Death of woman presenting with symptoms of headache and gastroenteritis (01HDC08153, 13 May 2003)

Public hospital ~ Emergency Department ~ General practitioners ~ Medical centre ~ Missed diagnosis of brain haemorrhage ~ Response by general practitioners ~ Sudden death ~ Right 4(1)

A woman's whanau complained about the services she received from an Emergency Department and a medical centre. The 38-year-old patient presented with common symptoms but was actually suffering from a life-threatening subarachnoid haemorrhage. The complaint was that at the Emergency Department a doctor failed to diagnose a brain haemorrhage and a nurse failed to recognise the seriousness of the patient's condition and respond appropriately. It was also alleged that the medical centre failed to recognise that urgent medical assistance was required and to respond appropriately when the patient's mother telephoned. In addition, the complaint was that one GP at the medical centre failed to follow up on blood tests, and another GP, when the patient's mother called her, failed to appreciate the patient's condition, further investigate the causes of her symptoms and refer her for further immediate investigation.

The Commissioner held that the Emergency Department did not breach Right 4(1) by not further investigating the cause of the patient's headache, or by not determining that the headache was caused by a brain haemorrhage, because in the absence of information suggesting that the headache was representative of a more serious underlying illness, it was difficult to make a diagnosis of subarachnoid haemorrhage, and the patient had other symptoms more indicative of a gastroenteritis-type illness, with a headache due to dehydration. The decision to discharge her home was reasonable. In addition, because it is very difficult for a nurse to make an assessment over the telephone, it was held appropriate for her to advise the patient's mother to contact the GP.

The first GP at the medical centre did not breach Right 4(1) as there was no obligation to undertake further investigation once the blood tests came back negative; his diagnosis was consistent with the patient's presentation and his management was appropriate. The second GP who was telephoned did not breach Right 4(1) as the previous doctors had had the opportunity to physically examine the patient, and there were no new symptoms on which to base a diagnosis, or any information indicating the need for immediate further investigations, so it was reasonable for her to indicate that there was little more that she could do at that time.

The tragic but critical fact was that the patient never displayed any clinical signs or symptoms that pointed specifically to a brain haemorrhage, and her symptoms remained consistent with the initial diagnosis. The Commissioner commented that no one was at fault — the brain haemorrhage simply did not manifest itself in a way that made diagnosis reasonably possible.