Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

Systemic and organisational issues led to delay in timely detection and treatment of sepsis
20HDC01240

Deputy Health and Disability Commissioner, Dr Vanessa Caldwell has found Te Whatu Ora Taranaki (previously Taranaki DHB) breached the Code of Health and Disability Servicers Consumers' Rights (the Code) for failures in the care of a woman at Taranaki Base Hospital.

The woman was referred to the hospital's Emergency Department (ED) by her GP after she reported feeling unwell following recent overseas cancer treatment.

The medical team in the ED did not recognise that the woman was seriously ill, and her acute condition was not identified until she was on a medical ward 12 hours after admission. The woman was transferred to the High Dependency Unit, however, her condition rapidly deteriorated and she passed away.

Dr Caldwell found that systemic and organisational issues led to a delay in the timely detection and treatment of the woman's sepsis (a life-threatening condition caused by the body's extreme overreaction to an infection). Accordingly, she found Te Whatu Ora in breach of Right 4(1) of the Code for failing to provide services to the woman with reasonable care and skill.

Dr Caldwell says, "The errors and omissions that occurred during the time the woman was at Taranaki Base Hospital were, in the main, not the result of isolated incidents involving individual staff members. Rather, many staff missed opportunities to recognise and respond to the woman's serious illness."

A number of failings were identified in the report including a significant delay before the woman was seen by a doctor, and there was no senior doctor meaningfully involved in her care in the first 13 hours of her admission.

Despite the woman's blood results and clinical features pointing to sepsis and the need to escalate her care, there were delays by a number of staff in recognising and appropriately responding to the situation.

Further, on two occasions the woman's care was not escalated in line with Te Whatu Ora's Early Warning Score (EWS) Mandatory Escalation Pathway. The taking of vital signs and observations to calculate the EWS were also poorly adhered to overall.

Finally, there were shortcomings in the quality of record-keeping by the medical team in the ED and by nursing staff in the ED and on the medical ward, which made it difficult to track her deteriorating condition.

Dr Caldwell expressed her sincere sympathy to the family for their loss. “Although the woman was living with metastatic cancer, she believed that chemotherapy could contain it and potentially allow her to live for another nine months to three years.”

Dr Caldwell acknowledged that Te Whatu Ora has made a number of changes since these events, including improving its staff training and education in relation to sepsis and use of EWS, introducing a 24/7 Patients at Risk nursing service and launching a Speaking Up for Patient Safety campaign for staff.

Dr Caldwell found the care fell significantly below accepted standards and considered it to be in the public interest to hold Te Whatu Ora accountable for that service delivery failure. She has referred the matter to the Director of Proceedings.

3 July 2023

Editor’s notes

The full report of this case will be available on HDC’s website. Names have been removed from the report to protect privacy of the individuals involved in this case.

The Commissioner will usually name providers and public hospitals found in breach of the Code, unless it would not be in the public interest, or would unfairly compromise the privacy interests of an individual provider or a consumer.

More information for the media, including HDC’s naming policy and why we don’t comment on complaints, can be found on our website here.

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

In 2021/22 HDC made 402 recommendations for quality improvement and providers complied with 98% of those recommendation.

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