittaker was transferred from Taranaki Base Hospital at 11.45am, 16 November 1997, to Wellington Hospital, Neurosurgical Unit, by the retrieval team. Mr Whittaker was pronounced dead at 9.10am on 17 November 1997 at ICU, Wellington Hospital.

Mrs Whittaker's evidence under oath continued:

"*They told me that they needed to fly Tommy to Wellington for specialist neurological care. They said they couldn't monitor him as well here in New Plymouth and his blood pressure was a concern because it was going up and down.*

He was monitored throughout the day (because he had to be stabilised to be moved).

When the plane arrived to take him to Wellington at about 6.00pm, even though Tommy had been unstable during the day, they decided to take what they thought as a more urgent case, an 11 year old boy who needed brain surgery.

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Taranaki Healthcare, Dr A, Mrs B, Dr C, Dr D, Dr E, Dr F

Opinion - Case 98HDC13685, continued

Information Gathered During Investigation *continued*

They said that the plane would come back for Tommy later that night. It did return, at about 11.00pm, but because of the weather couldn't land so he had to stay a further night in New Plymouth.

The plane then returned at about 11.45am the next day but it was not there at dawn as I had been told. I understand the reason was instrumental failure and the need to change planes.

On several occasions I was told that I could go to Wellington with Tommy and I got my bag packed. I could not believe it when they said just before he actually was able to go that I could not go with him.

They said there was not enough room but I could not understand why they told me I could go before if there was not enough room in any event.

By this time Arthur had come in from offshore (he works on an oil industry vessel).

He was flown by helicopter to the intensive care unit. Arthur and I drove down to Wellington because we were not able to go in the plane with Tommy.

At Wellington they told us that there was no survival rate for Tommy, that they believed his brain had died before he left New Plymouth and we agreed to discontinuing the life support and to him being an organ donor, though this caused us a great deal of anxiety and distress.

We were told by the specialists in Wellington that there was nothing they could have done in Wellington that was not done in New Plymouth (while he was in intensive care) so I did not know in the end why he ever went to Wellington. As I understand it the fatal deterioration occurred in New Plymouth.

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Taranaki Healthcare, Dr A, Mrs B, Dr C, Dr D, Dr E, Dr F

Opinion - Case 98HDC13685, continued

Information Gathered During Investigation *continued*

When we were back in New Plymouth Arthur and I had a meeting with [the Medical Director of the Emergency Department] and Dr C. Both of them agreed that had Tommy been attended to more promptly than he was, he could have made a full recovery.

One of them said words to the effect that 'the system had failed Tommy' and I particularly remember one of them using the words 'leaked through the cracks' to describe what happened to Tommy.

Arthur and I are both very distressed about Tommy's death and will probably never get over it.

We are all the more distressed to learn that he need not have died or indeed suffered any permanent harm at all.

Unfortunately nothing can now bring Tommy back but I hope that changes are made which will ensure that no-one else dies as a result of the system at Taranaki Healthcare Limited failing them or allowing them to 'leak through the cracks'."

Post-mortem results
The post-mortem report stated:

"*… The scalp showed bruising along the surgical line. The skull showed a small crack fracture close to the right frontal temporal burr hole extending forward into the frontal bone and medially to cross the anterior wing of the sphenoid bone. There was an area of localised dural elevation with a small quantity of residual blood clot consistent with an extradural haematoma.*

The brain was diffusely swollen, weighing 1650 grams. There was a marked cerebellar coning with necrosis of both cerebellar tonsils. There was an area of contusion on the under surface of the right frontal lobe. Sectioning of the brain showed diffuse necrosis with splinter haemorrhages through the white matter on the right side and necrosis of both occipital lobes.

…

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Taranaki Healthcare, Dr A, Mrs B, Dr C, Dr D, Dr E, Dr F

Opinion - Case 98HDC13685, continued

Information Gathered During Investigation *continued*

From the above examination, I concluded that death was due to diffuse cerebral oedema secondary to extradural haematoma following a head injury.

Comment: From my examination of the body and the clinical records, it is apparent that irreversible brain swelling commenced around the time that the extradural haematoma was drained in New Plymouth, and that subsequent delays in transportation to Wellington would not have altered the outcome in this case."

Coroner's hearing

At the subsequent Coroner's Inquest the Medical Director of the Emergency Department at Taranaki Healthcare, stated as follows:

"*<u>CHANGES THAT HAVE OCCURRED AS A PART OF TARANAKI HEALTHCARE'S CONTINUOUS QUALITY IMPROVEMENT</u>*

As of January 1998 Taranaki Healthcare now contracts with Taranaki Emergency Systems to provide 24 hour senior medical staff attached to the Emergency Department. Previously there was only senior staff for 16 hours per day.

These staff are dedicated to the emergency services exclusively and is complementary to the inpatient acute services teams (night resident medical officers and registrars).

This is a major step forward and will mean improved access for staff for senior medical advice who will now be 'on the floor' 24 hours a day.

[A doctor] *specialist in Emergency Medicine, has been appointed to visit the service on a regular basis. He is involved with audit, teaching, and giving oversight to the policies and procedures.*

Inservice education in the emergency department and for resident medical officers on various topics on Head Injury Management has been held in 1997/98.

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Taranaki Healthcare, Dr A, Mrs B, Dr C, Dr D, Dr E, Dr F

Opinion - Case 98HDC13685, continued

Information Gathered During Investigation *continued*

Instruction during the orientation programme to new resident medical staff of the ready access to consultant staff when the registrars are not immediately available.

This has been highlighted in a number of memorandums to staff.

All senior nursing staff are also aware that consultants are always prepared to discuss cases directly with staff if there is difficulty with access to acute registrars and house officers.

In September 1998 Taranaki Healthcare has approved the purchase of 6 new monitoring units capable of continuous surveillance of eight physiological parameters.

These units record to a central console that is able to store vital signs data, analyse, reports trends and alarm staff to important changes.

This equipment will improve the reliability of patient monitoring, allow full disclosure of all events.

This is not a replacement for but a significant augmentation of the maintenance of a high standard of clinical examination in the emergency department.

<u>CHANGES TO THE STANDARDS OF CLINICAL PRACTICE AS A DIRECT RESULT OF THIS CASE</u>

In February 1998 the standards and protocols pertaining to neurological observation were reviewed. Similarly so were those defining the criteria for CT scan examination (enclosed).

These noted the neurosurgical recommendations obtained in the investigation of this case. The recommendations have been implemented.

These are:

– *Neurosurgical observations must be made every 30 minutes.*

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Taranaki Healthcare, Dr A, Mrs B, Dr C, Dr D, Dr E, Dr F

Opinion - Case 98HDC13685, continued

Information Gathered During Investigation *continued*

– *A medical officer must validate the neurological assessment at a maximum interval of every 4 hours and record this in a clinical note.*

– *Increased emphasis on GCS calculation and reporting of deterioration.*

– *Emphasis on the importance of lateralising signs.*

– *Patients suspected of having co-morbidity of alcohol intoxication with head injury must be considered as high risk.*

– *Serum ethanol should be recorded in these circumstances.*

I also wish to produce instructions re head injury given to all new medical staff."

Internal investigation
Taranaki Healthcare conducted an internal investigation, which was undertaken by the Medical Management Director. As a part of the investigation, reports were obtained from Dr A, Dr F and Mrs B. The Medical Management Director also obtained reports from Dr C, consultant surgeon, the Medical Director of Emergency Department, and the Manager of Diagnostic Services. Mr Whittaker's clinical notes were reviewed, and Taranaki Base Hospital protocols obtained.

In his report Dr C advised the Medical Management Director that:

"***I*** *This young man was admitted in the early hours of 15/11/97 as an emergency after a fall. He died of complications from this a few days later. During the first hours of his admission he coned as a consequence of an extradural haematoma.*

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Taranaki Healthcare, Dr A, Mrs B, Dr C, Dr D, Dr E, Dr F

Opinion - Case 98HDC13685, continued

Information Gathered During Investigation *continued*

This haematoma was not detected as it developed until a late stage so that there was a fatal upshot from an injury a hospital is designed to detect early and treat with the expectation of a full recovery.

II *I was the consultant surgeon on call and have reviewed the case records. In my opinion the following points are relevant.*

a. An incomplete history was obtained in that there was a failure to appreciate the height of the fall. This oversight was caused by the failure of witnesses and the patient to give the whole story of the accident.

As a result of this 'head injury' was not listed on the problem list and the admitting consultant was the orthopaedic surgeon on duty. In fact if the patient had not had an obvious wrist fracture he might well have been discharged.

b. The mother accepted staff reassurances that blurred speech and jerky movements of the right (injured) arm and right leg were not of concern. With hindsight he became unconscious just before she left rather than dropping off to sleep.

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Taranaki Healthcare, Dr A, Mrs B, Dr C, Dr D, Dr E, Dr F

Opinion - Case 98HDC13685, continued

Information Gathered During Investigation *continued*

c. Neurological observations were not done hourly as ordered. There was a failure to formally score the observations on the Glasgow Coma Scale after they were taken and there was a failure to recognise and notify the significant changes in these scores as time went by. This should have occurred at least 0345 and 0430 hours and I enclose a table of time and GCS scores that I have made from the neurological observations taken.

TIME	*GCS*
0230	*12*
0330	*9*
0430	*6*
0530	*6*
0730	*3*
0800	*3*

I note that duplicate records were also made on a 'patient observation chart' as well as the head injury chart and that these did not show the same deterioration. It is possible that medical staff consulted overnight may have only seen this chart and not the head injury chart.

d. Once the house surgeon on duty became concerned there was further delay because the registrar could not be contacted. No attempt was made to bring the consultant on call directly.

e. The registrar notified the consultant just before 0800 hours [8.00am] *and surgery began just before 0900 hours* [9.00am] *after a CT scan had been performed.*

f. Additional stresses for this family are:

- *Delay of transfer to Wellington because of the weather and the need of another patient to be shifted first. This made no difference to the treatment or the course of the illness.*

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Taranaki Healthcare, Dr A, Mrs B, Dr C, Dr D, Dr E, Dr F

Opinion - Case 98HDC13685, continued

Information Gathered During Investigation *continued*

- *Permission was given by the family for organ donation but because of severe physiological abnormalities he was eventually thought to be unsuitable for this.*

III *This unfortunate state of affairs is well recognised and many senior doctors have experienced similar cases at first or second hand. There is a common failure to attribute abnormal, unco-operative or aggressive behaviour to alcohol rather than a coexisting brain injury.*

There are good protocols in place at Taranaki Base Hospital. This case is not a failure of protocol but a failure of implementation of the protocol for the reasons listed above.

Improvements can be made in two areas:

a. Firstly, I believe that the Emergency Department Head Injury Protocol should be expanded to require the taking of observations by alternating staff so that there is a double check on patients, and

b. Emergency Department medical staff should be encouraged to contact the consultant on call directly if there is any delay in getting the registrar."

The Medical Management Director's report to Taranaki Healthcare outlined the events that have been previously discussed as a result of the Commissioner's investigation. The Director concluded his report with the following comments:

"***Comments on the Case***

The management of Mr Whittaker by the Resident Medical Officer [Dr A]*, in my opinion was within accepted practice at Taranaki Healthcare Ltd. She reviewed the patient on a regular basis, responded when called by the nursing staff and sought advice from more experienced clinicians.*

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Taranaki Healthcare, Dr A, Mrs B, Dr C, Dr D, Dr E, Dr F

Opinion - Case 98HDC13685, continued

Information Gathered During Investigation *continued*

I am concerned about the delay in getting hold of the Registrar following the deterioration in the Glasgow Coma Scale at 0630 hours [6.30am]. *It is expected at Taranaki Healthcare Ltd that if the resident medical officer cannot get hold of the Registrar that they contact the Consultant immediately.*

The registrar's management of the case from 0720 hours [7.20am], *the surgical management and post-op phase were within accepted practice at Taranaki Healthcare Ltd.*

Steps taken and recommendations made as a result of this case

The Head Injury Management protocol for the Emergency Department was revised by the medical director for Ambulatory Care, the protocol at the time of Mr Whittaker's presentation was sound but since then we have introduced a system of two people doing the GCS. This is not regular procedure but a worthwhile safety mechanism.

I have again informed the resident medical officers to contact their consultants if registrars do not respond to their calls.

Taranaki Healthcare Ltd introduced changes to the staffing of the Emergency Department not directly linked to this case. The role of the resident medical officer as first point of contact in the Emergency Department has changed, Taranaki Healthcare Ltd introduced more senior medical staff in the form of Medical Officers to fulfil this duty."

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Taranaki Healthcare, Dr A, Mrs B, Dr C, Dr D, Dr E, Dr F

Opinion - Case 98HDC13685, continued

Information Gathered During Investigation *continued*

Dr A's response to the Commissioner's inquiry

As part of her response to the Commissioner, Dr A included a report of a review of the care she had provided to Mr Whittaker, that she had commissioned from a Professor of Medicine and specialist in internal medicine. The Professor made the following statement about Dr A's care of Mr Whittaker:

> "*… On careful review of the information available, I conclude that Dr A displayed a high standard of professional competency in the care of Mr Tommy Whittaker and in her duties at Taranaki Base Hospital on 15 November 1997. Such features included a thorough history and clinical examination of Mr Whittaker, repeated reassessments, sound clinical judgement, seeking senior medical opinion appropriately, and prioritising the importance of cases under her care including the recognition of suspected meningoccal meningitis in an at risk infant. In my opinion, her care was commensurate with that of a competent medical registrar two years her senior.*
>
> *I think it is also necessary at this stage to make a few comments concerning the report of Dr C, the consultant general surgeon. With respect to his comments:*
>
> *1. The statement that an incomplete history of the head injury was obtained and that this was oversight is misleading, as it is clear from the records that Dr A sought a detailed history in relation to the trauma, that the apparent injuries were compatible with the history that she obtained and that as a result, it was reasonable for her to accept the history she was provided by the patient and his friends.*

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Taranaki Healthcare, Dr A, Mrs B, Dr C, Dr D, Dr E, Dr F

Opinion - Case 98HDC13685, continued

Information Gathered During Investigation *continued*

2. The statement that the neurological observations were not done hourly is not compatible with Dr C's subsequent detailing of the hourly neurological observations. In addition, the statement that there was a failure to recognise and notify the significant changes in the scores as time went by is incorrect as Dr A reassessed the patient at 0530 in response to a significant change in the recordings. At this stage she undertook an appropriate neurological examination and interpreted the signs appropriately. Dr A's listing of Glasgow Coma Scale of 14/15 at 0530 would, in clinical terms, lead to a revision and reinterpretation of the previous changes in the Glasgow Coma Scale recordings prior to this time. Dr A then reassessed the patient one hour later, correctly interpreted the neurological signs and sought urgent senior medical review."

Following the hearing the Coroner concluded that:

"…

2 Having sustained injuries in his accident, Tommy Whittaker was entitled to prompt and efficient medical treatment from the services in the area where his accident occurred. This is the right of every person in this country. Whittaker was taken to Taranaki Base Hospital promptly. He was efficiently checked and was monitored throughout the morning of 15 November 1997. It was tragic that he died, notwithstanding the medical attention he received. I sadly accept the view expressed to Mr and Mrs Whittaker that 'the system had failed Tommy', and that he had 'leaked through the cracks'.

3 I am satisfied from the evidence I heard at the inquest that it was most unlikely Tommy Whittaker would have died had the seriousness of his head injury been recognised earlier by Mrs B and Dr A. It was a tragic outcome because Whittaker was monitored throughout the morning of 15 November 1997.

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Taranaki Healthcare, Dr A, Mrs B, Dr C, Dr D, Dr E, Dr F

Opinion – Case 98HDC13685, continued

Information Gathered During Investigation *continued*

4 As my decision shows, there were a number of factors which contributed to Tommy Whittaker's death. However there is one which has weighed heavily on my mind throughout the inquest. It is the fact that Dr A, Mrs B and Dr F were all unaware that Tommy Whittaker had sustained an accident in which he had free fallen from a height of about 15 metres. In my view this was a major contributing factor to Whittaker's death. Had any of the three medical officers known the true extent of Whittaker's fall, the treatment he received would have taken a different course.

Tommy Whittaker's death highlights the need for medical officers treating an accident patient to have full information about the nature and extent of the patient's accident – not just the injuries sustained.

5 It was sad to hear in the course of the inquest, Dr A state that she was the only doctor awake in charge of a hospital of about 250 patients. At the time Dr A was a first year house surgeon. Although Dr A had back up services, in my view it is undesirable for hospital authorities to require an inexperienced doctor to take such a responsibility. I urge hospital authorities throughout the country to see that the responsibility for emergency hospital services during night hours is vested in an experienced medical officer.

6 The expert evidence I heard at the inquest from Dr C, The Coroner's neurosurgeon] and {the Medical Director of the Emergency Department] contained a number of important recommendations. I have noted these earlier in this decision. I will not repeat them. However, the recommendations should be heeded and adopted by all hospitals offering emergency services. It is pleasing to note that Taranaki Healthcare Limited has already made changes to its accident and emergency protocol in line with the recommendations.

…"

Taranaki Healthcare, Dr A, Mrs B, Dr C, Dr D, Dr E, Dr F

Opinion - Case 98HDC13685, continued

Independent Advice to the Commissioner

The Commissioner sought advice from an emergency medicine specialist. The advisor's full report is attached as an appendix to this report.

The Commissioner also sought advice from a nurse advisor. The advisor answered questions from the Commissioner as follows:

1. Provide comment on Mrs B keeping two sets of observation records namely the patient observation sheet and the neurological observation sheet and the fact that some of the information is conflicting.

"Mrs B's statement to the HD Commissioner (para 29 & 40) indicates that she did not maintain two observation sheets. She states that her initial observations of Mr Whittaker were written on the blotter by first the ambulance officer, then the pool nurses who were assisting her, and that one of these nurses were using the green patient observation sheet rather than the neurological observation chart. Mrs B states (para 39 and 40) that she transposed the observations recorded on both the blotter and green patient's observation chart to the neurological observation chart at approx 0345hrs on 15 November, 1997. This does not account for observations still being recorded on the patient observation sheet at 0430hrs and 0515hrs. The elevated blood pressure (dynamap) is noted on the green observation sheet but not on the neurological observation chart whereas the deteriorating Glasgow Coma Scale (GCS) scores are evident on the neurological observation chart. It is possible, that with the duplication of recordings, the significant changes in the GCS scores were not noted. I also note observations were not recorded hourly as ordered, and Mrs B did not (from her own reports) recognise or notify the significant changes to the medical staff.

Continued on next page

Taranaki Healthcare, Dr A, Mrs B, Dr C, Dr D, Dr E, Dr F

Opinion - Case 98HDC13685, continued

Independent Advice to the Commissioner ***continued***

Mrs B notes that she was constantly observing and informally assessing Mr Whittaker and did not record the informal observations and that the formal recordings as per the neurological observation sheet are not an accurate reflection of Mr Whittaker's condition. It is therefore my opinion that Mrs B did not meet NZ Nursing Council requirements to obtain, document and communicate relevant clinical information (NZ Nursing Council, 1999, 4.3)."

2. Was it satisfactory that Mrs B did not total GCS scores?

"*No. If Mrs B had documented her informal recordings of Mr Whittaker's GCS scores and totalled them she would have supportive evidence for her professional judgement that Mr Whittaker's condition was not deteriorating. I accept that the night Mr Whittaker was admitted was busy and have no doubt that Mrs B made the observations she describes in her report to both the Coroner and H&D Commissioner. Nonetheless these were not recorded and it is my opinion that Mrs B did not make nursing judgements based on current nursing knowledge in relation to trends that need to be observed with GCS scores and did not notify Dr A of changes to Mr Whittaker's GCS scores (NZ Nursing Council, 1999, 3.1)."*

Continued on next page

Taranaki Healthcare, Dr A, Mrs B, Dr C, Dr D, Dr E, Dr F

Opinion - Case 98HDC13685, continued

Independent Advice to the Commissioner *continued*

3. According to the observations that Mrs B had been collecting on Mr Whittaker, when should she have notified Dr A of Mr Whittaker's deteriorating condition? Was it appropriate for her to contact at 5:30am?

"*The neurological observation chart shows that on admission at 0230 hours the GCS score was 12/15 despite the medical notes recording this as 14/15. At 0345 the same chart shows that GCS was 9/15 and accompanied by a rising blood pressure. In my opinion Mrs B should have contacted Dr A at 0345 hours. [The Medical Director of the Emergency Department] notes in his evidence to the Coroner (pg 74, 35) that the hospital protocol in 1997 was that a GCS under 12 was considered highly significant. According to the protocol described by [the Medical Director of the Emergency Department], Mrs B should have reported the dropping GCS score to Dr A at 0345 hours on 15 November 1997 or, at the very least, to have repeated and recorded the observations at the time to validate them.*"

4. Were the neurological observations taken sufficient given that they were not done on a strictly hourly basis as ordered?

"*The neurological observations were not recorded on an hourly basis as ordered but according to Mrs B she was constantly observing and monitoring Mr Whittaker during the night. During this time she was taking into account his fluctuating levels of response and didn't believe GCS scores alone reflected Mr Whittaker's head injury status (see 1. above). This was not recorded in either the neurological observation sheets or in the nurses notes and so in my opinion Mrs B did not meet professional standards of care for obtaining, documenting and communicating relevant client information (NZ Nursing Council, 1999, 4.3).*"

Continued on next page

Taranaki Healthcare, Dr A, Mrs B, Dr C, Dr D, Dr E, Dr F

Opinion - Case 98HDC13685, continued

Independent Advice to the Commissioner ***continued***

5. Should Mrs B have drawn Dr A's attention to the neurological observation sheet when Dr A reviewed Mr Whittaker at 5:30am?

"*Mrs B called Dr A at 0530 hours, as she was concerned about the high blood pressure. Dr A, in my opinion, should have asked to see the neurological observations as she had ordered them to be taken. Mr Whittaker's blood pressure was then done manually and found to be satisfactory by Dr A, as was his GCS score.*"

6. Please provide comment on Mrs B's statement about the effect of alcohol consumption on the GCS scores and her impression that Mr Whittaker had gone to sleep at around 4:30am.

"*Alcohol consumption can cause difficulty in accurate recording of head injury observations. In this case that was further exacerbated by the administration of an anti-emetic which can cause drowsiness. Mrs B indicated that she believed the combination of alcohol, the anti-emetic and the time of night was the basis of her belief that Mr Whittaker had gone to sleep at around 0430hours. In my opinion it is important for nursing staff to ensure that the effects of alcohol are not mistaken for deteriorating head injury status and the trend in GCS scores needs to be noted carefully to ensure this doesn't happen.*"

Continued on next page

Taranaki Healthcare, Dr A, Mrs B, Dr C, Dr D, Dr E, Dr F

Opinion - Case 98HDC13685, continued

Independent Advice to the Commissioner ***continued***

7. Please address the apparent conflict between Mrs B's GCS scoring and Dr A's differing GCS scores such as 14/15 found by Dr A at 5:30am.

"*At 0530hours the neurological observation chart recorded a GCS score of 6/15 and Dr A a score of 14/15. According to Mrs B, Dr A was more aggressive about waking the patient and that could account for the difference. When considering the downward trend of the GCS scores overnight and continued downward trend after 0530hours it would seem likely that Mrs B's GCS scores were the most accurate. GCS scores need to be looked at for the overall trends they represent and not as one-off recordings. Nonetheless Dr A was sufficiently concerned to reassess the situation at 0630hours.*"

8. Any other matter relating to professional standards that you believe are relevant to this complaint?

"*It is my opinion that Mr Whittaker was closely observed by Mrs B, for deterioration overnight. It is unfortunate that the records maintained by Mrs B that night do not reflect her close observation of Mr Whittaker. It is also my opinion that had Mrs B maintained accurate records she would have notified Dr A earlier of the deteriorating GCS score and increasing blood pressure.*"

Taranaki Healthcare, Dr A, Mrs B, Dr C, Dr D, Dr E, Dr F

Opinion - Case 98HDC13685, continued

Code of Health and Disability Services Consumers' Rights

The following Rights in the Code of Health and Disability Services Consumers' Rights are applicable to this complaint:

RIGHT 4
Right to Services of an Appropriate Standard

1) Every consumer has the right to have services provided with reasonable care and skill.

2) Every consumer has the right to have services provided that comply with legal, professional, ethical, and other relevant standards.

…

5) Every consumer has the right to co-operation among providers to ensure quality and continuity of services.

Professional Standards

***Nursing Council of New Zealand* 'Code of Conduct for Nurses and Midwives' (January 1995)**

PRINCIPLE TWO
The nurse or midwife acts ethically and maintains standards of practice.

Criteria
The nurse or midwife:

…

2.3 is accountable for practising safely within her/his scope of practice;

2.4 demonstrates expected competencies in the practice area in which currently engaged;

…

2.7 maintains and updates professional knowledge and skills in area of practice;

…

2.9 accurately maintains required records related to nursing or midwifery practice.

Continued on next page

Taranaki Healthcare, Dr A, Mrs B, Dr C, Dr D, Dr E, Dr F

Opinion - Case 98HDC13685, continued

Professional Standards *continued*

PRINCIPLE FOUR
The nurse or midwife justifies public trust and confidence.

Criteria
The nurse or midwife:
…
4.3 uses professional knowledge and skills to promote patient/client safety and wellbeing;
…
4.6 takes care that a professional act or any omission does not have an adverse effect on the safety or wellbeing of patients/clients; …

Nursing Council of New Zealand

Competencies for Entry to the Register of Nurses (October 1996)
3.0 *PROFESSIONAL JUDGEMENT*
…
Generic Performance Criteria
The applicant:
3.1 Makes nursing judgements based on current nursing knowledge, research and reflective practice.

4.0 *MANAGEMENT OF NURSING CARE*
…
Generic Performance Criteria
The applicant:
…
4.3 Obtains, documents and communicates relevant client information.

Taranaki Healthcare, Dr A, Mrs B, Dr C, Dr D, Dr E, Dr F

Opinion - Case 98HDC13685, continued

Other Relevant Standards

Taranaki Healthcare's protocols for neurological observation (dated June 1994 and revised September 1996) that were current at Taranaki Base Hospital in November 1997 were:

"*STANDARD:* *To accurately assess and record neurological status following surgery, trauma and other neurological events.*

CRITERIA:

1. *Explanation of procedure given to patient as appropriate to patient's level of consciousness and family/whanau.*
2. *Frequency of neurological observations will depend on the patient's condition and doctor's instructions.*
3. *Recordings should be documented on the neurological observation chart Classification number: 650-211-5805.*
4. *Any changes in observations will be noted and reported to house surgeon promptly.*

PROCEDURE:

1. *Take blood pressure, pulse, temperature and respiration rate.*
2. *Assess pupil size against example on chart.*
3. *Assess pupil reaction to light with torch.*
4. *Assess limb movement and strength.*
5. *Assess verbal response as per coma scale on chart.*
6. *Document findings on neurological observation chart.*
   Document Classification number: 650-211-5805.
7. *Assess for headache/increase in some.*
8. *Assess nausea/vomiting.*
9. *Assess for any abnormal eye movements.*

Continued on next page

Taranaki Healthcare, Dr A, Mrs B, Dr C, Dr D, Dr E, Dr F

Opinion - Case 98HDC13685, continued

Other Relevant Standards *continued*

N.B.:
If level of consciousness necessitates the application of painful stimuli to observe a response always provide family/whanau with an explanation.
Painful stimuli can be provided by exerting firm digital pressure on the nail beds, the Archilles tendon, the Sternum or the gastrocnemius muscle."

Taranaki Healthcare's protocol on head injuries (issued March 1993) that was current in November 1997 stated:

"*In order to adequately assess and manage head injured patients, the Glasgow Coma Scale is used and the presence of a skull fracture is determined, along with repeated neurological evaluations.*

CRITERIA FOR ADMISSION:

1. *All patients with GCS less than 15, even if brain impairment is thought to be due to alcohol or drugs.*

2. *Any radiological evidence of a skull fracture.*

3. *Any clinical evidence of a skull fracture:*
   - *periorbital bruising*
   - *retroaural bruising*
   - *CSF leakage*

4. *Focal neurological signs.*

5. *Persistent headache and vomiting especially in children.*

Continued on next page

Taranaki Healthcare, Dr A, Mrs B, Dr C, Dr D, Dr E, Dr F

Opinion - Case 98HDC13685, continued

Other Relevant Standards *continued*

6. Patients with concurrent medical problems, e.g. diabetes or coagulation disorders.

It is acceptable to discharge patients who are alert, have no skull fracture, no fits and no neurological signs, even if they have briefly lost consciousness following a head injury. Head injury advice and a reliable home situation is necessary.

CRITERIA FOR CT SCANNING

1. URGENT – Severe head injury (GCS less than or equal to 8)
- Moderate head injury (GCS 8 – 12) plus a small fracture.
- Neurological deterioration.

2. WITHIN 24 HOURS
- Minor head injury (GCS 12 – 14) persisting and a skull fracture.
- Severe headache and vomiting.
- Seizures."

Taranaki Healthcare, Dr A, Mrs B, Dr C, Dr D, Dr E, Dr F

Opinion - Case 98HDC13685, continued

Opinion: Breach

Dr F

In my opinion Dr F breached Right 4(1) of the Code as follows:

Conversation between Dr A and Dr F at 2.00am

Dr F was the surgical registrar on call at Taranaki Base Hospital on the night of 14/15 November 1997. In that role, Dr F had a responsibility to supervise the house surgeon on duty, Dr A, with due care and skill. His responsibility extended to providing Dr A with appropriate advice and assistance.

After several unsuccessful attempts, Dr A contacted Dr F at approximately 2.00am to ask his guidance on how to manage Mr Whittaker's injuries. Dr A and Dr F give differing accounts of their conversation regarding Mr Whittaker.

Dr A said that she contacted Dr F because she wanted him to listen to her description of Mr Whittaker's presentation and tell her what other investigations should be carried out and what she should be concerned about, and to advise his opinion on the seriousness of Mr Whittaker's injuries. She was concerned in particular about the periorbital haematoma, the right wrist fracture/dislocation, and the fact that Mr Whittaker had been vomiting blood. Dr A stated that she told Dr F everything because she did not feel that she had the experience to know what Dr F would or would not consider important. She had her notes in front of her and read from the notes. Dr A recalled giving Dr F a full account of her understanding of the extent of Mr Whittaker's injuries, including the periorbital haematoma and the fracture/dislocation of his wrist. She recalled telling Dr F of the confusion surrounding the mechanism of the injury and of Mr Whittaker's GCS score, restlessness and vomiting.

Continued on next page

Taranaki Healthcare, Dr A, Mrs B, Dr C, Dr D, Dr E, Dr F

Opinion - Case 98HDC13685, continued

Opinion: Breach Dr F *continued*

Dr F confirmed that he received Dr A's call some time about 2.00am. Dr F stated that he did not recall being told of Mr Whittaker's dislocated wrist, nor that he had a head injury or a periorbital haematoma. In response to my provisional opinion, Dr F advised me that if he had been told about the suspected dislocation of the wrist he would have come in, because the dislocation would have required immediate reduction and that was his task as on call registrar. Dr F stated that he was told that Mr Whittaker had bruising around the right eye. Dr F stated that he was told of Mr Whittaker's GCS. He did not recall whether Dr A discussed the fact that Mr Whittaker was vomiting blood nor was he clear about how she described the wrist injury. Dr F stated that the mechanism of the injury was not clear to him and that Dr A did not ask him to attend. Dr F stated that in these circumstances it was reasonable for him not to review Mr Whittaker immediately.

Mrs B was in the room at the time of the conversation but could not confirm the conversation. Mrs B was surprised that Dr F was not coming to see Mr Whittaker because fracture dislocations are usually attended to immediately.

Dr A was a first year house surgeon with limited A&E assessment skills. She was not rostered on to A&E during normal working hours because she lacked experience. I accept that Dr A was uncertain of the seriousness of the factors she observed in assessing Mr Whittaker, and properly sought guidance from her registrar on how to proceed. The presence of a periorbital haematoma, indicating a head injury, the possible fracture, the dislocation of Mr Whittaker's wrist and his vomiting blood were matters of sufficient complexity that Dr A needed to seek specific guidance on how to proceed. While it is not possible to know what was said during the conversation between Dr F and Dr A that night, I find Dr A's statement (that she "*told Dr F everything because I didn't feel I had sufficient knowledge to know what he might or might not consider was important*") compelling. Dr A stated that she read from her notes when telling Dr F of her findings.

Continued on next page

Taranaki Healthcare, Dr A, Mrs B, Dr C, Dr D, Dr E, Dr F

Opinion - Case 98HDC13685, continued

Opinion: Breach Dr F *continued*

My medical advisor has viewed the medical notes (written subsequently to the phone call) and stated that Dr A's initial assessment of Mr Whittaker was "*very thorough*". Although the notes do not use the term "periorbital haematoma", they do use the term "periorbital bruising", and I see no reason why Dr A would not have used that term in her conversation with Dr F. I am persuaded that Dr A told Dr F about Mr Whittaker's potential head injury and fracture dislocation. Accordingly, given Dr A's inexperience in A&E, a responsible registrar in Dr F's situation should have attended immediately, to satisfy himself that Mr Whittaker's condition was stable. Dr F was on call and has stated that (despite the problems with his pager) he was in the on call room on the hospital grounds, and therefore readily available to attend.

In my opinion, by failing to respond appropriately to Dr A's call, Dr F fell short of the standard expected of an on call surgical registrar, and did not supervise his relatively inexperienced house surgeon with due care and skill. Dr F therefore breached Right 4(1) of the Code.

Taranaki Healthcare, Dr A, Mrs B, Dr C, Dr D, Dr E, Dr F

Opinion - Case 98HDC13685, continued

Opinion: Breach Taranaki Healthcare

In my opinion Taranaki Healthcare breached Rights 4(1) and 4(5) of the Code as follows:

Right 4(1)

Staffing levels

Taranaki Healthcare, as a public hospital, is required to provide services with reasonable care and skill. This duty includes the provision of competent staff. Taranaki Base Hospital in 1997 had one medical staff member awake from 10.30pm to 8.00am. This staff member was in charge of the Accident and Emergency Department and all other wards in the hospital, with the exception of obstetrics. Other medical staff were available on call. Taranaki Healthcare rostered first year house surgeons onto this duty after they had six weeks' experience at the hospital. Dr A gave evidence that several first year house surgeons had raised their concerns about this practice with Taranaki Base Hospital management. However, no evidence of these concerns was documented by Taranaki Base Hospital personnel. In July 1997 Taranaki Base Hospital had noted that rostering first year house surgeons for night duty was an area for improvement.

My medical advisor noted that staffing levels in New Zealand public hospitals and A&E's in 1997 fell below international standards and that Taranaki Hospital's staffing levels were no different to other A&E's around the country. However, my advisor noted that for a hospital the size of Taranaki Base Hospital the clinician responsible for care should be, at a minimum, at least a second year house officer and ideally a third year house officer. Since 1 January 1998 senior medical staff have been required to be on duty at Taranaki Base Hospital A&E 24 hours a day.

In my opinion, Taranaki Healthcare did not meet its duty to staff the Emergency Department at Taranaki Base Hospital with appropriately experienced medical staff on the night of 14/15 November 1997. Taranaki Healthcare therefore breached Right 4(1) of the Code.

Continued on next page

Taranaki Healthcare, Dr A, Mrs B, Dr C, Dr D, Dr E, Dr F

Opinion - Case 98HDC13685, continued

Opinion: Breach Taranaki Healthcare *continued*

Neurological status protocol

Taranaki Healthcare had a duty to ensure that appropriate systems were in place to accurately assess Mr Whittaker's neurological status. The neurological status protocol that was current at the time of Mr Whittaker's admission to Taranaki Base Hospital stated "*Frequency of neurological observations will depend upon the patients condition and doctors instructions*". The protocol also stated that observations should be recorded in the Neurological Observation Chart and any changes should be reported to the house surgeon promptly. Mrs B stated that the informal policy at Taranaki Base Hospital for patients with a suspected head injury was to undertake neurological observations hourly.

My medical advisor commented on the accepted practice in New Zealand and overseas in 1997. Neurological observations for a patient with an admission GCS of 15/15 were to be taken half-hourly for three hours. If the patient's GCS remained at 15/15, the observations could be reduced to hourly for another two to three hours. If a patient had a GCS of 12-14/15 on admission GCS observations were to be taken half-hourly until the GCS improved to 15/15 and a doctor needed to examine the patient at least once every four hours.

The Taranaki Healthcare neurological status protocol in 1997 did not specify how often GCS observations and other neurological observations should be undertaken. There was no guidance for nurses on the parameters they were expected to monitor within, nor on what constituted a significant change in observations which necessitated calling a doctor.

In the absence of any guidelines on the matter, Dr A prescribed hourly neurological observations, which were inadequate by international and national standards.

In my opinion Taranaki Healthcare failed in its duty to provide staff with adequate neurological observation guidelines and thereby breached Right 4(1) of the Code.

Continued on next page

Taranaki Healthcare, Dr A, Mrs B, Dr C, Dr D, Dr E, Dr F

Opinion - Case 98HDC13685, continued

Opinion: Breach Taranaki Healthcare *continued*

Right 4(5)

On call medical staff

Taranaki Healthcare is required to ensure co-operation among providers (including its own staff) to enable quality and continuity of care for patients.

Taranaki Healthcare rostered one house surgeon to be awake and on duty to staff Taranaki Base Hospital, including the A&E department and the hospital. Sometimes, as on the night of 14/15 November 1997, this was a junior and inexperienced house surgeon. It was recognised that medical staff would need to contact more experienced staff on occasion. Taranaki Base Hospital had an on call system whereby house surgeons could contact more senior staff or registrars, as required, by pager or by telephone.

On 15 November 1997 from approximately 6.30am to 7.20am Dr A repeatedly attempted to contact Dr F, the on call registrar, because of her concerns about Mr Whittaker's deteriorating condition. She was unable to contact him by pager after several attempts. Dr A stated that she did not consider calling the consultant, Dr C, as she was not aware that house officers could contact consultants. Dr A went to look for Dr F in the areas of the hospital where she thought he might be. Dr A said that in contacting the registrar and attempting to find him she was using the only method she knew of to get advice from a senior colleague. I find this statement persuasive. It was an act of desperation for Dr A to leave her patient and physically search for the registrar; an action I believe that she would not have taken given Mr Whittaker's serious condition had she been aware that she could have directly contacted the consultant.

Continued on next page

Taranaki Healthcare, Dr A, Mrs B, Dr C, Dr D, Dr E, Dr F

Opinion - Case 98HDC13685, continued

Opinion: Breach Taranaki Healthcare *continued*

I have seen no evidence to suggest that Taranaki Base Hospital (or its consultants) had provided its junior medical staff, such as Dr A, with clear instructions that if they were unable, for whatever reason, to contact the on call registrar within five minutes, they should approach the on call consultant for advice and assistance. The supervisory responsibilities of a consultant include ensuring that junior medical staff (including house surgeons) know that they should not hesitate to contact an on call consultant for advice and assistance. Consultants are paid to be on call precisely so they can provide such advice, and it is not sufficient to assume that an inexperienced house surgeon will know to telephone for advice.

In my opinion, Taranaki Healthcare's failure to provide clear instructions about when junior medical staff should contact the on call consultant did not ensure quality and continuity of care for patients, and therefore breached Right 4(5) of the Code.

Contacting the 'on call' registrar
Dr F was the surgical registrar on call on the night of 14/15 November 1997. He was house surgeon Dr A's first point of referral for advice on the most appropriate treatment options in any clinical situation that was beyond her level of experience and expertise. It was essential that he was available when she called for advice about any patient of concern to her. This was particularly so given that Dr A was a first year house surgeon who was in sole charge of A&E and all other departments in Taranaki Base Hospital, excepting obstetrics.

My medical advisor informed me that standards of response to contacting on call registrars, especially during the night and from the Emergency Department, require a response within five minutes of the call. Being unable to contact the registrar within five minutes is unacceptable and a failure to contact within one hour is totally unacceptable.

Continued on next page

Taranaki Healthcare, Dr A, Mrs B, Dr C, Dr D, Dr E, Dr F

Opinion - Case 98HDC13685, continued

Opinion: Breach Taranaki Healthcare *continued*

On two occasions on the morning of 15 November 1997 Dr A and Mrs B attempted to contact Dr F and had difficulties in doing so. On the first occasion, between approximately 1.20am and 2.00am, there were several attempts to contact the registrar. Mrs B stated that she was asked to page the on call registrar by Dr A and she made two attempts through the operators, to which he did not respond. Dr A also attempted to page Dr F at this time. On her third attempt Mrs B stated that the operator offered to put a call through to Dr F's home. On this occasion contact was made. Dr F stated, under oath to the Coroner, that he was in the call room at Taranaki Base Hospital for the duration of that evening and morning and that, as far as he was aware, his pager was turned on, although it was possible that the switch knocked against something and turned to either buzz or off state. Dr F stated that he was contacted in the call room at around 2.00am.

On the second occasion at approximately 6.30am Dr A was concerned about Mr Whittaker's deteriorating condition and attempted to contact Dr F. She stated that she paged him herself rather than going through an operator. When there was no answer after five to ten minutes, she paged him again. Dr A stated during cross examination that she paged Dr F on two different numbers at least three times on each number and possibly more often than that. After being unable to contact him she went to the RMO room and the cafeteria to see whether she could physically locate him. Dr A was unable to find Dr F. Dr A returned to A&E and it seems probable that she paged Dr F again. At that point a nurse suggested that the operators kept a list of telephone numbers, including home numbers, and offered to ask the operators to contact Dr F using these numbers. Dr F was finally contacted by telephone at approximately 7.20am.

Dr F had a responsibility to be available. If he was unavailable for any reason, he should have taken steps to notify the hospital telephonist and arranged adequate cover. I note that Dr F has declared under oath that he was present on the hospital grounds on the morning of 15 November 1997. However he also needed to ensure that his pager was switched on. It is not acceptable for an on call registrar to accidentally have his pager switched to a buzz or off state, as Dr F suggested may have occurred.

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Taranaki Healthcare, Dr A, Mrs B, Dr C, Dr D, Dr E, Dr F

Opinion - Case 98HDC13685, continued

Opinion: Breach Taranaki Healthcare *continued*

I accept that Taranaki Base Hospital had a system in place by which on call assistance could be obtained when required. This included lists of pager numbers and home numbers for contacting medical and nursing staff. The staff member requiring assistance could either page the staff member directly or request the hospital operator to contact them by pager or phone.

Despite this system, Dr A was unable to contact the on call registrar in an emergency for a period of approximately one hour. My advisor noted that:

> "*In Tommy Whittaker's case this delay was significant according to the neurosurgical experts consulted both by the Coroner and by the family.*"

I agree with my medical advisor that the delay in contacting Dr F was totally unacceptable. While it may not ultimately have cost Mr Whittaker his life, it was an inexcusable lapse.

Taranaki Healthcare's system for contacting on call medical staff failed Mr Whittaker (and his family). Mr Whittaker did not receive the continuity of care that he was entitled to expect. In these circumstances Taranaki Healthcare breached Right 4(5) of the Code.

Taranaki Healthcare, Dr A, Mrs B, Dr C, Dr D, Dr E, Dr F

Opinion - Case 98HDC13685, continued

Opinion: Breach Mrs B **Right 4(1)**

In my opinion Mrs B breached Right 4(1) of the Code as follows:

As the nurse responsible for Mr Whittaker, Mrs B had a duty to provide services with reasonable care and skill in accordance with Right 4(1) of the Code.

Failure to notify Dr A
Both of my advisors said that Mrs B should have notified Dr A of the deterioration in Mr Whittaker's GCS.

Mrs B knew the importance of GCS recording as an estimate of neurological function. GCS records the state of three individual observations: opening the eyes to a verbal stimulus, responding verbally to command and movement on physical stimulus. Each individual score is added together and the total GCS gives an overall picture of brain function.

In Mr Whittaker's case none of these individual scores were totalled and recorded, although Mrs B said that she added them up in her head. My emergency medicine specialist said that totalling and recording these neurological observations is important because it provides a single source of trend information to clinical staff. This means that while an individual score may not appear significant, totalling the three scores gives a more detailed picture. It would have been a simple task to add three numbers and record the results. It is more difficult to analyse the information and give meaning to the outcome if the scores are not totalled and recorded.

Continued on next page

Taranaki Healthcare, Dr A, Mrs B, Dr C, Dr D, Dr E, Dr F

Opinion - Case 98HDC13685, continued

Opinion: Breach Mrs B *continued*

My medical advisor noted that on two occasions Mrs B should have notified Dr A about the fluctuating GCS. Dr A recorded that Mr Whittaker's GCS on arrival at 1.00am was 14/15. Mrs B recorded his GCS as 12/15 at 2.30am. Mrs B did not report a deterioration to Dr A at 2.30am even though Dr A was in the Emergency Department writing up her notes. Second, my advisor hypothesised that if Mr Whittaker could be roused when requested and squeeze Mrs B's hands at 3.45am, as Mrs B stated, his GCS would have been at least 10-11/15. At this level, Mrs B should have advised Dr A of the fall in Mr Whittaker's GCS at 3.45am.

My nursing advisor noted that the Medical Director of the Emergency Department's evidence to the Coroner indicated that a GCS under 12/15 was considered highly significant in terms of the hospital head injury protocol. My nursing advisor concluded that Mrs B should have contacted Dr A at 3.45am.

At 3.45am Mr Whittaker's GCS was 9/15. Mrs B recalls that Mr Whittaker spoke to her soon after that time which, at a maximum, would make his score 14/15. Dr A was not informed of these inconsistencies. At 4.30am another nurse took Mr Whittaker's GCS which totalled 6/15.

Mrs B said that she did not tell Dr A of these changes in scores because Mr Whittaker's overall condition had not altered. She added that it would also be unrealistic to telephone Dr A every time Mr Whittaker drifted off to sleep, which she attributed to the time of the night and alcohol. Mrs B said that she checked his GCS about 20 minutes after each of these formal observations and on each occasion it had returned to 14/15. In her experience alcohol made GCS unreliable.

Continued on next page

Taranaki Healthcare, Dr A, Mrs B, Dr C, Dr D, Dr E, Dr F

Opinion - Case 98HDC13685, continued

Opinion: Breach Mrs B ***continued***

Based on the information available to me I have drawn two possible conclusions about the reliability of GCS: either, all of the GCS observations (both recorded and not recorded) are correct and Mr Whittaker's neurological observations fluctuated between 6/15 and 14/15; or, the scores recorded hourly are correct and indicated a decline in neurological function. In either case, these observations were important indicators of neurological function and Dr A should have been informed of changes in the GCS. Mrs B knew the Taranaki Hospital protocols about when a CT scan should be taken and Dr A asked Mrs B to notify her if Mr Whittaker's observations changed.

I accept that Mrs B was particularly busy that night and the totalled (but not recorded) scores were not readily available to her. This made her decision about whether to notify a busy doctor more difficult. However, in my opinion it would have been reasonable for Mrs B to discuss the situation with Dr A, either by telephone or in person, sometime between 2.30am and 5.30am when she called Dr A about Mr Whittaker's elevated blood pressure.

Failure to maintain an adequate observation chart

At about 2.30am Mrs B noticed that two observation charts were being kept, although she can not account for how this happened. At about 3.45am Mrs B repeated Mr Whittaker's observations and transposed the observations recorded earlier from the blotter to the neurological chart (the grey chart). This is the only chart where GCS can be recorded and it also has space for recording other observations such as blood pressure and pulse. It was then that she noticed that another nurse had recorded Mr Whittaker's observations on the patient observation chart (the green chart). The green chart does not have a space for recording GCS. Anyone looking at the green chart would not have got a complete picture of Mr Whittaker's neurological state from previous recordings.

The grey and green charts continued to be used until 5.15am when Mrs B called Dr A because Mr Whittaker's blood pressure was elevated. Dr A attended immediately but consulted only the green chart. She took his GCS and in consultation with Mrs B confirmed his GCS at 14/15. Dr A did not know that his GCS had previously been as low as 6/15 because this recording was on the grey chart.

Continued on next page

Taranaki Healthcare, Dr A, Mrs B, Dr C, Dr D, Dr E, Dr F

Opinion - Case 98HDC13685, continued

Opinion: Breach Mrs B ***continued***

The way of finding out whether Mr Whittaker was stable was by reviewing all of the information and making clinical judgements on the patterns in observations depicted over time. In the hospital setting, medical staff must be able to rely on the attendant nurses to review, interpret and report relevant observation information in the light of the patient's circumstances. In this case Mr Whittaker had a potential brain injury.

In response to my provisional opinion Mrs B stated that she could not be held accountable for the documented observations of other relieving staff. Nevertheless, Mrs B was the registered nurse with responsibility for Mr Whittaker's overall care, and she was responsible for maintaining an adequate observation chart to ensure that it accurately recorded all relevant clinical information. Keeping complete records of accurate, reliable observations is fundamental to good nursing practice.

Conclusion

In my opinion Mrs B's failed in two areas of nursing practice: she failed to inform Dr A of the fluctuating/declining GCS; and she failed to maintain observations which would easily show Mr Whittaker's overall condition. These failings amounted to a failure to provide nursing services with reasonable care and skill. Mrs B therefore breached Right 4(1) of the Code.

Taranaki Healthcare, Dr A, Mrs B, Dr C, Dr D, Dr E, Dr F

Opinion - Case 98HDC13685, continued

Opinion: No Breach Mrs B

Right 4(2)

In my opinion Mrs B did not breach Right 4(2) of the Code as follows:

Mrs B is a registered nurse. As such she is expected to fulfil professional standards of care published by the New Zealand Nursing Council. The relevant professional standard of documentation required that Mrs B obtain, document and communicate all relevant clinical information.

Documentation of informal observations
Mrs B was almost constantly with Mr Whittaker from the time he was brought into the Emergency Department at 1.00am until he drifted off to sleep at about 4.00am. After her meal break she resumed his care but he remained quiet and she was able to attend to other tasks within the department. Mrs B said that she took his observations more frequently than hourly because she was concerned about the affect of alcohol in the circumstances of a potential brain injury. In this type of situation she found GCS an unreliable estimate of neurological function. Although she took his observations frequently, she did not record them more than hourly. In my opinion it would have been prudent for her to do so.

I accept the view of my independent nurse advisor that Mrs B failed to meet the Nursing Council competency for entry to the Register of Nurses (1996) of obtaining, documenting and communicating relevant patient information. However, I accept that a nurse's obligation to document must, as Mrs B's lawyer submitted "*be tempered by the practical situation*". I am satisfied that in light of the demands of other patients in the Emergency Department at that time and Mr Whittaker's overall physical demands that failing to document her informal observations was a relatively minor error. In my opinion, Mrs B took reasonable actions in the circumstances to comply with the professional requirement that a nurse accurately record relevant clinical information, and therefore did not breach Right 4(2) of the Code.

Taranaki Healthcare, Dr A, Mrs B, Dr C, Dr D, Dr E, Dr F

Opinion - Case 98HDC13685, continued

Opinion: No Breach Dr A

In my opinion Dr A did not breach Right 4(1) of the Code as follows:

Initial examination

Dr A conducted the initial examination of Mr Whittaker when he was brought into A&E at Taranaki Base Hospital. Although Dr A's examination was interrupted by the demands of other patients, she examined Mr Whittaker and gained a history of the fall, his injuries and his medical history from Mr Whittaker. Dr A recognised that Mr Whittaker may have suffered a significant head injury and requested hourly neurological observations. My medical advisor stated that Dr A undertook a very thorough assessment of Mr Whittaker with the exception of recording an examination of Mr Whittaker's optic fundi. It is therefore my opinion that Dr A undertook the medical examination with reasonable care and skill.

Ordering CT scan on admission

Dr A knew that Mr Whittaker had the potential for a head injury when he was brought into the A&E department at Taranaki Base Hospital. She performed a thorough neurological assessment. Mr Whittaker had a haematoma surrounding his right eye and was vomiting, but was alert with a GCS of 15/15 or 14/15. Mr Whittaker was able to a give his medical history and some information about his fall, and tell Dr A that he had no head or neck pain. My medical advisor stated that few, if any, New Zealand emergency department clinicians would request a CT scan based on this presentation. Even the presence of vomiting and the periorbital swelling around his right eye would not result in a request for a CT scan, particularly if it was erroneously believed that the injury was the result of a low impact fall. Dr A consulted Dr F about the appropriate diagnostic tool to determine whether Mr Whittaker had a head injury. In my opinion, in not ordering a CT scan for Mr Whittaker on arrival at Taranaki Base Hospital, Dr A did not breach Right 4(1) of the Code.

Continued on next page

Taranaki Healthcare, Dr A, Mrs B, Dr C, Dr D, Dr E, Dr F

Opinion - Case 98HDC13685, continued

Opinion: No Breach Dr A *continued*

X-rays

Dr A had a duty to provide medical services to Mr Whittaker with reasonable care and skill. Mr Whittaker, on his arrival at Taranaki Base Hospital, had extensive periorbital bruising, a broken wrist and a laceration over his right eye. Mr Whittaker was agitated and vomited for about 20 minutes after he was admitted and later required medication for his nausea. Dr A ordered hourly neurological observations. Taranaki Healthcare's protocol on head injuries noted that periorbital bruising could be clinical evidence of a skull fracture. This possibility could have been quickly and easily confirmed by requesting a head x-ray.

Dr A stated that medical staff had instructions to request only urgent x-rays at night, as radiographers had to be called in from home. Dr A called the radiographer in to take an urgent x-ray of Mr Whittaker's wrist and chest. Dr A stated that she considered whether she should also ask the radiographer to undertake a x-ray of Mr Whittaker's head and cervical spine but that, in her opinion, these x-rays did not seem to be clinically indicated at that time. Dr A indicated that she was uncertain of her clinical judgement in this regard. Given the high index of suspicion that Dr A maintained about the possibility of Mr Whittaker having sustained a head or brain injury, and the fact that she had already contacted a radiographer to come in and undertake urgent x-rays on Mr Whittaker, it is my opinion that requesting an additional x-ray of Mr Whittaker's head would have allowed her to eliminate or confirm the possibility that Mr Whittaker had a skull injury.

However, Dr A was aware of her comparative inexperience and sought clarification and advice from the on call registrar, Dr F, as to how she should proceed given the periorbital haematoma. I accept that Dr A relayed all the information she had gathered to Dr F and asked if there was any investigation, monitoring, or treatment that she needed to provide with regard to the periorbital haematoma. Dr A was told that, apart from backslabbing the wrist, nothing further needed to be done. I consider that it was reasonable in the circumstances for Dr A to rely on the judgement of Dr F, who as registrar had more clinical experience than she did. In my opinion, in not ordering a skull x-ray on Mr Whittaker's arrival at Taranaki Base Hospital, Dr A did not breach Right 4(1) of the Code.

Continued on next page

Taranaki Healthcare, Dr A, Mrs B, Dr C, Dr D, Dr E, Dr F

Opinion - Case 98HDC13685, continued

Opinion:
No Breach
Dr A *continued*

Neurological observations

Mrs B contacted Dr A at approximately 5.30am on the morning of 15 November to express her concerns about Mr Whittaker's elevated blood pressure. Dr A knew that Mr Whittaker had a periorbital haematoma and therefore had the potential to have a brain injury. Dr A had asked nursing staff to take neurological observations specifically designed to detect brain injury. Dr A asked that these observations be taken hourly and she was to be informed of any alteration in those readings. Dr A knew that an increase in blood pressure could signal a severe injury to the brain and came to A&E immediately when Mrs B told her that Mr Whittaker's blood pressure was high. Dr A viewed the patient observation chart where Mr Whittaker's blood pressure, respiration, and pulse were recorded along with his response to voice.

My medical advisor stated that, since Mrs B notified Dr A about her concerns with Mr Whittaker's rise in blood pressure and did not request a review by his GCS, it was reasonable for Dr A to review his vital signs in the patient observation chart. After reviewing the observation chart, Dr A's clinical judgement was that Mr Whittaker's (manual) blood pressure was within normal limits, not elevated and consistent with previous readings throughout the night.

On the patient observation chart blood pressure recordings began at 2.30am. Dr A did not refer to her admission notes to check Mr Whittaker's blood pressure on admission. Dr A did not ask Mrs B about Mr Whittaker's GCS and did not view the neurological observation chart where GCS, and pupil reaction, was recorded alongside the other neurological observations such as blood pressure. The blood pressure recordings on the neurological observations chart began on admission and illustrated the rising blood pressure trend more clearly.

In response to my provisional opinion, Dr A stated that she did not ask Mrs B about Mr Whittaker's GCS specifically because she had communicated to the nursing staff both verbally and in written form that she wanted to be notified if there was any change in GCS and knowing that the nursing staff were experienced and competent nurses, she expected that her instructions would be carried out.

Continued on next page

Taranaki Healthcare, Dr A, Mrs B, Dr C, Dr D, Dr E, Dr F

Opinion - Case 98HDC13685, continued

Opinion: No Breach Dr A *continued*

I accept that Dr A was called in by Mrs B because of Mrs B's concerns about high blood pressure and a sluggish pupil response in Mr Whittaker's left eye and that Mrs B expressed no concern about Mr Whittaker's GCS. Because of the sluggish pupil response Dr A checked Mr Whittaker's GCS which was 14/15 and unchanged.

I also acknowledge that as a first year house surgeon, Dr A, was in charge of the entire hospital, including A&E, and it was quite unrealistic for her to look at the chart of every patient she was asked to review. My medical advisor noted that it is possible to review documented monitoring parameters through a verbal exchange between a doctor and nurse. I am not satisfied that this occurred.

It is important to assess the recorded long-term trends when assessing neurological signs, including blood pressure and GCS. Observation records are designed to give information about the trends in observations over time. Where a single recording may fall within acceptable limits, deterioration (or improvement) in a patient's condition is detected by analysing the rise and/or fall of set observations taken at regular intervals. The way of finding out whether the patient is stable is by reviewing all of the information and making clinical judgements on the patterns in observations depicted over time. Medical and nursing staff are responsible for reviewing observation information and interpreting its meaning in the light of the patient's circumstances.

In my opinion it was reasonable for Dr A to rely on Mrs B to inform her of any changes in Mr Whittaker's neurological observations, especially as Mrs B was present at the time and Mr Whittaker's chart was readily accessible. Accordingly, in my opinion, Dr A provided services with reasonable care and skill and did not breach Right 4(1) of the Code.

Taranaki Healthcare, Dr A, Mrs B, Dr C, Dr D, Dr E, Dr F

Opinion - Case 98HDC13685, continued

Opinion: No Breach Taranaki Healthcare

In my opinion Taranaki Healthcare did not breach Right 4(1) of the Code as follows:

Dr F contacted a radiologist at home at approximately 7.30am to perform an urgent CT scan. The radiologist arrived at the hospital at about 8.00am and the CT scan commenced at 8.30am and finished at 8.45am. My medical advisor indicated that it is impossible and impractical to have CT scans in readiness mode 24 hours a day. The advisor stated that it generally takes 30 minutes for the on call radiographer to come in from home and start up the CT scanner. A delay of one hour was within the acceptable parameters for this equipment. I therefore conclude that Taranaki Healthcare provided services with reasonable care and skill and did not breach Right 4(1) of the Code.

Opinion: No Breach Dr E

In my opinion Dr E did not breach Right 4(1) of the Code as follows:

Dr E has informed me that he was involved with Mr Whittaker's care for a brief time only, from the completed CT scan through to setting up the anaesthesia in the operating theatre in conjunction with Dr D the morning of 15 November 1997. Once the equipment was set up Dr E left the operating theatre. Dr E was not on call when Mr Whittaker was admitted to the ICU department. My investigation has found no evidence of concerns regarding the anaesthesia administered to Mr Whittaker in theatre. In my opinion, Dr E did not breach Right 4(1) of the Code.

Taranaki Healthcare, Dr A, Mrs B, Dr C, Dr D, Dr E, Dr F

Opinion - Case 98HDC13685, continued

Opinion: No Breach Dr C

In my opinion Dr C did not breach Right 4(1) of the Code as follows:

CT scan

Dr A contacted Dr F at approximately 7.20am. Dr F arrived very quickly and assessed Mr Whittaker's condition. Dr F noted during his examination that Mr Whittaker was unresponsive to voice or stimuli, he had a large bruise on the right side of his head and a swelling of the lids around the right eye and his pupils were bilaterally fixed and dilated. After assessing the patient Dr F arranged at 7.30am for a CT scan of Mr Whittaker's brain. While waiting for the radiologist to call back Dr F contacted the consultant, Dr C, to inform him of the seriousness of the situation. It was after 7.30am when Dr C was first contacted about Mr Whittaker. Dr C advised Dr F to get the anaesthetist to arrange theatre to shave the patient's head, and to make sure his airway and blood pressure were satisfactory. Dr C approved Dr F's decision to undertake a CT scan.

My medical advisor stated that Mr Whittaker had, to all intents and purposes, been diagnosed with acute cerebral herniation at 6.30am. My advisor stated that, according to the standard current in 1995 for the resuscitation of the severe head injury patient, Mr Whittaker's deterioration should have resulted in a trauma call-out. This would have resulted in the surgical registrar, senior surgeon and anaesthetist responding rapidly to the scene and stabilising the airway and introducing mannitol. The CT scan could have been bypassed. The advisor stated that a patient with evidence of intracranial hypertension needs immediate release of the problem. If stabilisation and mannitol are ineffective the CT scan should be bypassed and the patient moved immediately to theatre for surgical intervention. If the CT scan had been bypassed it is possible that Mr Whittaker would have received surgery half and hour earlier than he did.

In response to my provisional opinion, Dr C stated that he did not accept that the performance of a CT scan led to or contributed in any way to Mr Whittaker's death. He stated that "*acute cerebral herniation*" was diagnosed at 6.30am and by implication it occurred earlier than this and Mr Whittaker was brain dead from that time.

Continued on next page

Taranaki Healthcare, Dr A, Mrs B, Dr C, Dr D, Dr E, Dr F

Opinion - Case 98HDC13685, continued

Opinion: No Breach Dr C *continued*

Following Dr F's call, Dr C went immediately to A&E and examined Mr Whittaker before his CT scan. Dr C stated that the examination and review of the notes showed him that Mr Whittaker had coned some time earlier. Dr C stated that Mr Whittaker's airway was satisfactory, there was no need for immediate intubation, and mannitol was given prior to commencing the operation.

Dr C advised that he could have countermanded the phone decision for a CT scan when he arrived at A&E, but in the absence of lateralising signs with the possibility of more than one site of injury and a GCS of 3-5, he felt it appropriate to do the scan to give the diagnosis and show the best position for any burr holes.

Taranaki Healthcare advised that CT scanning was required to guide Dr C, a general surgeon and not a neurosurgeon, where to place the burr holes because the patient did not demonstrate localising signs (indicating a site of haemorrhage and therefore an appropriate site for burr holes) and there was a possibility that there was more than one site of haemorrhage.

I accept that in these circumstances a CT scan could have been bypassed, but that it was reasonable for Dr C to wait for a CT scan. Accordingly, in my opinion, Dr C provided services with reasonable care and skill in approving Dr F's decision to undertake a CT scan, and did not breach Right 4(1) of the Code.

Surgery

Dr C was the surgical consultant on call at Taranaki Base Hospital on 15 November 1997. Dr C was unaware of Mr Whittaker's presence at Taranaki Base Hospital until Dr F contacted him sometime before 8.00am on 15 November 1997.

Continued on next page

Taranaki Healthcare, Dr A, Mrs B, Dr C, Dr D, Dr E, Dr F

Opinion - Case 98HDC13685, continued

Opinion:
No Breach
Dr C *continued*

Dr C drained Mr Whittaker's right extradural haematoma on the morning of 15 November 1997. Dr C was also involved in the management of Mr Whittaker in ICU. Dr C arranged for Mr Whittaker to be transferred to Wellington Hospital neuro-intensive care unit at 3.00pm on 15 November 1997. My investigation has found no evidence of concerns regarding the surgery performed on Mr Whittaker. My medical advisor informed me that Mr Whittaker's condition was carefully monitored in the Intensive Care Unit. The treatment provided was based on an evidence-based therapeutic strategy, and appropriate diagnoses were made. In my advisor's opinion the treatment provided in the ICU at Taranaki Hospital was appropriate and was unlikely to have exacerbated Mr Whittaker's head injury. The diabetes Mr Whittaker developed indicated the severe and unrecoverable nature of his brain injury by the time Mr Whittaker was admitted to ICU. In my opinion Dr C provided services to Mr Whittaker in the operating theatre and in ICU with reasonable care and skill and did not breach Right 4(1) of the Code.

Taranaki Healthcare, Dr A, Mrs B, Dr C, Dr D, Dr E, Dr F

Opinion - Case 98HDC13685, continued

Opinion: No Breach Dr F

In my opinion Dr F did not breach Right 4(1) of the Code as follows:

Referral for CT scan at 7.30am

Dr A contacted Dr F at approximately 7.20am. Dr F arrived very quickly and assessed Mr Whittaker's condition. After assessing the patient Dr F arranged at 7.30am for a CT scan of Mr Whittaker's brain. Dr F noted during his examination that Mr Whittaker was unresponsive to voice or stimuli, had a large bruise on the right side of his head and a swelling of the lids around the right eye, and his pupils were bilaterally fixed and dilated. While waiting for the radiologist Dr F contacted the consultant, Dr C, to inform him of the seriousness of the situation. Dr C advised Dr F to get the anaesthetist to arrange for Mr Whittaker's head to be shaved, and to make sure his airway and blood pressure were satisfactory. Dr C approved Dr F's decision to undertake a CT scan.

My medical advisor stated that Mr Whittaker had, to all intents and purposes, been diagnosed with acute cerebral herniation at 6.30am. Mr Whittaker's deterioration should have resulted in a trauma call-out and a rapid attempt to stabilise him. I accept that the standard current in 1995 for the resuscitation of the severe head injury patient should have resulted in a trauma call-out, which would have resulted in the surgical registrar, senior surgeon and anaesthetist responding rapidly to the scene and stabilising the airway and introducing mannitol. The CT scan could have been bypassed.

My advisor stated that a patient with evidence of intracranial hypertension needs immediate release of the problem. If stabilisation and mannitol are ineffective the CT scan should be bypassed and the patient moved immediately to theatre for surgical intervention. If the CT scan had been bypassed it is possible that Mr Whittaker would have received surgery half an hour earlier than he did.

Continued on next page

Taranaki Healthcare, Dr A, Mrs B, Dr C, Dr D, Dr E, Dr F

Opinion - Case 98HDC13685, continued

Opinion: No Breach Dr F *continued*

In response to my provisional opinion, Dr F referred to my advisor's comments and stated that after he arranged the CT scan he appropriately contacted the consultant. Dr F stated that Mr Whittaker had no difficulty with his airway. Mannitol was introduced within minutes of Dr F examining Mr Whittaker. I am satisfied that, once he had been located, Dr F acted with reasonable care and skill to assess and stabilise Mr Whittaker, and that his decision to arrange a CT scan did not breach Right 4(1) of the Code.

Surgery

Dr F assisted Dr C to perform surgery on Mr Whittaker, reduced Mr Whittaker's fractured and dislocated wrist, and participated in the management of Mr Whittaker in the Intensive Care Unit (ICU). My investigation has found no evidence of concerns regarding the surgery performed on Mr Whittaker or the reduction of his dislocation/fracture. My medical advisor informed me that Mr Whittaker's condition was carefully monitored in ICU. The treatment provided was based on an evidence-based therapeutic strategy, and appropriate diagnoses were made. In my advisor's opinion the treatment provided in the ICU at Taranaki Hospital was appropriate and was unlikely to have exacerbated Mr Whittaker's head injury. The diabetes Mr Whittaker developed indicated the severe and unrecoverable nature of his brain injury by the time Mr Whittaker was admitted to ICU. In my opinion Dr F provided services to Mr Whittaker during surgery and in intensive care with reasonable care and skill and did not breach Right 4(1) of the Code.

Taranaki Healthcare, Dr A, Mrs B, Dr C, Dr D, Dr E, Dr F

Opinion - Case 98HDC13685, continued

Opinion: No Breach Dr D

In my opinion Dr D did not breach Right 4(1) of the Code as follows:

Dr D was the consultant anaesthetist on call for theatre and the intensive care unit at Taranaki Base Hospital from 8.00am on 15 November 1997. Dr D administered the anaesthesia during Mr Whittaker's operation and was involved in monitoring Mr Whittaker while he was in ICU until Mr Whittaker's transfer to Wellington on 16 November 1997. No concerns about the anaesthetic services provided to Mr Whittaker have been raised in the course of my investigation.

My medical advisor informed me that Mr Whittaker's condition was carefully monitored in the Intensive Care Unit. The treatment provided was based on an evidence-based therapeutic strategy, and appropriate diagnoses were made. In the advisor's opinion the treatment provided in the ICU at Taranaki Hospital was appropriate and was unlikely to have exacerbated Mr Whittaker's head injury. The diabetes Mr Whittaker developed indicated the severe and unrecoverable nature of his brain injury by the time Mr Whittaker was admitted to ICU. In my opinion, Dr D provided treatment with reasonable care and skill and did not breach Right 4(1) of the Code.

Taranaki Healthcare, Dr A, Mrs B, Dr C, Dr D, Dr E, Dr F

Opinion - Case 98HDC13685, continued

Other Comments

During the course of this investigation a number of issues have come to my attention which should be addressed. These include:

- Need for National Head Injury Policy for Emergency Departments;
- Effects of alcohol ingestion on potential head injury victims; and
- Staff levels in Emergency Departments.

Affects of alcohol ingestion
The information gathered during the course of this investigation suggests that much of Mr Whittaker's deterioration was attributed to the affects of alcohol. My medical advisor pointed particularly to Mr Whittaker's flailing of his limbs as being attributed to intoxication, rather than being assessed as a change in focal neurology. It is very important that deteriorating head injury status is not mistaken for the effects of intoxication. The research referred to by my advisor indicates that alcohol is unlikely to influence levels of consciousness until the blood alcohol levels exceed 200 ml/L. Where it is known that a patient has been drinking alcohol and has a possible head injury, blood alcohol levels should be taken as a matter of course.

Need for a National Head Injury Policy for Emergency Departments
My medical advisor commented that it is important that national guidelines be developed for Accident and Emergency Departments in relation to the management of head injured patients. I endorse the need for such guidelines, to ensure national consistency in the care of patients who present to Accident and Emergency Departments with head injuries.

Staffing levels in Emergency Departments
After reviewing the numbers of staff on site on 15 November 1997 at Taranaki Base Hospital, my medical advisor concluded that there appeared to be acceptable numbers of both nursing and medical staff available to the A&E department, noting the capacity to call extra staff if required.

Continued on next page

Taranaki Healthcare, Dr A, Mrs B, Dr C, Dr D, Dr E, Dr F

Opinion - Case 98HDC13685, continued

Other Comments ***continued***

My medical advisor stated that it should be recognised that standards of staffing levels (numbers and competency) throughout New Zealand in 1997 were below the standards set by the Australasian College for Emergency Medicine, the British Association for Emergency Medicine and the American College of Emergency Medicine. Although the shortfall relates to funding of Accident and Emergency Departments, it also relates to the lack of a national framework for emergency services that recognises the requirements of a service that provides 24 hour care, seven days a week. My advisor concluded that as a result New Zealand Emergency Departments fall below standards required internationally for the provision of a safe, appropriate and effective service. My advisor noted that standards were even more problematic for rural hospitals, which struggle to have readily available experienced medical and nursing staff on-site or readily available. These issues need to be addressed at a national level.

Taranaki Healthcare, Dr A, Mrs B, Dr C, Dr D, Dr E, Dr F

Opinion - Case 98HDC13685, continued

Actions

I recommend that Mrs B:

- Apologises to Mr and Mrs Whittaker for her breaches of the Code in relation to the care provided to his son, Mr Tommy Whittaker. A written apology should be sent to the Commissioner and will be forwarded to Mr and Mrs Whittaker.
- Reviews her practice in light of the findings of this report.

I recommend that Dr F:

- Apologises to Mr and Mrs Whittaker for his breaches of the Code in relation to the care provided to his son, Mr Tommy Whittaker. A written apology should be sent to the Commissioner and will be forwarded to Mr and Mrs Whittaker.
- Reviews his practice in light of the findings of this report.

I recommend that Taranaki Base Hospital:

- Apologises to Mr and Mrs Whittaker for the breaches of the Code in relation to the care provided to Mr Tommy Whittaker. A written apology should be sent to the Commissioner and will be forwarded to Mr and Mrs Whittaker.
- Develops a written policy stating that where house surgeons are unable contact a registrar within five minutes, a call is to be made to the on call consultant. This policy should be included in all orientation for junior medical staff and for all personnel responsible for staff location.
- Amends the neurological assessment and observation of head injuries protocol and include clear parameters for blood pressure and pulse rate that the nurse is expected to monitor within and, if exceeded, to notify 'on call' medical staff. I recommend that the requirement to monitor focal neurological signs is dot-pointed on the form, as suggested by my medical advisor.
- Amends the neurological assessment form so that GCS score total is graphed as are the blood pressure, pulse rate and respiratory rate findings.
- Reviews its policy on CT scanning following head injury with reference to current practice in other New Zealand hospitals, including centres offering a neurosurgical service.

Continued on next page

Taranaki Healthcare, Dr A, Mrs B, Dr C, Dr D, Dr E, Dr F

Opinion - Case 98HDC13685, continued

Actions *continued*

CT scanning protocol

From the table '*Who to Scan*', in the article by Kramer and Richman referred to by my medical advisor, it seems that Mr Whittaker had at least five 'high risk factors' for a head injury (external signs of trauma, serious painful distracting injury, unreliable/unknown history of injury, vomiting, recent ingestion of intoxicants). Of the eleven low risk factors Mr Whittaker reliably had four on admission (no focal neurological signs, normal pupils, an initial GCS of 14 or 15, and intact orientation and memory). In my opinion 'No change in consciousness' could not be considered reliable information given that the witness, Mr Whittaker's friend, had to descend from the City Centre building before reaching Mr Whittaker, and was himself intoxicated.

In addition to the obvious high risk signs listed above, Mr Whittaker also had an undetected skull fracture and possibly went on to develop focal neurological signs given the limb movements observed by his mother, although this cannot be confirmed. The table indicates that a CT scan should be performed when a patient presents with a GCS of 14 or 15 in addition to high risk factors. Had this criteria been in place at Taranaki Hospital, Mr Whittaker, on admission, would have met the criteria for a CT scan on 15 November 1997.

These criteria are markedly more comprehensive and cautious than the CT scan policy in place at Taranaki Base Hospital at the time of Mr Whittaker's injury. I acknowledge that Taranaki Base Hospital has amended its CT scan policy as a result of Tommy Whittaker's death. However, I recommend that it consider adopting Kramer and Richman's criteria as its CT scan policy for patients presenting with a head injury.

Taranaki Healthcare, Dr A, Mrs B, Dr C, Dr D, Dr E, Dr F

Opinion - Case 98HDC13685, continued

Other Actions

- A copy of this opinion will be sent to the Medical Council of New Zealand.
- A copy of this opinion will be sent to the Nursing Council of New Zealand.
- A copy of this opinion, with personal identifying features removed, will be sent to the Minister of Health.
- A copy of this opinion with personal identifying features removed, will be sent to the Director-General of Health, with the recommendation that the Ministry of Health consider funding the development of national head injury guidelines and national CT scan referral guidelines for patients with head injuries. I further suggest that the Ministry of Health review staffing levels in A&E departments in public hospitals to ensure that staff numbers and staff competence are such that patients can be confident that they will receive safe, effective and quality care on presentation at A&E departments, particularly those in rural areas.
- A copy of this opinion, with personal identifying features removed, will be sent to the Australasian College of Emergency Medicine.
- Copies of this opinion, with personal identifying features removed will be sent to all Accident and Emergency departments in public hospitals in New Zealand.
- A copy of this opinion, with personal identifying details removed will be sent to Quality Health New Zealand.
- A copy of this opinion, with all personal identifying features removed, will be sent to St John's Ambulance Services.

Other Comments

I acknowledge that in the time which has elapsed since Mr Whittaker's death Taranaki Healthcare has implemented changes to its staffing that includes the availability in A&E of experienced doctors who are on duty 24 hours a day. My advisor has informed me that this practice exceeds the overnight expertise currently available in many New Zealand emergency departments. I accept that, until national standards for New Zealand emergency departments are developed, this is an appropriate arrangement.