Emergency Medical Officer, Dr E

Midwife, Ms F

Tairawhiti District Health Board

A Private Medical Company

A Report by the

Health and Disability Commissioner

(Case 04HDC04456)

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

Parties involved

Baby A	Consumer
Ms A	Complainant/Consumer's mother
Mr B	Consumer's father
Mrs C	Complainant's mother
Mrs D	Mr B's mother
Dr E	Provider/Emergency Department medical officer
Ms F	Provider/Independent midwife
Dr G	General Practitioner
Dr H	Medical Director, the private medical company, and Medical Director of Gisborne Hospital Emergency Department
Dr I	Director, the private medical company
Ms J	Manager Quality and Risk, Tairawhiti District Health Board
Dr K	Consultant Paediatrician
Dr L	General manager, the private medical company

Complaint

On 19 March 2004, the Commissioner received a complaint from Ms A about the care Ms F, midwife, Dr E, Emergency Department medical officer, a private medical company ("the Company") and Tairawhiti District Health Board provided to her daughter, Baby A. The following issues were identified for investigation:

Dr E
Whether on 4 January 2004 Dr E provided Baby A with services of an appropriate standard. In particular:

- *whether Dr E's assessment of Baby A and investigation of her condition was adequate*
- *whether Dr E provided appropriate treatment to Baby A and gave appropriate advice to her family before discharging her.*

Ms F
Whether on 4 January 2004 Ms F provided Baby A with services of an appropriate standard. In particular:

- *whether Ms F's assessment of Baby A was appropriate*
- *whether Ms F responded appropriately to Baby A's symptoms.*

Names (other than Gisborne Hospital, Tairawhiti District Health Board and expert advisors) have been removed to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

The District Health Board
Whether the staff at Gisborne Hospital provided Baby A with services of an appropriate standard following her admission to hospital on 5 January 2004. In particular:

- *whether the investigation of Baby A's condition was appropriate and conducted in a timely manner*
- *whether Baby A was provided with timely and appropriate treatment.*

Whether the staff at Gisborne Hospital kept Baby A's family adequately informed. In particular:

- *whether between 5 and 9 January 2004 adequate and timely information on Baby A's condition and the results of tests and investigations was provided to her family.*

An investigation was commenced on 9 August 2004. The Company was notified of the complaint on 24 September 2004.

Information reviewed

Information was received from:

- Ms A, consumer's mother
- Ms F
- Dr E
- Dr H
- Ms J
- Dr G
- Baby A's Well Child Health Book and clinical records from Gisborne Hospital.

The Company provided copies of relevant policies, and Tairawhiti District Health Board provided copies of relevant policies and procedures to accompany its response and the clinical records.

The following responses to my first provisional opinion were received:

- Tairawhiti District Health Board, dated 31 May 2005
- Dr H, on behalf the Company, dated 27 May 2005
- Dr L, on behalf of the Company, dated 26 May 2005.

Names (other than Gisborne Hospital, Tairawhiti District Health Board and expert advisors) have been removed to protect privacy. Identifying letters are assigned and bear no relationship to the person's actual name.

The following responses to my second provisional opinion were received:

- Tairawhiti District Health Board, dated 5 August 2005
- New Zealand College of Midwives (on behalf of Ms F), dated 8 August 2005.

Independent expert advice was obtained from Dr Scott Pearson, emergency medicine physician, and Ms Terryl Muir, midwife. The ACC Medical Misadventure Unit provided its records relating to Baby A's claim, with independent expert paediatric advice from Dr Thorsten Stanley.

Information gathered during investigation

Pregnancy

Ms A's pregnancy in 2003 was uneventful. Her lead maternity carer (LMC) was independent midwife Ms F. Ms F noted in the antenatal records for Ms A that she took a vaginal swab on 2 October 2003, which cultured a scant growth of Streptococcus B.

Ms F works in a decile 1 area and the majority of her patients are high risk. She said that Ms A was referred to her by the Women's Health Clinic as a high-risk mother. Ms A had already received surgical treatment by an obstetrician, as a day-stay patient, for vaginal warts, and because of these factors Ms F took the vaginal swab. Ms F said that Gisborne Hospital has a protocol that applies when a mother is found to be Group B Streptococcus positive. The mother is to be given a single one-gram dose of intravenous amoxycillin during the course of labour, which is to be repeated if the labour goes over six hours. Ms F followed the protocol and gave Ms A a gram of amoxycillin, but as she delivered within six hours she was not given the second dose of amoxycillin. (The antibiotic therapy is noted in the clinical notes on the "Infant Summary".)

Postnatal period

Baby A was born at Gisborne Hospital at 10.30pm on 7 December 2003 following an uneventful labour and delivery. Baby A weighed 3780g at birth and had a normal Apgar score of 9. Within half an hour of the birth, Ms A was able to breastfeed Baby A. Ms A took her baby home the following day.

Ms F saw Ms A for her first home visit on 8 December. She visited the following day and again on 12 and 13 December, noting that Baby A was feeding and progressing well. Ms F did not see Baby A between 15 December 2003 and 4 January 2004 because Ms A did not keep pre-arranged visits, return telephone calls or respond to notes left requesting that she contact Ms F.

Emergency Department presentation
Baby A became ill early in the morning of 4 January 2004. Ms A recalled:

> "On Sunday January 4th 2004 the time was 4.45am, the father of my baby with his mother took the baby to Gisborne Hospital for a medical check up. She wasn't looking well at all. My boy-friend and mother-in-law thought it might have been the hot summer weather."

Dr E, medical officer, was on duty at Gisborne Hospital emergency department on 4 January 2004 when Mrs D and Mr B (the baby's grandmother and father) brought Baby A in to be seen. Dr E had been working under contract to the Company as a full-time casualty medical officer at Gisborne Hospital from October 2003.

Dr E recalled that Mrs D and Mr B's primary concern was that Baby A was feverish and had not been taking her feeds well for about 24 hours. The registered nurse who assessed Baby A noted that she had taken only three 60ml bottles of infant formula in the last 24 hours instead of her normal six to eight 60ml bottles. Baby A was "hot to touch, sleepier than usual and fretful". The nurse noted that Baby A had not vomited, had no diarrhoea, that there had been the normal number of wet napkins, and her urine was normal — no blood or offensive smell. Her temperature was elevated at 38.5ºC (normal is 37ºC) but she did not have a rash. Baby A's weight was recorded as 8lb 5½oz and that her weight two weeks earlier had been 7lb 11oz.

Dr E conducted a full neurological examination on Baby A, as well as cardiovascular, respiratory and abdominal examinations. During the course of his examination of the baby, he picked her up out of her baby-carrier to evaluate her back and extremities. Baby A appeared well and Dr E could find no evidence of any abnormality. He considered that Baby A's symptoms could be due to the significant summer heat that the region had experienced over the previous 24 hours.

Dr E documented the following history:

> "4/52 old child
> + pyrexia of unknown origin
> not taking feeds N
> + bottle fed"

Dr E informed me:

> "At the time I saw [Baby A] with her father and grandmother in the ED, I was unaware of the health problems her mother faced during her pregnancy. That is, I was completely unaware of the mother having treatment for a Group B streptococcus infection during labour.

> The delivery notes did not form part of the baby's records. At the time delivery notes were not part of the paediatric patient's file and it was regular practice to call for them.
>
> …
>
> During my examination I did specifically consider meningitis as a cause of the fever. However, in the absence of other signs, and the otherwise good clinical presentation I did not consider I was dealing with an acutely unwell child."

Dr E did not prescribe any treatment but he said that he was aware that the nurse telephoned the paediatric ward for advice and was told that paracetamol is not usually given to a child of Baby A's age. Dr E acknowledged that the clinical records do not record this, but stated that he and the nurse discussed this advice. He believed that it was reasonable to rely on the advice provided by the paediatric staff.

Dr E stated:

> "With that advice in mind and the fact that the warm clothing and blankets had been removed, I expected [Baby A's] temperature would decrease. On the basis of my own clinical examination I also considered that paracetamol was unwarranted at that stage."

Before they went home, Dr E instructed Baby A's father and grandmother "to keep an eye on her" and to continue the cooling measures and tepid sponging to decrease her temperature. He advised the family to watch for any display of abnormal behaviour such as overt floppiness, failure to feed or vomiting, any new skin rash or increase in muscle tone. Dr E does not recall whether the family was given an information sheet. He said that while he was writing up his notes of his assessment the nurse reinforced to the family his advice on cooling and that they should contact their general practitioner or return to the Emergency Department if Baby A did not improve, or if her condition deteriorated.

Midwife's home visit

The baby's condition did not improve after she returned from the hospital, and at about 4.30pm on 4 January Ms A telephoned the midwife to discuss her concerns. Ms A told Ms F that Baby A had a temperature and was fitting, and that she had been assessed at Gisborne Hospital emergency department earlier that morning for the same symptoms. Ms A told Ms F that the emergency doctor had said to keep Baby A cool.

Ms F stated that because of the urgent nature of the telephone conversation, she told Ms A she would visit as soon as possible and instructed her to run a cool bath and immerse the baby in the water until she arrived.

Ms F arrived at the address within 20 minutes. She was surprised to find that the baby had a wet flannel on her head and was still clothed in a "stretch-and-grow", and that Ms A had not run the bath as directed. Ms F recalled that Baby A was twitching and making "fretful

noises". She said that it was a hot day and, although Ms A had a fan going in the small flat, it was very hot.

Ms F examined Baby A and found that she was hot to touch and flushed. She was distressed, her facial muscles were twitching, but her overall muscle tone was not rigid. Ms F assessed her hydration status, noting that her anterior fontanelle tension was normal — it was neither shrunken nor retracted or bulging. (If the fontanelle — the soft spot on the head of a young baby — had been shrunken, it would have indicated dehydration. A bulging fontanelle can be a sign of brain abnormality.) While Ms F was examining the baby, she asked Ms B about their trip to Gisborne Hospital at 5am. Ms B did not have any documentation from the assessment and told Ms F that the baby was no worse than she had been at that time.

Ms F stated:

> "I would have expected [Baby A] to have reasonable checks and tests done in A&E before she was discharged that day. I had no information stating otherwise. All the whanau said was that they were to take her home and keep her cool.
>
> Around that time at Gisborne Hospital — there was a new administrative protocol for all midwives to include copies of the mother's obstetric admission, obstetric record, a copy of the labour and birth summary, and a copy of the baby summary page at the back of the mother's notes for access by hospital staff to be used in making up the baby's file. I therefore assumed that the hospital staff in A&E would have access to this information, which included information about the scant Group B strep found on the vaginal swab and the antibiotic administration during labour, while [Baby A] was being assessed in A&E."

Ms F removed Baby A's stretch-and-grow and immersed her in a bath of cool water. She also asked Ms A to cool some boiled water to give to Baby A in a bottle. Ms F recalled that after 30 minutes Baby A was calm and not hot to touch. She instructed Ms A to give Baby A extra fluids, dress her in a napkin only and lie her on the couch, as opposed to her cot, so that cool air from the fan could blow over her.

Ms F discussed with Ms A (and wrote her instructions in the Well Child book) that, if Baby A became worse or stopped feeding, or if they were worried, they were to take her back to the Emergency Department. Baby A was calm and asleep when Ms F left at 6pm. Ms F arranged to call again the following morning.

Hospital admission

At about 11.30am on 5 January Mrs A took Baby A to the health centre where she was seen by the general practice locum. The locum noted:

> "4 week old who has felt hot since yesterday am. Brought into A and E yesterday at 5am. Had a temp of 38 but was checked by doctor and told to bring back if worse.

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Hasn't fed since this 3am. Put bottle into mouth but won't suck. Has funny shakes and postures. Still feels very warm. Pregnancy and delivery were normal.
Temp 38.4 tympanic
Sick looking child, groaning
Increased tone in legs and arms. Fontanelle bulging
Chest clear. HS normal. No rash visible
Assess: ? infection, meningitis
Plan: Send to Gisborne Hospital, paeds [Dr K]."

The locum alerted Dr G, the senior medical practitioner at the health centre, to her concerns about Baby A. Dr G stated, "Although I suspected that she had meningitis, I didn't pick her to be as sick as she was. However, she was shipped off immediately to the Paeds Dept at Gisborne Hospital."

Dr K, consultant paediatrician, saw Baby A as soon as she arrived at Gisborne Hospital Paediatric Department at midday. Dr K stated that Baby A was "obviously a sick child, with pyrexia, pallor and tachycardia. She was also stiff with an arching back and 'staring' with a full fontanelle."

Ms F called to see Baby A on the morning of 5 January and found no one at home. She contacted the hospital and was told that Baby A had been admitted.

Hospital treatment
Dr K diagnosed severe sepsis with probable meningitis. An intravenous line was sited and bloods taken and sent for full blood count, glucose, chemical analysis and cultures. Baby A was commenced on intravenous ceftriaxone and amoxycillin (antibiotics) and started on intravenous fluids. A urine sample was taken and a lumbar puncture was performed.

The investigations confirmed that Baby A was suffering severe sepsis and meningitis; the causative organism was found to be Group B Streptococcus. CT scans were performed on Baby A's brain on 7 January which showed severe structural abnormalities. Dr K asked a consultant paediatrician at another city hospital to review the scans. This second consultant paediatrician agreed with Dr K's findings, and advised that Baby A's long-term prospects were poor and recommended three weeks of antibiotics. Baby A's family were informed of her condition.

Baby A completed three weeks of antibiotics and, although her temperature improved and her blood chemistry improved, she remained stiff, did not follow movement and was unable to suck, needing to be fed by nasogastric tube.

On 28 January, Baby A developed a further fever. Repeat CT scans were performed and reviewed by the second consultant paediatrician. They showed destruction of almost all of the brain tissue.

Baby A's prognosis
Dr K described Baby A's prognosis as follows:

> "The opinion from [the city hospital] (and also ourselves) was that the brain was severely damaged, the long-term prognosis in terms of neurodevelopmental outcome was bad, she would have quadriplegic cerebral palsy, she would not walk, talk, not live dependently. She will need all her daily cares provided by others.
>
> …
>
> [Baby A] was finally discharged home on 11th Feb 04. She was continuing to be tube fed and remained stiff with little visual response. Family have been offered support and have been fully informed of her prognosis. She will continue to need regular input from the visiting neurodevelopmental therapist and dietician, and regular follow-up by myself."

The Company contract for Gisborne Hospital ED
Tairawhiti District Health Board contracts the Company to provide medical staffing of the Emergency Department at Gisborne Hospital, an arrangement which commenced on 19 January 1998. A copy of Schedule A of the contract is attached as Appendix 2. Schedule A, "Services To Be Provided (the Services)", sets out medical staff competencies.

The contract in Schedule F, "General Terms", point 2 states:

> "Review of Clinical Practice
>
> [The Company] will participate in THL's [Tairawhiti Healthcare Ltd] system of clinical practice review. The emphasis of the system will be upon the development, implementation, management, revision and monitoring of best practice procedures and systems. THL will provide [the Company] with clinical management protocols for the management of clients who present to A&E and may require specialist services."

Dr H, Medical Director of the Company, explained Dr E's employment and orientation:

> "[Dr E] [worked] under contract to [the Company] with [the Company] in turn providing medical staff under contract to TDHB [Tairawhiti District Health Board].
>
> I provide supervision for [Dr E] and am an agent for [the Company] here in Gisborne. … [Dr E] arrived in Gisborne on 1st of October 2003. On each of the first two days of his arrival into Gisborne, [Dr E] and I spent several hours, one on one, discussing matters pertinent to his new position. These matters included … the orientation/induction process for [Dr E]. … [Dr E] was also taken on a guided tour of the Emergency Department (ED) and greater hospital by myself where he was shown through the different departments, introduced to staff members, and further explanation of accessing investigations and services given. In the guided tour of ED, the existence and location of ED guidelines and protocols were demonstrated to him. The existence

and location of the 'paediatric guidelines' were indicated to [Dr E] although the protocol relating to the management of fever in a child was not identified specifically.

[Dr E's] first three shifts were 'buddy' shifted meaning that he was rostered on with another casualty officer in a supernumerary role. This allowed further one on one 'tutelage' as well as an initial period of observation of his colleague progressing to being observed in turn in order to ascertain readiness to work. At the end of three buddy shifts [Dr E] reported a confidence to working without a 'buddy' and the two doctors that had worked with [Dr E] reported that they were confident and comfortable with his level of expertise and that he did not need any further 'buddy' rostering.

…

I can also attest that during [Dr E's] orientation process and in the two months after his arrival [Dr E] was informed of the preference of the paediatricians of Gisborne Hospital for casualty officers to have a low threshold for admitting children into their service, and if in doubt about social supports for children or their clinical condition, then to err on the side of offering admission for observation rather than management as an out-patient. [Dr E] was also made aware of processes for contacting senior medical staff including paediatricians during hours and out of hours."

Responses to Baby A's case

Dr E
Dr E advised:

> "To my knowledge and to the knowledge of the nurse on duty at that time, there were no protocols in existence at the time regarding a child presenting to the Emergency Department with an elevated temperature.
>
> I was completely unaware of the existence of any paediatric protocols, and subsequently discussed that with the nurse involved who advised she was also unaware of any paediatric protocols."

Dr E was apparently not aware of Gisborne Hospital protocol for management of pyrexia of unknown origin (attached as Appendix 1).

The Company
Dr H, who is Medical Director of the Company, is also the Medical Director of Gisborne Hospital Emergency Department. He is a Fellow of Accident Medical Practitioners Association. Dr H advised:

"Following the initial presentation of [Baby A] on the 4th of January 2004 and the subsequent admission with streptococcal meningitis on the 5th of January 2004, a sentinel event review utilising the NZ Standard SNZ HB 8152;2001 was triggered and conducted.

As a direct consequence of this review several outcomes were actioned. These included:

- Formal documentation of familiarity with protocols and guidelines during orientation. A checklist was to be developed to assist orientation processes. Specifically the checklist would include facility to record that any medical practitioner starting work in the ED had been informed of the existence and location of ED and hospital policies and guideline documents. A copy of the checklist developed since the review is attached.
- All children attending the ED under the age of 12 months with a fever were to be admitted into or reviewed by the in-patient paediatric service.
- Increased contact between the ED casualty officers and paediatric services would be instituted. The fortnightly paediatric interactive sessions and paediatric ED discharge sheet review referred to above have occurred since January 2004 and are in no small part related to the above review."

Tairawhiti District Health Board

Ms J, Manager Quality and Risk, Tairawhiti District Health Board advised:

"Information regarding treatments and procedures was provided to [Baby A's] family in an ongoing manner by medical and nursing staff. [Dr K] reported back to [Baby A's] family on discussions with [the city hospital] specialists. This included discussing the proposed treatment plan.

On the 9th of January at the parents' request a family meeting was facilitated to provide all the family with up to date and complete information about [Baby A's] condition and the treatment. This meeting was attended by between 30 to 40 family members.

…

An internal case review was commenced on the 19th of January 2004. The family have not yet [at 7 September 2004] been informed of the outcome of the review due in part to the delay in completing the final report. The paediatric team have regular contact with the family, and intend to discuss the outcome with them now that the report has been completed. We regret the delay.

[Dr E] participated in the review. However, the focus of the review was to examine systems issues rather that the performance of any individual. …

The progress on the recommendations from the internal review have been included in the review documents. In summary the following has been achieved:

- Education regarding the Management of Sepsis in Infants has been provided in the Emergency Department and through the Maternity Services Meeting.
- Orientation for Emergency Department Medical Officers has been improved and also includes a checklist to ensure all areas are covered.
- Further general guidelines for the Management of Paediatric Patients in the Emergency Department have been developed and approved.
- Uploading of paediatric protocols onto the intranet is underway.
- Regular fortnightly meetings have been established to review all paediatric presentations to the Emergency Department. In addition a copy of all Emergency Department discharge summaries are reviewed by the paediatrician.
- [A paediatrician] has assumed the role of ED/Paed liaison.
- Separate clinical records are being established for all newborn infants."

In August 2004, Tairawhiti District Health Board approved an organisational policy for "Management of acute paediatric referrals between emergency department and child health".

In September 2004, the case review into the circumstances of Baby A was reported. The report's opening paragraph stated:

> "The purpose of this report is to provide information about the circumstances and analysis of the systems which may have contributed to the failure to diagnose meningitis of [Baby A] on 4 January 2004, and provide details of the recommendations and actions that Tairawhiti District Health Board (TDHB) has taken as a result."

The review identified the main areas that contributed to the failure to diagnose Baby A's condition and made recommendations on improving awareness of protocols, training in risk awareness regarding Group B Strep, communication between the Emergency Department and paediatrics, and the need for separation of the mother's records from the infant's so that important information is not lost.

Ms A was not sent a letter about the outcome of the case review, although Dr K informed the family of the issues identified by the review.

ACC medical error finding

On 14 October 2004, ACC advised Ms A that her claim on behalf of Baby A had been accepted as medical error on the part of Dr E. Their decision was based on independent expert advice provided by Dr Thorsten Stanley, a paediatrician. Dr Stanley concluded his advice as follows:

> "I have little doubt that [Baby A's] neurological injury was a result of Group B streptococcus meningitis and septicaemia. As discussed, there was a real chance of a

reasonably good outcome had she been admitted when first seen in the early hours of the previous day [4 January 2004].

Even if treatment has started promptly there is still a risk of neurological sequelae in this serious illness. However, I believe the sequelae would have been much milder had they occurred.

…

By the time she saw the midwife apparent seizures had already been seen and several valuable hours lost. Even at this stage however, treatment would have undoubtedly led to a significantly better outcome …. A better partnership between midwives and paediatricians might encourage midwives to seek earlier reassurance when they meet with symptoms they cannot explain.

… Failure to recognise serious signs of sepsis occurred whilst she was in the care of [Dr E] and also, subsequently, whilst in the care of [Ms F].

I also have serious concerns regarding the organisation of the Emergency Department associated with Gisborne Hospital whereby referral of febrile four week babies does not occur directly to the paediatric department. I would also recommend (and this may well have taken place) that protocols or guidelines for the management of children should be readily available in the Emergency Department and a process be put in place whereby these are automatically accessed by staff where an infant or child is seen."

Independent advice to Commissioner

Emergency medicine advice
The following independent expert advice was obtained from Dr Scott Pearson, emergency medicine physician:

"I have been asked to provide an opinion to the Commissioner on case number 04/04456/WS. I have read and agree to follow the Commissioner's Guidelines for Independent Advisors.

I am a Specialist Emergency Physician working full time in a District Health Board Emergency Department. I am a Fellow of the Australasian College for Emergency Medicine and have been since 1996. I have worked at Consultant level in emergency departments in New Zealand, Australia and United Kingdom. I graduated as a medical practitioner in 1988. My qualifications are MB.Ch.B and FACEM. I am currently the New Zealand Regional Censor for the Australasian College for Emergency Medicine.

Background

At 5am on 4 January 2004, 4-week-old [Baby A] was taken by her father ([Mr B]) and paternal grandmother ([Mrs D]) to Gisborne Hospital Emergency Department with a history of fever and not feeding. After the initial triage by the department's nurse, [Baby A] was seen [by] [Dr E], a junior medical officer working under contract to [the Company], which provided medical staff under contract to the DHB. [Dr E] had been working in Gisborne Hospital Emergency Department since October 2003.

[Dr E] examined [Baby A] and noted that an elevated temperature was the only abnormal sign. Although he considered the possibility of meningitis, he ruled it out on the grounds of a normal clinical examination and [Baby A's] normal behaviour. Unable to form a definitive diagnosis, [Dr E] suspected a viral infection to be the cause of the presenting symptoms. Unaware of the hospital's protocol for the management of pyrexia of unknown origin (PUO), [Dr E] discharged [Baby A] with no treatment prescribed. The follow-up advice given to the family was to keep an eye on [Baby A], continue with cooling measures and, if she did not improve, seek medical attention either from a GP or bring her back to the Emergency Department. The family was informed of the signs and symptoms to be on the lookout for.

Later that day, at approximately 4.30pm, [Baby A's] mother ([Ms A]) telephoned her midwife ([Ms F]) and informed her that [Baby A] had a temperature and was fitting ([Ms F] belonged to a Midwives Collective which was contracted by the Ministry of Health to provide 'an appropriate service to meet the needs of 'at risk' clients') … [Ms F] came to the house, examined [Baby A] and noted that she was ' twitching', 'distressed', and making 'fretful noises'. Further attempts were made to cool her down. By the time [Ms F] left at 6pm, [Baby A] was asleep. The family was instructed that should [Baby A] get worse or not drink, to take her back to the Emergency Department. The family was advised to take [Baby A] to their GP the next day and that she herself would return in the morning.

The next day, 5 January 2004, [Baby A] was taken by the family to their GP ([Dr G]) who arranged urgent transfer to the Paediatric Service at Gisborne Hospital. On arrival at the hospital at 11am, [Baby A] was seen by [Dr K], a paediatrician. In view of suspected diagnosis of severe sepsis with meningitis, [Baby A] was immediately commenced on intravenous antibiotic therapy. Blood and CSF tests showed Group B Streptococcus infection.

A CT scan of the brain performed on 7 January 2004 showed severe destruction of brain tissue. As a result, [Baby A] was left with severe and permanent brain damage requiring long term 24-hour care.

In October 2004 ACC's Medical Misadventure Unit accepted the claim as a medical error on the part of [Dr E] (severe brain injury caused by a delay in diagnosing serious signs of sepsis by a health professional).

Supporting Information

I have read and understood the following documents in preparations of this report:

- Letter of complaint from [Ms A] dated 7 December 2003 (pages 1–4 marked 'A'.
- Record of telephone conversation with [Ms A] on 20 October 2004 (page 5) marked 'B'.
- Record of telephone conversation with [Ms A] on 2 November 2004 (pages 6–7) marked 'C'.
- Record of telephone conversation with [Mrs C] ([Ms A's mother]) on 23 July 2004 (pages 8–9) marked 'D'.
- Record of telephone conversation with [Ms D] ([Ms A's] mother-in-law) on 3 November 2004 (pages 10–12) marked 'E'.
- Response from [Dr E] to the Assistant Commissioner dated 27 August 2004 (pages 13–17) marked 'F'.
- Record of telephone conversation with Dr E on 3 November 2004 (page 18) marked 'G'.
- Response from [the Company] ([Dr H]) to the Assistant Commissioner dated 23 August 2004 (pages 19–22) marked 'H'.
- Response from [the Company] ([Dr L]) to the Commissioner dated 26 October 2004 including a letter from [Dr H] to the Medical Council dated 12 September 2003 and [the Company] Medical Officers' orientation programme for Gisborne Hospital (pages 23–29) marked 'I'.
- Letter from [Ms F] (midwife) to the Commissioner dated 23 August 2004 (page 30) marked 'J'.
- Record of telephone conversation with [Ms F] on 25 August 2004 (page 31) marked 'K'.
- Response from [Ms F] to the Assistant Commissioner dated 21 September 2004 (pages 32–35) marked 'L'.
- Response from Tairawhiti District Health Board to the Commissioner dated 7 September 2004 including the letter from [Dr K] to the Commissioner dated 4 February 2004, notes from the meeting of 30 January 2004, audiology report from dated 27 January 2004, review of the case dated September 2004, DHB protocol for management of fever and DHB policy on management of acute paediatric referrals between the Emergency Department and Child Health (pages 36–53) marked 'M'.
- [Ms A's] / [Baby A's] records from [Ms F] (pages 54–65) marked 'N'.
- [Baby A's] 'Well Child Health Book' (pages 66–137) marked 'O'.
- [Baby A's] records from [Dr G], general practitioner (pages 138–141) marked 'P'.
- [Baby A's] records from Gisborne Hospital (pages 142–309) marked 'Q'.
- [Baby A's] records from ACC including reports from [Dr E] dated 26 April 2004, [Ms F] dated 28 April 2004, [Dr K] dated 12 March 2004, [Dr G] dated

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17 March 2004, Dr Scott Pearson (Specialist Emergency Physician — advisor to ACC) and Dr Thorsten Stanley (Paediatrician — advisor to ACC), and ACC decision (pages 310–340) marked 'R'.

Expert Advice Required

To advise the commissioner whether, in your opinion, [Dr E] provided [Baby A] with an appropriate standard of care.

1. Did [Dr E] take adequate history from [Baby A's] family on January 2004?
To answer this question, I should first clarify that there may well be a difference between the history obtained by [Dr E] and the history documented in the clinical record. There will frequently be some variation between the two. However, in commenting on this case, I can only refer to the information available to me — that being the clinical records and the reports provided by various health professionals.

The following history has been documented by [Dr E]:

'4/52 old child
+ pyrexia of unknown origin
not taking feeds N
+ bottle fed'

[Dr E] comments further in his letter to the Commissioner dated 27 August 2004. 'The main presenting symptoms were:

- Feverish for +/- 24 hours
- Drinking less than usual, being 3–4 out of 6 bottles per day'

He also comments that the baby's mother was unavailable and the history was obtained from the baby's father and paternal grandmother. They had described to him that she was not taking all her feeds but when questioned, advised there had been 'no nausea, vomiting or diarrhoea.' [Dr E] was also aware of the triage nursing notes. He states that this contained the following information:

'Born at term, normal vaginal delivery
Breast fed for 1 week only.
No skin rash, plenty of wet nappies.'

There is other information in the triage notes. The information regarding volume of milk is recorded here. Also the triage nurse has noted 'Feels hot to touch, sleepier than usual, fretful.' Further comments note no vomiting nor diarrhoea, and normal urine with no offensive smell or blood. 'Plenty of wet naps' and finally 'no rash' is also documented by the triage nurse.

The information documented by the triage nurse is excellent and serves as a guide as to what historical information can be further explored.
In my opinion, the following information would have been useful:

- mother's antenatal (pregnancy) history. Any problems? Those family members present may have been aware of the vaginal swab result and treatment given.
- 'sleepier than usual' — what is meant by this? Sleeping how much in relation to normal for her?
- 'fretful' — to explore this issue. Ask the caregivers to explain this in more detail. Unusual cry? Irritability?

[Mrs D], during a telephone discussion with HDC, states that before taking [Baby A] (the baby) to hospital, [she] felt warm and let out an unusual cry when placing her hand behind the baby's neck. [Ms A] (mother) states that [Baby A], when brought to her from the hospital, was continually crying. She was 'pale, hot and crying.' [Dr E] makes no mention of unusual behaviour observed by him during his assessment.

I note that [Dr E] assessed [Baby A] somewhere between 0510–0520 hrs on 4/01/04 (the clinical records vary) and then she was discharged from the hospital at 0530 hrs. Exact time of hospital departure may have been closer to 0600 hrs. This is a relatively short time, therefore, for any health professional to observe for evidence of unusual behaviour.

I also note, in [Dr E's] letter of 27 August, that the absence of nausea is noted on 3 occasions. This is not a symptom one would expect to obtain from a 4 week old neonate. This reflects, to me, [Dr E's] relative inexperience in managing neonates.

I believe the history obtained by [Dr E] is inadequate. Whilst I acknowledge that his efforts may have been hampered by the absence of [Baby A's] mother, I believe that the symptoms brought to his attention were not explored in sufficient detail. This may be acceptable if the baby is admitted to hospital and the history will be obtained again by other health professionals. It is unacceptable, in my opinion, if the baby is discharged home. He didn't ask why the baby was brought to hospital at the unusual time of 0500 hrs. What specifically were the family concerned about? More detailed history may have led to admission for a longer period of observation.

2. Should [Ms A's] obstetric records have been assessed at the time of [Baby A's] presentation to the emergency department? If so, who should have organised this?
The obstetric notes provided to me by HDC comment on the scant growth of strep.B on vaginal swab (2/10/03). This is displayed on the front page of the notes under 'Medical History' and again in a different location on the front page. I cannot find reference in the notes to the administration of intravenous amoxycillin during labour but I acknowledge I may not have all clinical notes available.

In terms of gathering information in the assessment and management of the febrile neonate, these obstetric notes are important. The vaginal swab result is very important and may be another trigger to alert the clinician about possible causes of the fever. Ideally, these obstetric records would automatically be requested by Emergency Department administration staff when a patient attends. I can see the relevance of such notes in managing infants < 3 months, pregnant women receiving antenatal care, and postpartum women with a possible obstetric complication. This process may be relatively uncomplicated in a hospital such as Gisborne which has obstetric services and the Emergency Department in the same hospital. The process would be complicated and delayed in those areas where such services are geographically separated.

In conclusion, I believe obstetric clinical records should be available in certain situations (such as this) in the Emergency Department. This issue is not isolated to obstetrics but one can see the relevance of timely access to notes from other departments. This issue needs to be explored in detail by Gisborne Hospital staff. In regards to this case, either the triage nurse or [Dr E] could have requested the obstetric notes.

3. Was the clinical assessment of [Baby A] at triage and by [Dr E] adequate?
A history was obtained and documented by the triage nurse. No vital signs were recorded. This should ideally be done by either the triage nurse or assistant nurse. However I accept that staffing levels may not permit the triage nurse to perform these recordings. However, at some stage during baby [Baby A's] attendance, vital signs should have been recorded. This provides objective information that can be used to follow progress (or decline) and is observer independent. Particularly important in the neonate is an accurate weight.

[Dr E] states other vital signs were taken but not recorded and later notes that the heart rate was approximately 150/minute. He checked the temperature (per axillary) which was 38.5°C. I note that [Dr E] fully undressed [Baby A] during his examination which is to be commended. There was no respiratory distress and fontanelles felt normal. He noted a tachycardia which he felt was due to the baby's elevated temperature. He considered she had normal responses and primary reflexes. No ear/nose/throat examination was performed.

In my opinion, this examination was fair but with notable exceptions. The lack of documented vital signs is difficult to support.

4. Did [Dr E] request or perform adequate and appropriate tests? If not, what tests should have been performed in this situation?
[Dr E] made a diagnosis of fever of unknown origin and recommended cooling cares and follow up with the general practitioner. He later states that he was unable to form a definitive diagnosis. He suspected a viral infection and elevated body temperature due to warm weather and inappropriate clothing. No tests were performed. This is inadequate.

Gisborne Hospital has a protocol for management of febrile infants. It states that any febrile child under 3 months of age, unless remarkably well or has a clear focus of infection, should have blood cultures, urine obtained and a lumbar puncture to obtain cerebrospinal fluid. I would also regard a chest X-ray as part of this investigation screen. Antibiotics should then be commenced pending culture of the above samples for 48 hours. I attach 3 references which emphasise appropriate management pathways for febrile neonates where no focus is apparent.

5. Did [Dr E] give adequate consideration to the possibility of meningococcal disease or take adequate actions to rule it out as a possible cause of the presenting symptoms?

The unwell neonate can be very difficult to recognise which is why emphasis is placed on objective abnormal vital signs. Protocols are widely available for the management of the febrile neonate with no focus. Meningococcal disease (septicaemia and/or meningitis) can be notoriously difficult to detect in the early stages. This is even more so in the neonate or infant. Bacterial sepsis is difficult to detect by clinical examination in the neonate which is why, should a fever be detected, full and thorough investigation and empiric treatment is required. [Dr E] states that there was no sign of a rash symptomatic of meningitis. However, meningococcal disease can exist in the absence of a rash. The alarming feature in this case was the fever in a neonate with no focus. This should have triggered admission to hospital for investigation and management as per the protocol.

6. Was the diagnosis of PUO reasonable in the circumstances and did he provide appropriate treatment?

The diagnosis itself is very reasonable — pyrexia of unknown origin. However, the subsequent management was inadequate as previously stated.

7. Who had the primary responsibility to ensure [Dr E] was aware of the existence and location of the hospital's Paediatric Medical Guidelines and the protocol for management of PUO in neonates in particular?

We have conflicting reports in regard to this. [Dr E] states that he 'was completely unaware of the existence of any paediatric protocols' and 'to my knowledge and to the knowledge of the nurse on duty at that time, there were no protocols in existence at the time regarding a child presenting to the Emergency Department with an elevated temperature.' There is no report provided by the triage nurse. [Dr H], Medical Director of the Emergency Department, states that he personally gave [Dr E] a guided tour of the Emergency Department when [Dr E] started employment. He states that the existence and location of ED guidelines and protocols were indicated to [Dr E] at this time.

In my opinion, each new doctor working in an Emergency Department requires orientation. This should include a copy of guidelines or knowledge of where they can be found. Detailed review, at this time, of every guideline would be an onerous task but the doctor should be encouraged to review the guidelines available and utilise them.

I note that the existing guideline for management of the febrile infant is written from the perspective of the Paediatric Department and makes no reference to admission / discharge decisions. I also note that this has subsequently been updated.

To conclude, I believe the orientating doctor has a responsibility to convey the existence and location of guidelines. The new doctor has a responsibility to familiarise himself with the guidelines and to adhere to them. In this case there is conflict as to these fundamental issues. This is not for me to resolve but I note that a nurse and doctor seem to both be unaware of the existence of such guidelines.

8. Were [Dr E's] follow-up instructions to the family on discharge reasonable and appropriate?

This is difficult given that discharge was inappropriate. Clearly, [Baby A's] caregivers were concerned enough to bring her to hospital at the unusual time of 0500 hrs. [Dr E] states 'I told [Baby A's] father and grandmother to keep an eye on her and to continue with the cooling measures and tepid sponging to decrease the child's temperature.' He continues 'any abnormal behaviour, not feeding or vomiting feeds, new skin rash or an increase in muscle tone should result in reassessment'. [Dr E] does not mention that her feeding is already inadequate. The family have already observed abnormal crying (behaviour) at this stage. I think it is an unreasonable expectation of the caregivers to recognise further deterioration in a 4-week-old neonate. I believe the advice was given with the best intentions but based on unrealistic expectations.

9. Are there any other issues that arise from [Dr E's] responses and other information provided?

Considerable breadth of knowledge is required for doctors working in Emergency Departments. Such departments see all those attending with 'perceived' emergencies. With the increasing complexity of healthcare, Emergency Medicine doctors require considerable training to reach the level of expertise required to safely and expediently manage those attending. This level of expertise is demanded (quite correctly) by the public. Until this training is completed, Emergency Medicine doctors require supervision by appropriately trained senior doctors. This supervision is obviously graduated depending on the experience (or lack of) of each doctor.

The Australasian College for Emergency Medicine has developed a training programme for Emergency Medicine trainees. This requires a minimum of 7 years' training (post medical degree) — 2 years of basic training, 5 years advanced training. Trainees are required to work in hospital positions where they are supervised by specialists in Emergency Medicine or other specialists in related disciplines.

I am not familiar with the arrangement at Gisborne Hospital Emergency Department. [The Company] are contracted to provide emergency medicine services and doctors are employed directly by them. I am not aware of the level of supervision of doctors in the

Emergency Department. [Dr H] comments that [Dr E] had 3 'buddy' shifts and it was then felt that he did not require further 'buddy' rostering. By this, I assume it was considered reasonable that he work without direct supervision in the ED. I also assume that this may mean he was working in the department alone i.e. as the only emergency doctor on duty. I note that [Dr E] is new to New Zealand and relatively inexperienced given he has 3 years' experience post graduation.

I note the amount of continuing medical education and quality programmes that are in place at Gisborne Hospital for Emergency Medicine doctors and this is to be commended. However it is unclear to me the level and quantity of direct supervision of the non-specialist doctors working in the ED. Whilst I am sure there are systems in place to manage critically ill patients e.g. major trauma, there are many other patients attending the emergency department who are not critically ill but will become so if incorrect decisions are made by well meaning doctors with limited experience. [Baby A] was not critically ill when brought to the ED on 4th January.

I also note in comments made by [Dr E] that the triage nurse telephoned the paediatric ward on the 4th January regarding use of paracetamol in a febrile baby. Whilst I have no idea regarding the details of this conversation it seems to me an opportunity for paediatric staff to remind emergency staff about the protocol for managing febrile neonates. There is no report from the triage nurse available.

Summary

In my opinion, the care provided to [Baby A] was not of an appropriate standard. There has been a moderate departure from the standard. This departure refers particularly to [Dr E's] practice. However there are concerns on my part about the level of supervision in the ED at Gisborne Hospital. This may be unfounded but the nature of emergency medicine services at Gisborne Hospital has not been previously encountered by me. I would be particularly interested in the level of 'on the floor' supervision of the non-specialist doctors working in the ED. Whilst guidelines are useful additions and aids, they are not a substitute for direct supervision by specialists in Emergency Medicine.

References

1. Brook I. Unexplained fever in young children: how to manage severe bacterial infection. BMJ, Vol 327, 8 Nov 2003 pp 1094–1097
2. Browne G, Currow K, Rainbow J. Practical approach to the febrile child in the emergency department. Emergency Medicine (2001) 13, 426–435 and addendum p 415
3. "Starship Hospital Emergency Department protocol for Management of the febrile child under 2 years of age."

Additional emergency medicine advice

In a follow-up telephone conversation on 29 June 2005, Dr Pearson explained that the definition of pyrexia of unknown origin (PUO) requires a fever to exist over a period of

several weeks. He agreed with the comments from the DHB's paediatricians to this effect. Dr Pearson explained that his comment that Dr E's diagnosis of PUO was reasonable was made on the basis that he interpreted Dr E as meaning that he could not identify the focus of Baby A's fever.

Dr Pearson also informed me that he has visited emergency departments where particularly relevant protocols and guidelines are put together in small compendiums or just one or two folders, with electronic forms also being available.

Midwifery advice
The following independent expert advice was obtained from Ms Terryl Muir, midwife:

> "Thank you for the request for independent advice about whether [Ms F], midwife, provided an appropriate standard of care to [Baby A].
> DOB: 07/12/03
> Date of incident: 04/01/04
> Claim relates to neurological damage as a result of group B streptococcal meningitis and septicaemia.
>
> I have reviewed all the documents sent to me.
>
> **Background:**
>
> At 5am on 4 January 2004, 4-week-old [Baby A] was taken by her father ([Mr B]) and paternal grandmother ([Mrs D]) to Gisborne Hospital Emergency Department with a history of fever and not feeding. After the initial triage by the department's nurse, [Baby A] was seen by [Dr E], a junior medical officer working under contract to [the Company], which provided medical staff to Tairawhiti District Health Board. [Dr E] had been working in Gisborne Hospital Emergency Department since October 2003.
>
> [Dr E] examined [Baby A] and noted that an elevated temperature was the only abnormal sign. Although he considered the possibility of meningitis, he ruled it out on the grounds of a normal clinical examination and [Baby A's] normal behaviour. Unable to form a definitive diagnosis, [Dr E] suspected a viral infection to be the cause of the presenting symptoms. Unaware of the hospital's protocol for the management of pyrexia of unknown origin (PUO), [Dr E] discharged [Baby A] with no treatment prescribed. The follow-up advice given to the family was to keep an eye on [Baby A], continue with cooling measures and, if she did not improve, seek medical attention either from a GP or bring her back to the Emergency Department. The family was informed of the signs and symptoms to be on the lookout for.
>
> Later that day, at approximately 4.30pm, [Baby A's] mother ([Ms A]) telephoned her midwife, [Ms F] and informed her that [Baby A] had a temperature and was fitting. [Ms A] told her that [Baby A] had been taken to A&E earlier that morning with the same symptoms and was discharged with instructions to keep her cool.

[Ms F] came to the house, examined [Baby A] and noted that she was 'twitching', 'distressed', and making 'fretful noises'. [Ms F] was aware that [Ms A] had tested positive for Group B Strep during pregnancy. [Ms A] had been treated with IV antibiotics during labour, however, owing to the speed of the labour these were only given two hours prior to the birth, which was to insufficient to offer adequate protection to the baby.

[Ms F] says [Ms A] told her that the noises were the same as they had been in the morning. Further attempts were made to cool her down. By the time [Ms F] left at 6pm, [Baby A] was asleep. The family was instructed that should [Baby A] get worse or not drink, to take her back to the Emergency Department. The family was advised to take [Baby A] to their GP the next day and that [Ms F] would return in the morning.

The next day, 5 January 2004, the family took [Baby A] to their GP, [Dr G], who arranged urgent transfer to the Paediatric Service at Gisborne Hospital. On arrival at the hospital at 11am, [Baby A] was seen by [Dr K], a paediatrician. In view of suspected diagnosis of severe sepsis with meningitis, [Baby A] was immediately commenced on intravenous antibiotic therapy. Blood and CSF tests showed Group B Streptococcus infection.

A CT scan of the brain performed on 7 January 2004 showed severe destruction of brain tissue. As a result, [Baby A] was left with severe and permanent brain damage requiring long term 24-hour care.

In October 2004 ACC's Medical Misadventure Unit accepted the claim as a medical error (severe brain injury caused by a delay in diagnosing serious signs of sepsis by a health professional).

Issues:

1. Assessment at the visit
2. Response to symptoms/advice given
3. Awareness of late onset GBS

1. Assessment at the visit:

[Ms F] received a call from [Ms A] at 1630 hours asking her to attend. [Ms F] was told the baby had a temperature and was fitting. She was also told that the baby had already been taken to hospital where she was examined and discharged.

[Ms F] responded very promptly to this call. She went immediately, this shows that she recognised the call as potentially serious.

A midwife is not a medical practitioner and is not trained to diagnose medical illness. However, a midwife is to ensure that potentially life-threatening situations take priority (NZ College of Midwives, Handbook for Practice). It was reasonable for [Ms F] to

think that weighing the baby was not a priority at this visit, this baby was hot and fitting, the medical advice had been to cool the baby, [Ms F] concentrated on this aspect of the care. [Ms F] could have taken [Baby A's] temperature, particularly to know that the temperature had reduced. However, [Ms F] was told that the baby's temperature was up, she could probably tell by the look of the baby and the history given that it was up. It would be reasonable to assume that the baby's temperature had lowered by her behaviour settling.

[Ms F] spent a whole hour with the baby, during this time she would have been able to make a reasonably thorough assessment. She also had plenty of time to talk to [Ms A]. I am happy that [Ms F's] assessment of [Baby A] was reasonable for a midwife.

2. Response to symptoms/advice given:

[Ms F] knew that this baby was 'twitching', 'distressed', and making 'fretful noises'. A midwife is to identify deviations from normal and after discussion with the woman, to consult and refer as appropriate (Standard six, NZ College of Midwives Handbook for Practice). A midwife has a responsibility to refer to the appropriate health professional when she has reached the limit of her experience (Standard six, NZ College of Midwives Handbook for Practice). Normally, if [Ms F] had been called to a sick baby I would expect her to ring the paediatric team at the hospital and ask for an opinion, or to send the family to A&E. It seems quite probable that the admission to A&E in the morning and the advice given has influenced [Ms F's] care. She did not consult with anyone at this time, it was reasonable for her to think that a referral had already taken place and to follow the advice given. However, [Ms F] did ask the family to go back to A&E if her condition worsened, she advised to take her to her GP the next morning and she made an appointment to return to check on the baby the following day. [Ms F's] follow-up care was within a reasonable standard in the circumstances (being seen by a doctor earlier in the day).

3. Awareness of late onset GBS:

Group B strep infection in newborns has received a lot of publicity among midwives. Group B strep disease in the newborn can either be an early onset disease which develops in the first 7 days of the baby's life but most often within 24–48 hours or a late onset disease which is very rare and occurs between 7 days and 3 months of age. The NZ College of Midwives has worked on a consensus statement throughout most of 2003 & 2004. Part of the consensus statement states that 'all newborn babies showing signs of sepsis should undergo immediate referral and assessment from a paediatrician'. This consensus statement was in circulation during 2004 but only in draft form, it was not ratified until September 2004.

All DHBs will have a policy/guideline on management of positive group B strep swabs which will include giving the mother IV antibiotics in labour to protect the baby. As [Ms

F] gave [Ms A] IV antibiotics in labour I'm sure she was familiar with group B strep management.

Part of the management of group B Strep is to inform the woman about the disease and the signs to check in their baby. Early signs may include: nostrils flare as the baby breathes, the baby's chest sucks in with breathing, the baby makes grunting noises with breathing, the baby might be sleepy and not feed well, and the baby might be pale and floppy. Late signs of the disease becoming severe include a floppy baby, a pale baby, breathing difficulty becoming worse and seizures.

Unfortunately most of the information given to midwives has been mostly about early onset group B strep disease. Awareness of group B strep disease was not as strong at the beginning of 2004 as it is now. It is possible that [Ms F] did not even consider late onset disease until the baby had been diagnosed. [Ms F] has not shown that she had a good knowledge of group B strep disease in the newborn, in particular late onset disease or its ability to develop into meningitis.

A midwife is to work in partnership with a woman, she is to share relevant information with a woman and is to be satisfied that the woman understands the relevant information (Standard one & two, NZ College of Midwives Handbook). I would like to know what information [Ms A] was given about group B strep disease after her birth, particularly since she was treated in labour for group B strep and she went home early.

Care of this baby has fallen short of what is expected. Most of the responsibility rests with the doctor at the hospital. His assessment and advice continued to have effects after [Baby A] was sent home. The family should have had the confidence to return to hospital, they did not do this. The midwife's assessment and care was influenced by the assessment already done. [Ms F] was not a medical practitioner and not experienced in caring for or assessing sick babies, it would be reasonable for her to take the advice of a doctor who was. It would also be reasonable for [Ms F] to think that during an admission to hospital, old notes would be looked at and the history of the baby known (i.e. the group B strep).

Reference list:

New Zealand College of Midwives Handbook for Practice, 2002.

New Zealand College of Midwives Group B Streptococcus Consensus Statement, 2004.

Group B Streptococcus Lecture Notes, Otago Polytechnic, 2004."

Additional midwifery advice
Ms Muir provided the following additional advice on 6 October 2005:

> "Thank you for the request for further expert advice about whether it was appropriate for [Ms F] not to seek a medical review of [Baby A]. Taking into account all the circumstances including [Baby A's] condition and the time that had elapsed since she was seen at the Emergency Department of Gisborne Hospital.
>
> Claim relates to neurological damage as a result of group B streptococcal meningitis and septicaemia.
>
> I have reviewed all the documents sent to me.
>
> - Letter of complaint from [Ms A] dated 7 December 2003 (pages 1–4) marked 'A'.
> - Record of telephone conversation with [Ms A] on 20 October 2004 (page 5) marked 'B'.
> - Record of telephone conversation with [Ms A] on 2 November 2004 (pages 6–7) marked 'C'.
> - Record of telephone conversation with [Ms C] ([Ms A's] mother) on 23 July 2004 (pages 8–9) marked 'D'.
> - Record of telephone conversation with [Mrs D] ([Ms A's] mother-in-law) on 3 November 2004 (pages 10–12) marked 'E'.
> - Response from [Dr E] to the Assistant Commissioner dated 27 August 2004 (pages 13–17) marked 'F'.
> - Record of telephone conversation with [Dr E] on 3 November 2004 (page 18) marked 'G'.
> - Response from [the Company] ([Dr H]) to the Assistant Commissioner dated 23 August 2004 (pages 19–22) marked 'H'.
> - Response from [the Company] ([Dr L]) to the Commissioner dated 26 October 2004 including a letter from [Dr H] to the Medical Council dated 12 September 2003 and [the Company] Medical Officers' orientation programme for Gisborne Hospital (pages 23–29) marked 'I'.
> - Letter from [Ms F] (midwife) to the Commissioner dated 23 August 2004 (page 30) marked 'J'.
> - Record of telephone conversation with [Ms F] on 25 August 2004 (page 31) marked 'K'.
> - Response from [Ms F] to the Assistant Commissioner dated 21 September 2004 (pages 32–35) marked 'L'.
> - Response from Tairawhiti District Health Board to the Commissioner dated 7 September 2004 including the letter from [Dr K] to the Commissioner dated 4 February 2004, notes from the meeting of 30 January 2004, audiology report from dated 27 January 2004, review of the case dated September 2004, DHB protocol for management of fever and DHB policy on management of acute paediatric

referrals between the Emergency Department and Child Health (pages 36–53) marked 'M'.
- [Ms A's] / [Baby A's] records from [Ms F] (pages 54–65) marked 'N'.
- [Baby A's] 'Well Child Health Book' (pages 66–137) marked 'O'.
- [Baby A's] records from [Dr G], general practitioner (pages 138–141) marked 'P'.
- [Baby A's] records from Gisborne Hospital (pages 142–309) marked 'Q'.
- [Baby B's] records from ACC including reports from [Dr E] dated 26 April 2004, [Ms F] dated 28 April 2004, [Dr K] dated 12 March 2004, [Dr G] dated 17 March 2004, Dr Scott Pearson (Specialist Emergency Physician — advisor to ACC) and Dr Thorsten Stanely (Paediatrician — advisor to ACC), and ACC decision (pages 310–340) marked 'R'.
- Response to provisional opinion from Tairawhiti District Health Board.

After reading the Response to provisional opinion from Tairawhiti District Health Board, I have discussed this issue with two other midwifery colleagues, […]. Both of whom are expert advisors for the New Zealand College of Midwives. My advice is as follows:

1. Assessment at the visit:

A midwife is to ensure that potentially life-threatening situations take priority (NZ College of Midwives, Handbook for Practice).

[Ms F] spent a whole hour with the baby and with [Ms A], this was plenty of time to make a thorough assessment.

It was reasonable for [Ms F] to think that weighing the baby was not a priority at this visit. During the hour [Ms F] spent with [Baby A] she would have been able to make assessments of the baby's temperature, respirations and heart rate. The Wellchild book states 'to give cold drink in a bottle, breast if she is able'. I am assuming by this that [Baby A's] feeding was discussed.

The opinion from Tairawhiti District Health Board is quite correct in not assuming that a settled baby could in fact be a seriously ill baby. I am still happy that [Ms F's] assessment of [Baby A] was within appropriate standards for a midwife.

2. Response to symptoms/advice given:

A midwife is to identify deviations from normal and after discussion with the woman, to consult and refer as appropriate (Standard six, NZ College of Midwives Handbook for Practice). A midwife has a responsibility to refer to the appropriate health professional when she has reached the limit of her experience (Standard six, NZ College of Midwives Handbook for Practice).

Names (other than Gisborne Hospital, Tairawhiti District Health Board and expert advisors) have been removed to protect privacy. Identifying letters are assigned and bear no relationship to the person's actual name.

Normally, if [Ms F] had been called to a sick baby I would expect her to ring the paediatric team at the hospital and ask for an opinion, or to send the family to A&E. The admission to A&E in the morning and the advice given by the doctor has influenced [Ms F's] care. However, [Ms F] should still have contacted the hospital to confirm the treatment advice and to discuss ongoing management of this baby. It is my opinion that [Ms F's] assessment of [Baby A] was thorough enough for her to know that this baby was unwell and based upon that assessment she should have consulted and referred appropriately.

The care of this baby has fallen short of what is expected. [Ms F's] response to the symptoms present was inappropriate and although her actions and advice were influenced by the admission to hospital it would be unreasonable of a midwife not to consult medical advice again.

I wish to alter my previous statement and now wish to say that the response to the symptoms and the advice given have fallen short of an acceptable standard of care for a midwife."

Investigation process

First provisional opinion
On 19 April 2005 I sent the parties copies of my first provisional opinion, in which I set out my provisional view that Dr E had breached the Code of Health and Disability Services Consumers' Rights (the Code) in relation to his treatment of Baby A. My provisional view was that the Company and Tairawhiti District Health Board were vicariously liable for Dr E's breach of the Code. My provisional opinion was that Ms F had not breached the Code.

Second provisional opinion
On 5 July 2005 I sent the parties copies of my second provisional opinion. On the basis of the responses to my first provisional opinion, I stated that in addition to Dr E, Ms F had breached the Code in relation to her response to Baby A's symptoms, but that the Company and Tairawhiti District Health Board were not vicariously liable for Dr E's breach of the Code.

Names (other than Gisborne Hospital, Tairawhiti District Health Board and expert advisors) have been removed to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

Responses to first provisional opinion

Tairawhiti District Health Board

Vicarious liability
In response to my first provisional opinion, the Tairawhiti District Health Board (DHB) gave a number of reasons why it did not consider that it should be held vicariously liable for Dr E's breach of the Code.

The DHB did not agree that it had allowed Dr E to appear to be its agent. Its understanding of an agency relationship is that the agent is able to alter the principal's legal relations with third parties. While Dr E had the ability to admit patients to Gisborne Hospital, it is the hospital that then controls the provision of services to those patients and Dr E cannot require them to be treated. The DHB also expressed concern about the implications of my finding on this issue, noting that it funded a wide range of public health services and has contracts with a number of providers such as Primary Health Organisations and pharmacies. Its contract with the Company is one such contract and my provisional finding would mean that the DHB was potentially vicariously liable for acts or omissions of all the service providers that it funds.

Even if Dr E could be considered to be an agent of the DHB, the DHB submitted that the effect of the wording of section 72(3) of Health and Disability Commissioner Act 1994 (the Act) is that a principal will be liable only if it approves or adopts the actions or omission of the agent. The DHB stated that Dr E was authorised only to provide care of an appropriate standard and that it did not authorise Dr E to provide substandard services to Baby A.

The DHB interpreted section 72 of the Act to mean that the defence to vicarious liability set out in section 72(5) is not available where an employing authority is found to be vicariously liable for the acts or omissions of an agent under section 72(3). In its view the limited availability of this defence supports a higher threshold for liability under section 72(3). The DHB also noted that vicarious liability for acts or omissions of an employee exists whether or not it took place with the knowledge or approval of the employing authority, whereas liability for the acts or omissions of an agent depends on whether they took place with the authority of the employing authority. On the basis that the section 72(5) defence is available only to employers and, given the differing thresholds in sections 72(2) and 72(3), it would create an anomalous situation if the DHB was held vicariously liable for unauthorised acts of an agent.

Appropriateness of midwifery services
The DHB expressed concern about my first provisional view that Ms F had not breached the Code, stating that this undermined the confidence that it (and other district health boards) have in the ability of midwives to recognise when a newborn baby needs assistance.

The DHB referred to the scope of practice for midwives, in particular providing care for newborn babies and identifying complications that may arise in a baby. The DHB also

referred to my expert advisor's comment noting standard 6 of the NZ College of Midwives Handbook for Practice and the responsibility to refer to the appropriate health professional when the limit of her experience had been reached. In its view there were sufficient signs that Baby A's condition warranted urgent medical attention. The fact that Baby A had been seen at the Emergency Department was not an acceptable reason not to take further action. Ms F failed to recognise that Baby A was unwell and required treatment.

Emergency medicine expert advice
The DHB noted Dr Pearson's comment about the availability of obstetric clinical records and stated that such records are available to all clinical staff at Gisborne Hospital and would have been provided to Dr E had he requested them.

The DHB also noted Dr Pearson's comment that staffing levels may not permit the triage nurse to perform vital sign recordings. It stated that there is sufficient staffing at Gisborne Hospital to permit nurses to perform such recordings and they are expected to do so.

The DHB's paediatricians did not accept Dr Pearson's statement that Dr E's diagnosis of pyrexia of unknown origin was a reasonable one. The DHB provided two definitions of pyrexia of unknown origin, both of which refer to fever over a period of at least three weeks, and stated its strong view that these definitions should be adhered to. The DHB agreed with Dr Pearson's statement that, in this instance, a fever with an unknown cause should have triggered admission.

The DHB expressed concern that Dr Pearson made conclusions about its services without having complete information and possibly based on his knowledge of a large emergency department in a major metropolitan area rather than a provincial emergency department such as that at Gisborne Hospital. In response to Dr Pearson's concerns about the level of supervision provided to Dr E, the DHB informed me that it contracted the Company to provide the medical service to the emergency department and that the contract required the provision of "experienced, competent, appropriately qualified" staff. Dr E's level of supervision was determined and provided by Dr H. Indirect supervision was available via direct access to consultants on call.

Group B streptococci
The DHB was concerned that the result of Ms A's vaginal swab in pregnancy (which showed scant growth of Group B Streptococci) was being inappropriately focused on. There should be a high index of suspicion and knowledge about the late onset of Group B Streptococci and a negative swab result in pregnancy should not be considered reassuring.

The Company
Dr H, Director of the Company, explained that the Company provides a doctor to staff Gisborne Hospital Emergency Department 24 hours a day, seven days a week. It requires all its doctors to have at least three years' postgraduation work experience (including significant emergency department work) and have completed certain courses (either Advanced Cardiac Life Support, Advanced Trauma Life Support or Early Management of

Severe Trauma, and Paediatric Advanced Life Support or Advanced Paediatric Life Support). Dr E satisfied these criteria. All long-term medical staff are encouraged to undertake and complete the Diploma in Community Emergency Medicine.

Dr H provides supervision to all the medical staff of the Emergency Department at Gisborne Hospital. This supervision includes meeting new medical officers on arrival, completing MRSA tests, and carrying out pre-employment health checks. He runs through the orientation and induction checklist now in place and a powhiri is organised. New medical officers have a series of "buddied shifts" where they first observe other doctors work and then are observed by other doctors. Following these shifts new medical officers work weekday daytime shifts during which other doctors are also on duty in the department. They progress to afternoon shifts, then night and weekend shifts. A new medical officer is not rostered on night duty until the series of buddy and daytime shifts has been completed. When on night duty, doctors are informed about processes for contacting other medical staff where appropriate and getting back-up if necessary.

In the first week, Dr H meets daily with all new medical officers. Thereafter, meetings occur several times per week, including handovers, peer review meetings, X-ray review meetings, paediatric review meetings, tutorial sessions and mortality and morbidity meetings. Dr H also has a chance to observe medical staff at work and periodically audits aspects of the services such as X-ray self-reporting, laboratory and radiology call- outs, and unplanned re-attendances within 24 hours of first presentation, as well as being involved in other audits.

Doctors who have vocational registration in accident and medical practice are supervised "at a distance" by a doctor with vocational registration emergency medicine. Dr H is the only doctor at Gisborne Hospital with vocational registration in accident and medical practice and is supervised by a doctor from the Emergency Department at another hospital. Dr H is aware that the Australasian College of Emergency Medicine and Fellows of the Australasian College of Emergency Medicine prefer Emergency Departments in New Zealand to be headed by Fellows of the Australasian College of Emergency Medicine. Dr H supports this and is pursuing it with the DHB; however, there are resource constraints with only 79 such doctors in New Zealand. The majority of provincial hospitals face similar issues.

The Company referred to Dr H's letter to the Medical Council in relation to Dr E's induction and orientation process, noting that it states that Dr E would "commence familiarisation processes with the layout, guidelines and policy for the department". This process was carried out in full including "communicating to Dr E the existence and location of the department guidelines". The Company informed me that, since the events complained of, the orientation and induction process has been modified and a checklist is now used which requires the medical officer to record that each component has been performed. Dr H is confident that he discharged his duties appropriately by conveying to Dr E the "existence and location of (the) guidelines" during his orientation period.

The Company stated that it "effectively did supply copies of protocols and guidelines to Dr E prior to commencing work and ensured he was familiar with these in a reasonable and practicable manner and to a standard practiced widely throughout Emergency Departments in New Zealand". In its view the volume of protocols and guidelines made it impractical to provide copies to medical officers prior to their commencing work.

The Company
The Company, in a submission made by Dr L, General Manager, commented on my suggestion that it may be more effective to provide copies of guidelines and protocols to medical officers prior to their commencing work. In its view this suggestion demonstrated a fundamental lack of understanding of the nature of such protocols, which are thousands of pages long and would fill a large suitcase, making it "completely impractical" to provide a copy to medical officers prior to commencing work. Electronic versions are unavailable and are unlikely to be developed for "some years". Therefore, in the Company's view, it is reasonable to simply indicate the location of the protocols and convey the expectation that the medical officer familiarise themselves with them. Any medical officer with three years' postgraduate experience working in emergency departments around the world would be well aware of the existence and relevance of such protocols. Dr L submitted that "the existence of such protocols … is so basic to the functioning of day to day practice in an ED that I find it difficult to believe that a medical officer of any experience could be unaware of their existence". He also stated that an audit of the orientation process carried out for new medical officers commencing work in three of the four major Auckland metropolitan emergency departments shows that the location of the protocols is simply indicated and the expectation stated that medical officers will become familiar with them. It its view, the process now followed by the Company (using a checklist) goes beyond what is reasonable, given current practice in the profession.

Responses to second provisional opinion

Tairawhiti District Health Board
In its response to my second provisional opinion, the DHB accepted my further provisional findings but stated that it still had reservations about the finding that Dr E was its agent. The DHB considered that this decision appears to widen its liability for funded provider's actions.

The DHB informed me that it had recently completed a review of material provided to new medical officers and that it would work with the Company to ensure that a similar review was undertaken for its employees.

Ms F
Ms F's legal representative responded to my second provisional opinion on behalf of Ms F. Ms F's legal representative requested that I reinstate my first provisional opinion regarding

Ms F. She stated that I should not accept Ms Muir's advice and then decide to depart from it without proper and reasonable cause. Ms F's legal representative stated that Ms Muir is a highly regarded expert whose advice must be considered to be of considerable weight.

Ms F's legal representative stated that concerns expressed by the DHB should not change my original acceptance of Ms Muir's advice. She noted that the DHB is a party to the investigation and not an independent advisor. Ms F's legal representative stated that it is unclear who provided the opinion from the DHB and the basis on which the DHB is authorised to speak for other district health boards. In her view, the DHB's expressions of concern are just that, whereas Ms Muir is an accepted expert on the standards and scope of midwifery practice and a peer of Ms F.

Ms F's legal representative submitted that while the DHB's concerns may be genuinely held, they are completely without foundation and incorrectly imply that a "no breach" finding would be a licence for midwives not to refer in cases where a baby is unwell. She stated that she would not expect anyone to take such a message from my first provisional opinion as it was very clear that there were lessons to be learnt and practices to be improved.

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.

…

RIGHT 6
Right to be Fully Informed

1) Every consumer has the right to the information that a reasonable consumer, in that consumer's circumstances, would expect to receive, including —
(a) An explanation of his or her condition;

…

(f) The results of tests; and

(g) The results of procedures.

…

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Opinion: Breach — Dr E

When four-week-old Baby A was brought into Gisborne Hospital Emergency Department by her father and grandmother on 4 January 2004, she was feverish and not feeding. The triage nurse took thorough notes of the baby's condition and history. Dr Pearson stated that the medical officer, Dr E, should have built on that information by asking about Baby A's mother's antenatal history and whether she had experienced any problems. This might have revealed the vaginal swab result and the treatment given by the midwife during labour, and would have provided further useful information to aid Dr E's assessment of her baby. Unfortunately, Baby A's mother did not accompany Baby A to the hospital. Dr Pearson stated that Dr E should also have asked the family to elaborate on the nurse's note that Baby A was "sleepier than usual" and "fretful", asking if her cry was unusual or whether she had been irritable.

Dr E's assessment of Baby A was inadequate, as the symptoms brought to his attention were not explored in sufficient detail. Dr Pearson advised that Baby A was assessed by Dr E at 5.10 to 5.20am and left the hospital between 5.30 and 6am, which is a relatively short time for a health professional to observe an unwell baby for evidence of unusual behaviour. A more detailed history may have led to admission and a longer period of observation.

Dr E fully undressed Baby A to examine her, which is to be commended. He noted that her temperature was elevated at 38.5ºC, and checked whether there was evidence of respiratory distress or abnormality of the fontanelles. He found that Baby A had normal responses and primary reflexes, but she had a rapid heartbeat which he attributed to the elevated temperature. Dr Pearson advised that Dr E's examination was generally fair; however, there were notable exceptions — he did not examine her ears, nose or throat, and most importantly he did not record her vital signs of pulse and respiration rate, or her weight. These recordings provide objective information that can be used to follow progress. An accurate weight is a particularly important measurement in the neonate.

The unwell neonate can be very difficult to recognise, which is the reason why emphasis is placed on objective abnormal vital signs. Meningococcal disease is notoriously difficult to detect in the early stages, even more so in the neonate or infant, and bacterial sepsis is difficult to detect by clinical examination alone. Accordingly, when a fever is detected, a full and thorough investigation and proven treatment are required.

Dr E suspected that Baby A was suffering from a viral infection and that her elevated temperature was due to the warm weather and inappropriate clothing, but he performed no tests on her. This was inadequate. Gisborne Hospital had a protocol for the management of febrile infants, which stated that any febrile child under three months of age unless remarkably well (or with a clear focus of infection) should have blood cultures, urine tests and a lumbar puncture for cerebrospinal fluid. According to my expert, a chest X-ray should be included in this screen. The protocol stated that antibiotics should be then given for 48 hours, pending the results of screening tests.

Dr Pearson commented that the alarming feature in Baby A's case was that her fever had no focus. This should have alerted Dr E to admit her to hospital for investigation and management, as specified in the hospital's protocol.

Dr E stated that he was unaware of the existence of any paediatric protocols at Gisborne Hospital. He said that the nurse who was on duty when Baby A was brought in to the Emergency Department was also unaware that there was a protocol regarding children presenting to the department with an elevated temperature. However, Dr H, the Medical Director responsible for orientating and supervising medical officers in the Emergency Department at Gisborne Hospital, had apparently told Dr E about these protocols and their location within the department during Dr E's orientation. In any event, as noted by my expert, a new doctor in a department has a responsibility to familiarise himself with the guidelines provided by that department/hospital and to adhere to them.

Following his examination of Baby A and on the assumption that her symptoms were due to summer heat and inappropriate clothing, Dr E advised the family to take her home, keep her cool and seek medical advice if her condition did not improve or deteriorated. Dr Pearson stated that it was unreasonable for Dr E to expect Baby A's family to recognise further deterioration in a four-week-old baby. Although Dr E gave his advice with the best of intentions, it was based on unrealistic expectations.

I accept Dr Pearson's advice that Dr E's care of Baby A on 4 January was not of an appropriate standard, and constituted a moderate departure from accepted standards. Dr E did not adequately assess Baby A; he did not obtain the level of detail he needed to establish the seriousness of her symptoms; and he did not keep her in the emergency department long enough for thorough observation. Baby A had an elevated temperature, but Dr E did not follow the hospital's guidelines for the treatment of febrile children and order tests to establish the focus of the infection. Dr E was also unrealistic in his expectations that the family would be able to determine when the baby's condition deteriorated and seek appropriate and timely medical assistance. In these circumstances, Dr E did not provide medical services with reasonable care and skill and therefore breached Right 4(1) of the Code.

Opinion: Breach — Ms F

Ms A telephoned her midwife, Ms F, at 4.30pm on 4 January 2004 to inform her that she was concerned about Baby A. Her description of Baby A's condition alerted Ms F that the situation was potentially serious, and she responded promptly.

My independent midwifery expert, Terryl Muir, stated that, although a midwife is not a medical practitioner and is not trained to diagnose medical illness, she must ensure that potentially life-threatening situations take priority. Group B Streptococcus disease in the

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newborn can be either early-onset disease (within the first seven days) or late-onset (from one week to three months), which is rare. Ms Muir advised that part of the management of Group B Stretococcus is to inform the mother about the disease and about the signs to check for in her baby, which include not feeding well. Throughout 2003 and 2004, the New Zealand College of Midwives worked on a consensus statement (which was ratified in September 2004) that stated: "All newborn babies showing signs of sepsis should undergo immediate referral and assessment from a paediatrician." Ms Muir noted that awareness of Group B Streptococcus was not prevalent amongst midwives at the beginning of 2004. However, Ms F demonstrated that she was aware of the significance of the "scant Group B Strep" cultured from Ms A's vaginal swab. She followed the hospital guidelines in treating Ms A with the recommended antibiotic regime, although it appears that she did not consider late-onset Group B Streptococcus disease on 4 January.

When Ms F arrived at the house, she found that Baby A was hot and fitting and that the medical advice given to the family 11 hours earlier at the hospital Emergency Department had been to keep the baby cool. Ms F was not provided with any hospital documentation about the baby's earlier condition to guide her, and had to rely on the information provided by the family. She knew that Baby A's temperature had been elevated (her own observations would have told her that this was still the case) and that the treatment order was to keep her cool. Ms F concentrated on this aspect of the baby's care.

Baby A was twitching, distressed and making fretful noises. A midwife's role includes identifying deviations from the normal and, after discussion with the mother, consulting and referring as appropriate. Ms Muir advised that she would have expected Ms F when presented with a sick baby to contact the paediatric team at the hospital and ask for an opinion, or ask the family to return to the Emergency Department. In not taking these steps, it is likely that Ms F was influenced by the earlier medical assessment and advice. However, Ms F's own assessment was thorough enough for her to know that Baby A was unwell. Based on that assessment she should have contacted the hospital to confirm the treatment advice and to discuss ongoing management. Ms Muir advised that it was unreasonable not to seek such medical advice and that Ms F's response to the presenting symptoms was inappropriate.

I accept my advice that the earlier Emergency Department visit was not an adequate reason for Ms F to fail to take the precautionary steps of contacting the paediatric team or sending the family back to the hospital. A significant amount of time had elapsed since the ED visit, and Baby A's condition had not improved and may have deteriorated. Either scenario should have prompted further action given the nature of Baby A's symptoms, which included fitting.

In my opinion, Ms F did not fulfil the standard of reasonable care and skill expected of a midwife in such circumstances, and therefore breached Right 4(1) of the Code.

Opinion: No Breach — The Company

Vicarious liability
Under section 72(2) of the Health and Disability Commissioner Act 1994 (the Act), an employing authority may be vicariously liable for an employee's failure to comply with the Code. Section 72(1) of the Act states that the term "employing authority" means a health care provider or a disability services provider. Section 3(k) of the Act states that a health care provider includes any person who provides health services to the public. The Company provides health services to the public, and thus falls within the definition of health care provider and qualifies as an employing authority.

Dr E was employed as an Emergency Department medical officer by the Company, which contracted with Tairawhiti District Health Board to provide emergency services at Gisborne Hospital. As Dr E's employer, the Company is potentially vicariously liable for his breaches of the Code.

Under section 72(5) it is a defence for an employing authority to prove that it took such steps as were reasonably practicable to prevent its employees breaching the Code.

Dr E arrived in New Zealand from overseas in October 2003 after completing three years' postgraduate experience in emergency medicine. Dr H, the Medical Director for Gisborne Hospital Emergency Department, provided supervision to Dr E and orientated him to the department. This included informing him of the existence and location of the department's guidelines. Dr H assigned Dr E to work with two other casualty doctors during his orientation and was reassured (at the end of three shifts) by Dr E's two "buddy" doctors that they were confident and comfortable with his level of expertise and that he did not need any further "buddy" rostering.

Dr H (on behalf of the Company) explained that once the "buddy" rostering is no longer necessary, a new medical officer is confined to working dayshifts along with other doctors. The new medical officer moves to afternoon shifts, and then night and weekend shifts, only when he or she is comfortable doing so and Dr H (taking into account nursing feedback) is also comfortable. When on night shifts, all medical officers are made familiar with the processes for notifying medical staff or getting back-up when necessary.

Dr E had a "buddy" for his first three shifts and then worked day and afternoon shifts with other doctors until he was comfortable working night shifts by himself. On night shifts the only supervision available is from on-call doctors. During a working week Dr H meets with all medical staff several times and regular review meetings are carried out.

Dr H stated that, during his orientation, Dr E was told that the paediatricians at Gisborne Hospital have a "low threshold" for admitting unwell children, and that medical staff, if in doubt about a child's condition, are to err on the side of caution and offer admission for

observation rather than outpatient management. Dr E was also made aware of the procedures for contacting the paediatricians.

My initial view was that the Company had not taken sufficient action to ensure that Dr E was familiar with local practice conditions and Gisborne Hospital protocols, and that simply indicating the location of protocols on the doctor's first two days at work did not afford a new doctor from another country a reasonable opportunity to familiarise himself with those protocols before commencing work. Dr E stated that he was unaware of the paediatric protocols.

I accept that new doctors have a general responsibility to familiarise themselves with guidelines and to adhere to them, but it remains the employer's responsibility to confirm that a new doctor has "learnt the ropes". Since this case, the Company has developed a checklist to assist the orientation process. The medical officer is now required to confirm that he or she has been informed of the existence and location of the relevant guidelines and policies. I commend the Company for taking steps to improve its orientation process.

In my first provisional opinion, I suggested that it may be more effective to provide copies of the protocols and guidelines prior to the medical officer commencing work. The Company responded that is impractical to do so given the volume of protocols and guidelines. I accept that it may have been impractical to provide Dr E with all Gisborne Hospital protocols and guidelines prior to commencing work. However, in my view the Company overstated its case. Dr Pearson advised that other emergency departments fit the relevant guidelines and protocols in two to three folders and also have them readily available in electronic form. It appears that the volume of protocols and guidelines (or at least the main ones most likely to be referred to) will not always be so large as to make it impractical to provide copies to new medical officers. If the protocols at Gisborne Hospital are thousands of pages long and would fill "a large suitcase", one must question whether they are in a form that is readily accessible by medical officers when in a hurry.

Although Dr E stated that he was unaware of the protocols, I am satisfied that Dr H had indicated where they were located and could reasonably expect that Dr E would have noted the existence of the protocols either on his initial orientation or during the "buddy" shifts and day shifts.

While I remain of the view that Dr E's orientation could have made him more familiar with protocols, the level of supervision provided by Dr H and other doctors meant Dr E could reasonably be expected to have "learnt the ropes" by January 2004 and be aware of the existence of the relevant protocols and guidelines. I am satisfied that the Company took such steps as were reasonably practicable to prevent its employee, Dr E, from the omissions in his care for Baby A. Accordingly, the Company is not vicariously liable for Dr E's breach of Right 4(1) of the Code.

Opinion: No Breach — Tairawhiti District Health Board

Provision of information
Under Right 6 of the Code, Baby A's family had the right to be provided with an explanation of her condition and the results of the tests and procedures performed.

Dr K, consultant paediatrician at Gisborne Hospital, saw Baby A immediately she arrived at Gisborne Hospital Paediatric Department at 12pm on 5 January 2004, on referral of the general practitioner. Dr K commenced antibiotic therapy while she performed diagnostic investigations. When the tests confirmed severe sepsis and probable Group B Streptococcus meningitis, and a CT scan showed severe brain damage, Dr K conferred with the consultant paediatrician at the city hospital, to confirm her diagnosis. When the consultant paediatrician confirmed the diagnosis, Dr K informed Baby A's family of the results of the tests and Baby A's condition.

On 9 January (at the family's request), a family meeting was held to explain Baby A's condition and treatment. Between 30 and 40 family members attended the meeting.

Baby A was monitored and treated for three weeks at Gisborne Hospital Paediatric Department, but on 28 January she developed another fever. Repeat brain scans were performed. Again Dr K discussed the findings with the consultant paediatrician at the city hospital before she explained to the family that the second fever had destroyed almost all of Baby A's brain tissue. Dr K informed Baby A's family that her long-term outcome was very poor, and assured them that following her discharge on 11 February 2004 she would be followed up by a visiting neurodevelopmental therapist, a dietitian and by Dr K herself.

The DHB held a case review of Baby A's case on 19 January. A written report of the outcome of that review was not provided to the family, but Dr K and the paediatric team have been in regular contact with the family and have explained the key information.

In my opinion, the DHB took appropriate steps to inform the B family about Baby A's condition and the results of the various tests and investigations, and therefore did not breach Right 6(1) of the Code.

Vicarious liability
Under section 72 of the Act, an employing authority may be vicariously liable for acts or omissions by an employee, an agent or a member.

Section 3(a) of the Act states that a health care provider includes someone in charge of providing health care services within the meaning of the Health and Disability Services (Safety) Act 2001. The DHB falls within this definition and is therefore also an employing authority for the purposes of section 72 of the Act.

It is necessary to consider whether Dr E was acting as an employee or an agent of the DHB when providing services to Baby A, and, if so, whether the DHB is vicariously liable for any

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omissions by Dr E that breached the Code. Since Dr E was employed by the Company (which contracted with the DHB to provide emergency services at Gisborne Hospital), he was not an employee of the DHB.

Agency

This leaves open the question whether Dr E was acting as an agent of the DHB. The DHB did not expressly hold Dr E out as its agent, and its contract with the Company specifically states that nothing in the contract should be construed as giving rise to a partnership, agency or employment relationship. Even so, there are circumstances in which the actions of a person can lead to a relationship of agency being implied. As noted by the Court of Appeal:[1]

> "The legal principles relating to ostensible or apparent agency are well settled. A person who by words or conduct has allowed another to appear to a third party to be his or her agent cannot afterwards repudiate that agency."

In my opinion, the DHB allowed Dr E to appear to be its agent. In my first provisional opinion I noted that the agreement between the Company and the DHB gives medical officers such as Dr E the ability to admit patients to Gisborne Hospital and commit the hospital to provide services to that person, something which in my view is consistent with an agency relationship. The DHB disagrees with this view, stating that Dr E cannot alter its legal relations with third parties and, while he can admit patients to Gisborne Hospital, he cannot require that they be treated. The DHB states that it provides services to such patients on the basis of its statutory responsibilities and ethical obligations, not as a result of Dr E's actions. The DHB accepts that it has an obligation to provide emergency medical services, but submits that contracting a third party to do so does not mean that the DHB is responsible for the acts and omissions of that third party, even if that party is working on its premises.

The relevant provision of the contract between the Company and the DHB states: "[The Company] is responsible for determining, in accordance with generally accepted standards and protocols, whether any qualifying person requires treatment or care and for determining priority of access to be afforded to that person."[2]

The DHB expressed concern that finding Dr E to be its agent on this basis would have wider implications and result in the DHB being liable for the actions of most health care providers in the Tairawhiti region. It funds the provision of health services through contracts with providers such as Primary Health Organisations and pharmacies, and considers these contracts to be the same as its agreement with the Company. The DHB

[1] *Arthur Watson Savage v Kathleen Taylor* (unrep, CA 103/95, 19 March 1996, Richardson P).

[2] Clause 1.1, Schedule F, Contract between Tairawhiti District Health Board and the Company, dated 20 January 1998.

stated that it would be surprised if referrals from such providers committed it to provide services and created a relationship of agency.

I do not accept that the DHB is potentially vicariously liable for the actions of each and every provider it funds. Staff in the ED (even if medical services are funded via a separate contract with an independent company) work on the hospital campus in a proximate relationship with inpatient services. This is very different from the situation of most independent health care providers funded by the DHB in the Tairawhiti region.

A second key factor in determining whether there is an ostensible agency relationship is the outward appearance to third parties. What would be the understanding of most patients attending the Emergency Department at Gisborne Hospital? Would patients consider the Emergency Department medical officers to be part of the hospital (and the DHB) in the same way as doctors in other departments are? Would patients expect the hospital and DHB to be responsible for the quality of the services provided by those doctors and for ensuring their competence? There is no evidence that patients are made aware of the nature of the DHB's contractual arrangements. Indeed, the complaint by Ms A suggests that she views Dr E as being employed by Gisborne Hospital.

Vicarious liability arises under section 72(3) only if the acts or omissions in question took place with the express or implied authority of the DHB. Dr E's *actual* (express) authority was only to provide medical services of an appropriate standard to patients at Gisborne Hospital. However, his *ostensible* authority was simply to provide medical services at the ED. The DHB took no steps to limit the appearance of full authority. Furthermore, while the DHB did not expressly authorise Dr E to make acts or omissions which breached the Code, these acts and omissions were directly connected with the medical services that Dr E had been expressly authorised to provide. Liability on this basis is consistent with the approach taken by the Court of Appeal in relation to common law vicarious liability.[3]

The DHB also submitted that the defence of taking "such steps as were reasonably practicable" (section 72(5)) is not available to employing authorities in respect of agents. It argues that employing authorities cannot be held liable for unauthorised acts or omissions of agents, as to do so would mean imposing a stricter liability than for the acts or omissions of employees.

In my view the defence in section 72(5) is also available in relation to the acts or omissions of agents. The High Court considered this issue in relation to the equivalent provision of

[3] In the case of *S v Attorney General* [2003] 3 NZLR 450 (CA), the Department of Social Welfare was held vicariously liable for abusive acts by foster parents (who were considered to be its agents) on the basis that the abuse occurred in the course of the performance of their agency duties and that such abuse was sufficiently connected with the purpose of foster parenting, even though it was absolutely contrary to the intentions of the Department.

the Human Rights Act 1993.[4] Its conclusion was that because the subsection dealing with principal and agent deals with a situation that extends beyond that contemplated by the subsection relating to employees, there should be a defence available which reflects the less direct nature of the relationship. The Court "read in" a general defence covering all aspects of vicarious liability. I therefore conclude that the section 72(5) defence is available to employing authorities in respect of vicariously liability for agents and members under the Health and Disability Commissioner Act.

In considering the issue of vicarious liability I have taken into account the purpose of the Act, namely to promote and protect the rights of consumers. The imposition of vicarious liability in the current circumstances encourages employing authorities to take reasonable steps to ensure that all health practitioners who work on their premises are practising competently and are familiar with relevant protocols and guidelines. From a patient's perspective, this is important, irrespective of the background contractual arrangements.

I do not consider that there is any "anomaly" in viewing an employing authority as being potentially liable for acts or omissions of an agent that are closely connected conduct expressly authorised by the employing authority.

Similarly, a responsibility to take all reasonably practicable steps to avoid a breach of the Code by an agent/employee/member is more in keeping with the statutory purpose of consumer protection than taking the view that an employing authority faces liability only if it has authorised its agent or member to provide substandard services. It is difficult to envisage an employing authority ever authorising an agent or member to provide substandard services. The approach suggested by the DHB would exclude any liability for the provision of services of an inappropriate standard.

These policy factors lead me to conclude that section 72(3) should be interpreted liberally, to better protect the rights of consumers. In my opinion, Dr E was an agent of the DHB for the purposes of section 72(3) of the Act, and was acting within the scope of his ostensible authority when he provided services to Baby A.

Defence of taking "reasonable steps"
After Dr E's arrival in New Zealand from overseas he received an orientation from Dr H, which included informing him of the existence and location of the department's guidelines. Dr H stated that during Dr E's orientation he was informed that the paediatricians at Gisborne Hospital have a "low threshold" for admitting unwell children, and that medical staff, if in doubt about a child's condition, are to err on the side of caution and offer admission for observation rather than outpatient management.

[4] *Totalisator Agency Board v Gruschow* [1998] NZAR 529.

Dr Stanley, the pediatrician who advised ACC, expressed concern that Gisborne Hospital did not appear to have systems in place for the direct referral of a febrile four-week baby from the Emergency Department to the Pediatric Department.

In January 2004, Gisborne Hospital guidelines for the management of a febrile infant in the Emergency Department advised the examining doctors to take a history of the specific symptoms, immunisation status and possible contact with an infectious disease, and to examine for skin rashes and potential sites of infection and to evaluate vital signs; if the presenting child had no focal signs and looked relatively well, the cause was probably viral. The guidelines recommended that a urinalysis should then be performed, followed by cooling measures and observations. If after a period of observation there was a deterioration of the child's condition, the doctor was guided towards other interventions.

Although the guidelines did not specify mandatory referral to or consultation with the paediatric team, there was sufficient detail to guide staff in providing appropriate assessments and care for an unwell child. Had Dr E been aware of the guidelines, there would at the very least have been an increased chance that his assessment and treatment of Baby A would have been of an appropriate standard.

My initial view was that the DHB did not take sufficient steps to ensure that Dr E was familiar with the hospital guidelines and protocols. Although the DHB had contracted its emergency services to the Company, it remained responsible for ensuring that medical staff working in the hospital campus were familiar with hospital guidelines and protocols. The DHB did not provide me with any information about the steps it had taken to fulfil this responsibility. However, information provided by the Company about Dr E's orientation and ongoing supervision persuades me that it took (on behalf of the DHB) reasonably practicable steps to ensure that Dr E was familiar with the hospital protocols. Accordingly, Tairawhiti DHB is not vicariously liable by Dr E's breach of Right 4(1) of the Code.

ED supervision at Gisborne Hospital

My independent emergency medicine advisor, Dr Pearson, expressed some concern about the level of supervision in the Emergency Department at Gisborne Hospital. He was provided with Dr H's statements regarding the measures in place for orientating, training and monitoring medical officer performance in the Emergency Department. Dr Pearson commented that he had not encountered a contracting out of the provision of emergency services at a public hospital and queried the level of "on the floor" supervision of the non-specialist doctors working in the department. Dr Pearson stated that "whilst guidelines are useful additions and aids, they are not a substitute for direct supervision by specialists in emergency medicine".

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Dr H responded on behalf of the Company that it supports the concept of supervision by an emergency medicine specialist and would like to achieve this at Gisborne Hospital, but currently faces difficulties because of the scarcity of such doctors — a situation faced by other provincial hospital emergency departments.

The DHB and the Company expressed concerns that Dr Pearson's comments were based on incomplete information and on his experience in a large emergency department in a large metropolitan area. However, Dr Pearson has confirmed his familiarity with smaller emergency departments.

The DHB's decision to contract the Company to provide medical staff in the Emergency Department does not lessen the DHB's responsibility for ensuring that the medical officers provided under this arrangement are competent and provide services of an appropriate quality. Entering into a contract for the provision of appropriately qualified, skilled and trained medical officers does not of itself fulfil the obligation to provide appropriate emergency services. The performance of that contract must be monitored and remedial action taken when necessary.

I am concerned at the Company's statement about the protocols and guidelines in the Emergency Department. If there are indeed thousands of pages of such documents, reorganisation of the material is needed. The DHB stated that it has recently reviewed the material provided to new medical officers and will ensure a similar review is undertaken by the Company. In my view, such a review should occur as a matter of urgency and the doctors employed by the Company should be working from the same material as doctors employed by the DHB. They are, after all, working at the same hospital.

Recommendations

I recommend that Dr E:

- apologise in writing to Ms A and Baby A's family for his breach of the Code;
- review his practice in light of this report.

I recommend that Ms F:

- apologise in writing to Ms A and Baby A's family for her breach of the Code;
- review her practice in light of this report.

I recommend that Tairawhiti District Health Board:

- ensure that the Company complies with the above recommendation;

- confirm to the Commissioner (by 2 December 2005) that it is satisfied that the current arrangements ensure the provision of ED services of an appropriate standard at Gisborne Hospital.

Follow-up actions

- A copy of this report will be sent to the Medical Council of New Zealand, the Australasian College for Emergency Medicine (NZ Faculty), the New Zealand College of Midwives and the Director-General of Health.

- A copy of this report, with details identifying the parties removed (but naming Gisborne Hospital and the Tairawhiti District Health Board), will be sent to the Royal Australasian College of Physicians, the Paediatric Society of New Zealand, the Accident and Medical Practitioners Association and to all District Health Boards, and be placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

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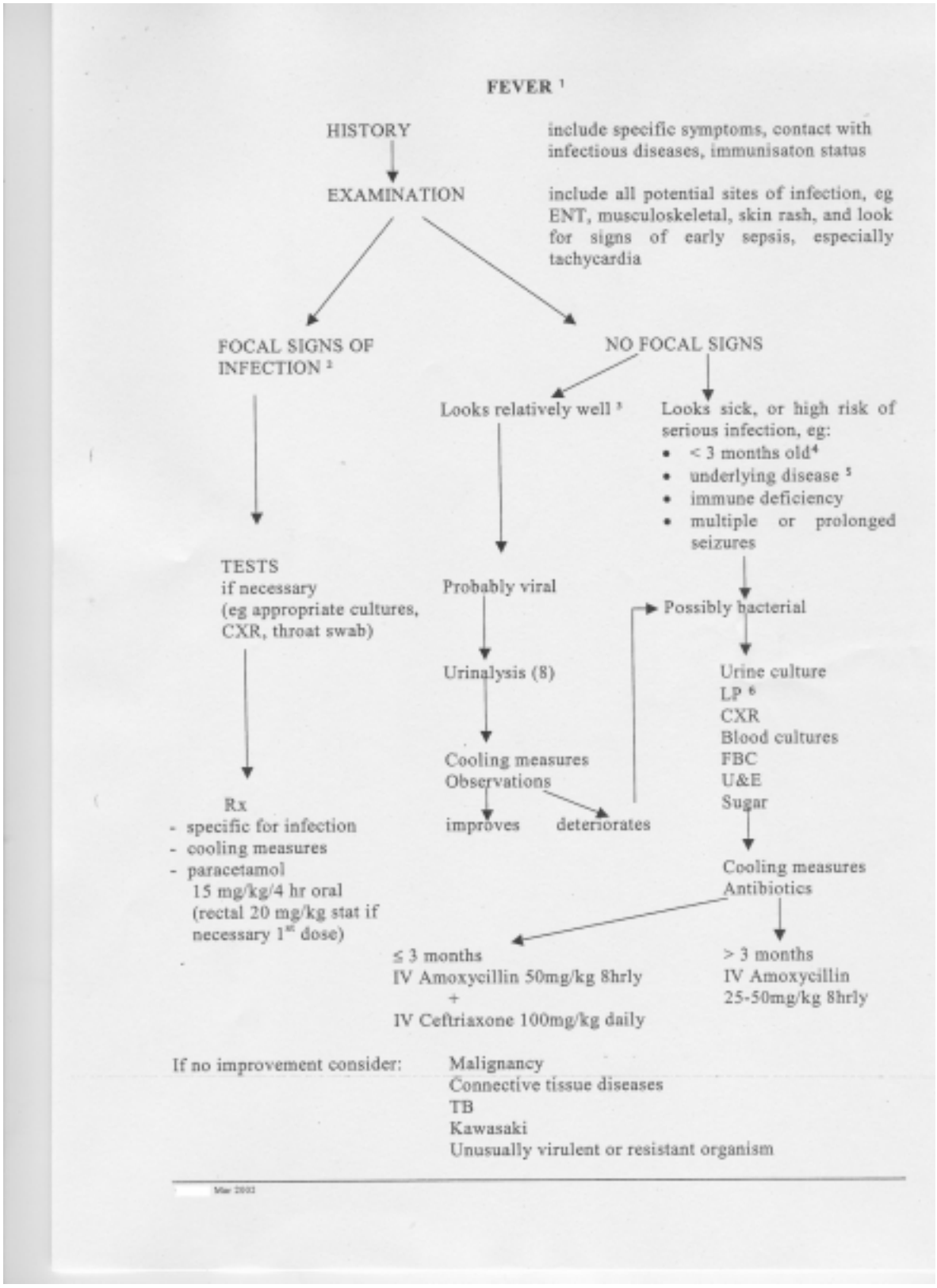
Appendix 1



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NOTES ON FEVER

1 At least one documented temp of ≥38.5 axillary or 38 rectal is usual in acute febrile illness. Fever may be absent or low grade however in infectious disease in young infants (esp < 3months old) or in the severely ill child with peripheral shutdown.

2 Focal findings include both obvious sources of fever and also suggestive physical findings, such as tachypnoea (chest infection etc), murmur (rheumatic fever, sbe etc), rash (exanthem, meningococcus etc), points of tenderness or pain. Upper respiratory tract symptoms and diarrhoea and/or vomiting should be interpreted carefully, as sometimes a more serious illness (eg meningitis) may start with apparently benign and non-specific features

3 Components on overall examination suggesting a well child include:

i Child looks and focuses on clinician and spontaneously explores the room.
ii Child spontaneously makes sounds and talks in a playful manner
iii Child plays and reaches for objects
iv Child smiles and interacts with mother or doctor
v Child quiets easily when held by parent

4 Children under three months with serious infection often have no specific signs. They also may have infections with unusual organisms (Listeria, E coli). Any febrile child under three months unless remarkably well or has a clear focus of infection, should have blood cultures taken, urine (by SPA or catheter if possible) and a LP. An older child with temp >41 should also be carefully considered for thorough investigation, as the higher the fever, the more likely is bacteraemia. Overall the rate of bacteraemia in febrile infants < 2yr with no focus of infection is 3%. Antibiotics can be stopped at 48 hours if well, cultures negative and if no focus has emerged.

5 Underlying cardiac, pulmonary, neurological or immunodeficiency (sickle cell, neoplasms, steroids etc) diseases require early evaluation and treatment regardless of age and height of fever.

6 Signs of meningitis are unreliable in babies under 1 year old, and the absence of neck stiffness does not exclude meningeal irritation. School aged children with meningitis will have signs of meningism, so the decision regarding the need for LP in febrile children is dependent on age as well as on physical signs. If you cannot exclude meningitis clinically, and consider that antibiotics are necessary, then LP should be done, unless contraindicated. Do not do a LP if:

- There are signs of significantly raised intracranial pressure with severely depressed level of consciousness (eg Por U on the AVPU score), or papilloedema.
- Purpura is evolving or there are other signs to suggest a bleeding tendency.

References: Starship guideline. Textbook of paediatrics, Forfar and Arneil. APLS manual

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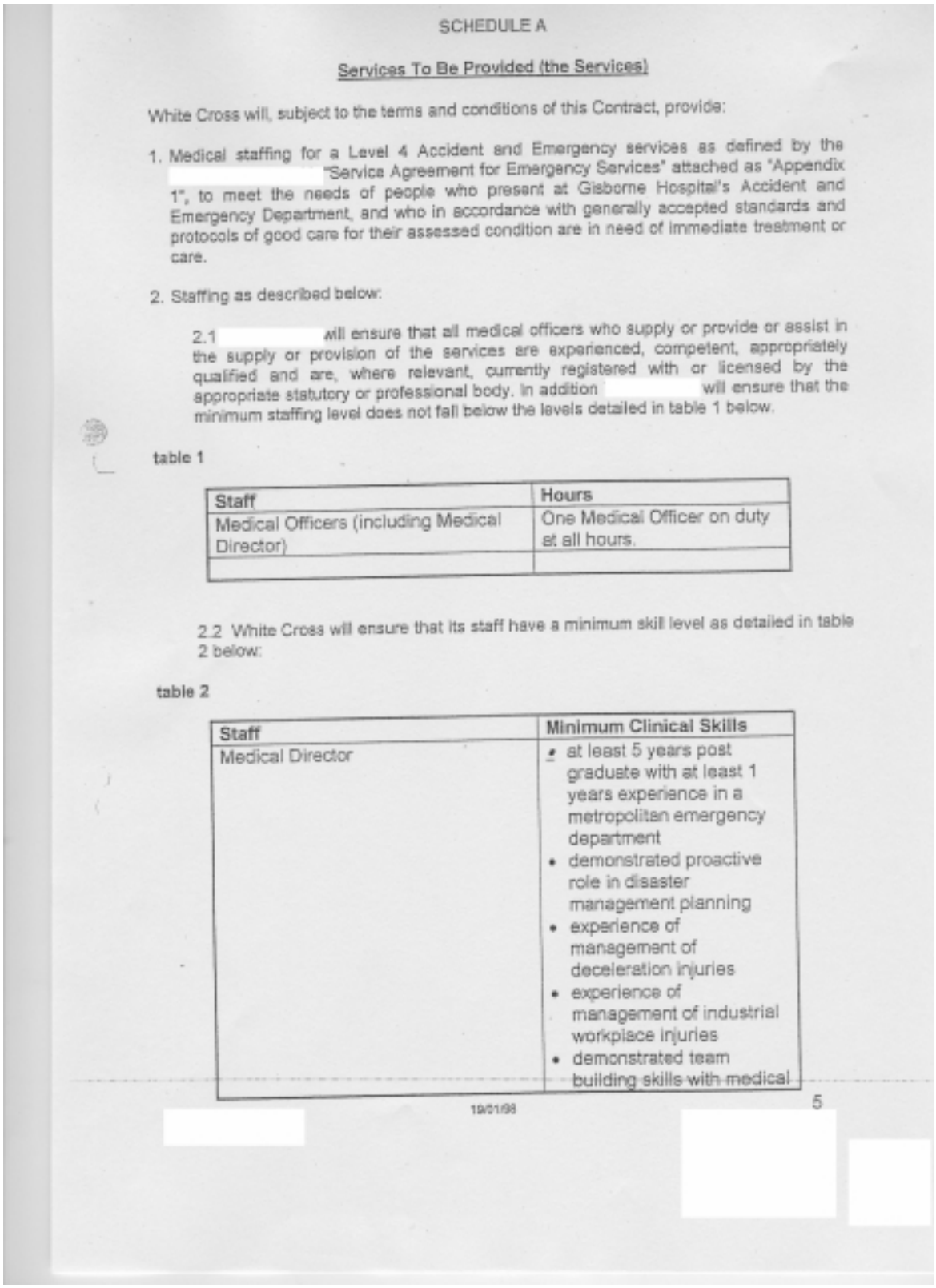
Appendix 2



SCHEDULE A

Services To Be Provided (the Services)

White Cross will, subject to the terms and conditions of this Contract, provide:

1. Medical staffing for a Level 4 Accident and Emergency services as defined by the "Service Agreement for Emergency Services" attached as "Appendix 1", to meet the needs of people who present at Gisborne Hospital's Accident and Emergency Department, and who in accordance with generally accepted standards and protocols of good care for their assessed condition are in need of immediate treatment or care.

2. Staffing as described below:

   2.1 will ensure that all medical officers who supply or provide or assist in the supply or provision of the services are experienced, competent, appropriately qualified and are, where relevant, currently registered with or licensed by the appropriate statutory or professional body. In addition will ensure that the minimum staffing level does not fall below the levels detailed in table 1 below.

table 1

Staff	Hours
Medical Officers (including Medical Director)	One Medical Officer on duty at all hours.

2.2 White Cross will ensure that its staff have a minimum skill level as detailed in table 2 below:

table 2

Staff	Minimum Clinical Skills
Medical Director	• at least 5 years post graduate with at least 1 years experience in a metropolitan emergency department • demonstrated proactive role in disaster management planning • experience of management of deceleration injuries • experience of management of industrial workplace injuries • demonstrated team building skills with medical

19/01/98 5

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	and nursing colleagues.
All Medical Officers (including Medical Director)	• at least two years post registration experience • airway management skills - including intubation of adults and paediatric and neonatal clients • current knowledge of advanced resuscitation practises • ability to assess orthopaedic injuries and perform fracture manipulation and plastering under local anaesthetic blockade when necessary • recognised general surgical assessment skills • recognised general medical assessment skills, particularly respiratory medicine

3. Medical cover within Gisborne Hospital from 10:30pm to 8:00am every day, as the only Medical Officer on duty. This cover extends to Accident & Emergency, and all ward duties. will provide "back-up" to this position by way of an "on-call" house officer. In addition the White Cross Medical Officer will provide assistance as required to the THL House Officer on duty between the hours of 4:30 p.m. to 10:30 p.m. on weekdays and throughout weekends.

The medical officers will attend all cardiac arrests and resuscitations in all departments at all times.

4. Liaison with the Regional Trauma Service for management and transfer of major trauma, ambulance services and other emergency agencies as required.

5. Specific training opportunities for approximately 4hrs per day for junior medical staff to work with a more experienced medical officer to obtain experience in acute assessment and emergency medicine.

6. Observation and treatment services to prevent unnecessary admissions to Gisborne Hospital

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6

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