



Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

**Te Whatu Ora breaches Code in care of man who died following incorrect
intubation
21HDC02785**

The Deputy Health and Disability Commissioner has found Hawke’s Bay District Health Board (now Te Whatu Ora Te Matau a Māui) breached Right 4(1) of the Code of Health and Disability Services Consumers’ Rights. The breach relates to its failure to provide services of an appropriate standard to a man who died after suffering a severe hypoxic brain injury sustained from an incorrect intubation.

The man had been taken to Hawke’s Bay Fallen Soldiers’ Memorial Hospital for the treatment of two wounds to his back. As the impact of his wounds was unknown, a decision was made to perform a series of CT scans to check for internal injuries. Because of his agitated state, the man was anaesthetised to be able to insert a breathing tube into his trachea.

The procedure was performed in the emergency department where, unfortunately, the tube was incorrectly placed in the man’s oesophagus instead of his trachea. This error was not picked up for 15 minutes and, during that time, the man sustained a fatal brain injury. Following a successful intubation, the man was placed in the intensive care unit for 15 days until his ventilation was removed and he passed away.

In her decision, Dr Vanessa Caldwell commended the man’s whānau for raising their concerns. “I acknowledge Mr A – Te Tangata. Nō reira ka tuku a mātou nei aroha, a mātou nei rangimarie ki a koutou katoa – Mauri Ora.”

She identified several factors that contributed to the man’s death. These included a lack of standardised equipment, superior equipment not being made available and staff members believing that certain equipment was not functioning properly.

“I am critical that Te Whatu Ora did not ensure that there was suitable equipment for difficult airway management available in the ED, and that there was a lack of standardised equipment across the hospital. I am also critical that the staff were not made aware of the equipment that was available, and that the staff were not reassured that the equipment was functional and being maintained adequately. In my view this contributed to the delay in diagnosing the oesophageal intubation.”

In response to his whanau questioning consent not being obtained prior to the procedure, Dr Caldwell noted “Given the emergency situation following Mr A’s arrival in the ED, the decision to intubate was necessary, and in these circumstances it is reasonable that Mr A’s consent could not be sought at the time.”

Te Whatu Ora Te Matau a Māui has made several changes since the event. These include purchasing new equipment and forming an airway committee comprising

anaesthetics, ICU, ED and ear, nose and throat departments. The committee has reviewed and standardised airway equipment between ED, ICU and the operating theatre. It has also established an equipment testing and checking regime, developed difficult intubation, and airways checklists, and reviewed the ED red alert response. Interdepartmental simulation training has also been put in place.

Dr Caldwell has recommended Te Whatu Ora provide a written apology to the man's whānau and put in place regular training for all current staff in ED and ICU on the standard practice in emergency airway management.

29 April 2024

Editor's notes

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

The full report of this case can be viewed on HDC's website - see HDC's '[Latest Decisions](#)'.

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

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

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

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

[Read our latest Annual Report 2023](#)

Learn more: [Education Publications](#)

For more information contact:

Communications team, Health and Disability Commissioner

Email: communications@hdc.org.nz, Mobile: +64 (0)27 432 6709