

Failures in care provided to man whose condition deteriorated following surgery

1. On 16 June 2022, the Health and Disability Commissioner (HDC) received a referral from the Coroner in relation to the death of Mr B (aged 62 years). Mr B was admitted to Gisborne Hospital (Health New Zealand | Te Whatu Ora Tairāwhiti [Health NZ]) on 16 July 2019 for an elective ileostomy¹ and ileosigmoid anastomosis procedure.² The Coroner raised concerns about the standard of care provided in the Intensive Care Unit (ICU). Mr B was admitted to the ICU after the surgery but, days later, developed respiratory distress and went into cardiac arrest. Sadly, Mr B died³. I extend my sincere condolences to Mr B's whānau for their loss.

Information gathered

Summary of events leading to Mr B's death

2. On 16 July 2019, Mr B underwent an uneventful elective ileostomy and ileosigmoid anastomosis procedure for reversal of a previous ileostomy. This was performed by Dr A, surgeon. The plan after surgery was to send Mr B to the ward for recovery; however, he was heavily sedated with an intraoperative dose of morphine⁴ so was given naloxone⁵ and admitted to the ICU for observation.
3. At 7am on 17 July, a house officer (junior doctor) assessed Mr B because his blood pressure was low. He was given intravenous fluids, which improved his blood pressure. An anaesthetist reviewed him at 7.30am, after which Mr B was given a unit of red blood cells because bloody fluid was found in his abdominal drain and his haemoglobin⁶ levels had dropped. Mr B's Glasgow Coma Scale score⁷ remained at 15/15, indicating that he was fully awake, and his blood pressure remained stable, although he was noted to be sleepy.
4. On 18 July, Mr B's haemoglobin was noted as stable, and he was alert and tolerating clear fluids orally. At this stage, Mr B's abdomen was soft and non-distended, and he was mobilising throughout the day. Dr A reviewed Mr B at 4.30pm, and he was advanced to a light diet.

¹ A surgical procedure that creates an opening, or stoma, on the abdomen. The end of the small intestine is brought through the skin, allowing digestive waste to exit the body into an external pouch.

² Converts the proximal colon into a blind intestinal segment that is excised during surgery.

³ An autopsy established that the cause of Mr B's death was aspiration pneumonitis (a lung inflammation that occurs when stomach contents or other sterile fluid is inhaled into the lungs, causing a chemical burn and inflammatory response) secondary to postoperative paralytic ileus (temporary inability of the gastrointestinal tract to function normally after surgery).

⁴ Medication used to treat severe pain.

⁵ A medication used to rapidly reverse an opioid overdose.

⁶ An iron-containing protein in red blood cells that carries oxygen from the lungs to the body's tissues.

⁷ A tool used to assess a person's level of consciousness.

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5. On 19 July, nursing notes state that Mr B had been agitated and restless all night and that his respiratory rate had increased, with readings ranging from 20 to 28 breaths per minute between 7pm and 5am.⁸ At 5am, nursing notes document that Mr B was coughing up sputum⁹ and green fluid, indicating that his condition was deteriorating. Health NZ told HDC that, at the time, the Early Warning Score (EWS) pathway¹⁰ was being used in other departments but not in the ICU. The EWS pathway recommends monitoring of vital signs (such as respiratory rate) every four hours for patients with acute illness and up to every hour if the patient is showing signs of deterioration. The clinical notes show that Mr B's respiratory rate was taken seven¹¹ times between 7pm on 18 July and 5.30am on 19 July. Between 6am and 8.30am, Mr B's respiratory rate was taken five¹² times, with readings between 28 and 40 breaths per minute.
6. A house surgeon called to review Mr B noted that he was short of breath, cold, and clammy. The house surgeon also noted their impression of Mr B as possibly experiencing aspiration¹³ or pulmonary embolism¹⁴ and recorded a plan for intravenous antibiotics, a chest x-ray, further blood tests – including the D-Dimer test¹⁵ – and anaesthesia and surgical review.
7. At 7.35am, nursing notes state that Mr B was given further oxygen but that he was 'yet to have' a chest x-ray and/or the further blood tests. It is unclear from the information available whether the further investigations were ordered. In addition, senior staff other than the anaesthetist (such as a Senior Medical Officer [SMO] and/or a surgeon) were not contacted to review Mr B.
8. The anaesthetist on call reviewed Mr B in person at around 8.45am. He was noted to be in respiratory distress and complaining of increasing back pain. While a Bilevel Positive Airway Pressure¹⁶ machine was being set up, Mr B vomited and went into cardiorespiratory arrest.¹⁷ Cardiopulmonary resuscitation was commenced for 20 minutes but was unsuccessful.

Internal reviews

9. Health NZ completed an Event Report and Serious Event Review (SER) in 2019 after Mr B's death. The internal reviews made the following findings:

⁸ Normal respiratory rate is around 12–20 breaths per minute.

⁹ Mucus coughed up from the lower airways and lungs.

¹⁰ A national system to detect and respond to patient deterioration.

¹¹ At 7pm (24), 9pm (20), 11pm (22), 12am (24), 2am (22), 4am (20), and 5am (28).

¹² At 6am (36), 7am (30), 7.30am (28), 8am (30), and 8.30am (40).

¹³ A condition in which food, liquids, saliva, or vomit is breathed into the airways.

¹⁴ A life-threatening blockage in a lung artery, most often caused by a blood clot.

¹⁵ A blood test that detects fragments released when the body breaks down a blood clot. A positive result suggests increased clot formation and breakdown, but it can also indicate other conditions such as pregnancy, infection, or surgery.

¹⁶ A non-invasive breathing support device that delivers two different air pressures to the user via a mask.

¹⁷ The sudden and complete cessation of effective heart function and breathing, resulting in a lack of blood circulation and oxygen to the body's organs.

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- There was a lack of clear responsibility/ownership for patients in the ICU and a lack of clarity around how, and to whom, a deteriorating patient in ICU should be escalated.
- The EWS pathway was not being used in the ICU, and it was left to staff to determine when to escalate a deteriorating patient.
- Dr A was not consulted about Mr B's condition.
- There may have been barriers to staff contacting the on-call SMO to escalate Mr B's care, and the SMOs seem to have been unaware of Mr B's poor state.
- There was a delay in seeking a chest x-ray when Mr B's condition was deteriorating, and staff may have been delaying ordering such investigations to 'protect the resource'.
- 'The problems in ICU are much deeper than just "safety out of hours", of which this is a product, and affect patient care at all hours of the day. Such problems include: 1. A lack of detailed medical input and direction, 2. Deficient nursing management and leadership, 3. Lack of nurse education and "best practice", 4. A lack of policy, procedures and guidelines.'

10. The internal reviews made the following recommendations:

- Provide more support for nurses and house surgeons out of hours by increasing skilled nursing levels in the ICU and rostering registrars to provide timely review and management of deteriorating patients.
- Provide training, education, and support of nursing and junior doctor staff to recognise a deteriorating patient and be empowered to escalate concerns with prompt communication and clear handover.
- Implement EWS in the Emergency Department and the ICU to promote recognition of a deteriorating patient and empower staff to escalate concerns appropriately.
- Address the night-time culture of 'do not disturb' the off-site call-back staff to protect their down time.
- Formulate robust guidelines for good nursing/clinical care in standard situations, such as this case, with clear identification of red flags to signify potential for serious clinical complications.

Implementation of recommendations

11. Health NZ told HDC that it was unable to locate the 'recommendations implementation plan' because 'key personnel ... have since left [Health NZ]'. The implementation plan would have included all the recommendations, who was responsible for their implementation, and the timeframe for completion.
12. Health NZ provided evidence that some of the recommendations had been implemented, including that the ICU now has its own EWS chart. Health NZ said that staff have been trained in the EWS pathway, and it provided the training package to HDC. Registered nurses are expected to complete mandatory training on the Ko Awatea LEARN platform and are given

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an orientation booklet as part of their orientation. Health NZ said that it has also appointed an Intensivist¹⁸ and a new Charge Nurse Manager (CNM).

13. Health NZ told HDC that the ICU had previously employed an Educator and Clinical Coach but that those roles are currently vacant. Health NZ said that the former ICU Educator developed a professional development/education plan for ICU staff; the ICU leadership (CNM and Intensivist) have been reviewing and discussing the plan with staff and are working towards finalising the ICU professional development/education plan and appointing an Educator to drive the full implementation of the plan.
14. Health NZ said that there is no dedicated ICU quality assurance role but that the CNM is working with staff on quality initiatives and audits. The Quality Auditors from Quality Service are also able to support the ICU in developing and completing ICU-specific audits.
15. Health NZ did not provide information regarding the progress of the following recommendations or evidence that they had been implemented: increasing out-of-hours support, addressing the culture of 'do not disturb' for off-site call-back staff, providing support for nurses by increasing skilled nursing levels in ICU, providing support for house surgeons by rostering registrars to review and manage deteriorating patients, or implementing the EWS in the Emergency Department. However, in response to the provisional opinion, Health NZ provided evidence that most of the outstanding recommendations made in its internal reviews had been actioned.

Responses to provisional opinion

Mr B's family

16. Mr B's sister was given the opportunity to respond to the 'information gathered' section of the provisional report, but she did not provide a response.

Health NZ

17. Health NZ was given the opportunity to respond to the provisional report. It provided an update on some of the recommendations made in the provisional report and its internal reviews. In particular, Health NZ advised that it had implemented the following:
 - Since 2019, a medicine registrar training programme has been established to provide overnight coverage and support to junior staff. An SMO or registrar is rostered overnight, and an Intensivist covers ICU calls most nights.
 - Escalation procedures are defined under the EWS Policy and ICU Patient Management and Admissions Policy.
 - Escalation pathways are embedded in the ICU Patient Management and Admissions Policy and the RMO Handover Policy.
 - The Clinical Education Team now runs a 'deteriorating patient' study day and monthly resuscitation simulations for staff. ICU staff receive refresher training, and the ICU CNM

¹⁸ An Intensivist, also known as a critical care doctor, is a medical practitioner that specialises in the care of critically ill patients, most often in an ICU.

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sits on the Resuscitation and Deteriorating Patient Committee to ensure learnings are fed back to staff. A Patient at Risk team is being established in 2026.

- EWS is now fully implemented across the hospital, including the ICU (since 2020). Audits are conducted monthly as part of the Te Tāhū Hauora Health Quality & Safety Commission programme, and work continues to ensure accurate scoring and consistent escalation documentation.
- The revised EWS and ICU policies mandate escalation of any deteriorating patient and reinforce a safety-first culture that eliminates the previous 'do not disturb' practice.
- The EWS system now acts as a red-flag tool for clinical deterioration and is supported by updated ICU admission guidelines and escalation pathways to ensure that patients are identified and managed appropriately.

Opinion

Appropriateness of clinical care – breach

18. After carefully reviewing the SER and agreeing with its findings, I proposed to Health NZ that HDC adopt the findings of Health NZ's internal reviews. I also proposed that I find Health NZ in breach of Right 4(1)¹⁹ of the Code of Health and Disability Services Consumers' Rights (the Code), as Health NZ had acknowledged a lack of clear responsibility/ownership for patients in the ICU, that the EWS pathway was not being used in the ICU and staff were left to determine when to escalate a deteriorating patient, that there may have been barriers to staff contacting the on-call SMO to escalate Mr B's care, and that there was a delay in seeking a chest x-ray when Mr B's condition was deteriorating. Health NZ accepted HDC's proposed breach finding.
19. In my opinion, there was a systemic failure to ensure that Mr B's deteriorating condition on the morning he passed away was recognised and appropriately escalated and investigated. In my view, the findings of the SER detailed above highlight the systemic deficiencies that led to the failures in Mr B's care. As such, I find Health NZ in breach of Right 4(1) of the Code.

Implementation of recommendations for improvement – adverse comment

20. Health NZ identified several recommendations for improvement as a result of its 2019 internal reviews.
21. Health NZ told HDC that it was unable to locate the 'recommendations implementation plan', which included all the recommendations, who was responsible for their implementation, and the timeframe for completion. I am concerned about this inability to locate the plan.
22. Despite this, Health NZ provided evidence that some recommendations had been implemented. However, given that six years have passed since the internal reviews, I am concerned that several recommendations are yet to be implemented and that it remains unclear what action is being taken to complete them. I acknowledge that, in response to the

¹⁹ Right 4(1) of the Code states that 'Every consumer has the right to have services provided with reasonable care and skill'.

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provisional opinion, Health NZ provided evidence that most of the outstanding recommendations have now been implemented; however, the extensive delay in taking these remedial actions is of concern.

Recommendations and follow-up actions

23. In the provisional opinion, I recommended that Health New Zealand | Te Whatu Ora Tairāwhiti:
 - a. provide a written apology to Mr B's whānau for the failings identified in this report. The apology is to be provided to HDC within three weeks of the date of this report for forwarding to Mr B's whānau;
 - b. develop a new recommendations implementation plan for the remaining recommendations (as outlined at paragraph 15), with a timeline for completion of each recommendation. Health New Zealand | Te Whatu Ora Tairāwhiti is to provide the recommendations implementation plan to HDC, along with an update of its progress on the remaining recommendations, within three months of the date of this report;
 - c. provide HDC with an update on its recruitment of the ICU Educator and Clinical Coach roles, provide a copy of the professional development/education plan for ICU staff, and provide a copy of the quality audit schedule for the ICU, within six months of the date of this report.
24. In response to the provisional report, Health New Zealand | Te Whatu Ora Tairāwhiti provided evidence that recommendations 23(b) and most of recommendations in 23 (c) had been completed, and it provided a written apology to Mr B's whānau for forwarding as per 23(a). Accordingly, I recommend that Health New Zealand | Te Whatu Ora Tairāwhiti provide an update on its recruitment of the ICU Educator and Clinical Coach roles, and the plan to provide more support for nurses by increasing skilled nursing levels in ICU, within six months of the date of this report.
25. A copy of this report with details identifying the parties removed, except Health New Zealand | Te Whatu Ora Tairāwhiti and Gisborne Hospital, will be placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

Dr Vanessa Caldwell
Deputy Health and Disability Commissioner

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