HEALTH & DISABILITY COMMISSIONER
TE TOIHAU HAUORA, HAUĀTANGA

Two-year-old required major surgery following misdiagnosis

Introduction

1. The Health and Disability Commissioner (HDC) received a complaint from Mr and Mrs A about the care provided to their daughter, Miss A, at Wellington Hospital in July 2022. Mr and Mrs A are concerned that Miss A was not assessed appropriately and was misdiagnosed with gastroenteritis.[1] Miss A was subsequently diagnosed with a ruptured appendix[2] and required surgery to remove part of her bowel and further surgery to create an ileostomy.[3] Mr and Mrs A believe that major surgery and the ileostomy could have been avoided if Miss A had been treated with appropriate care and skill.

2. After assessing all the information gathered during this investigation, I find that Health New Zealand | Te Whatu Ora – Capital, Coast and Hutt Valley (Health NZ) failed to provide services with reasonable care and skill, in breach of Right 4(1)[4] of the Code of Health and Disability Services Consumers' Rights (the Code).

Recommendations

3. I recommend that Health NZ:

a) Provide a formal written apology to Mr and Mrs A for the breach of Right 4(1) of the Code identified within this report. The apology is to be sent to HDC within three weeks of the date of this report for forwarding to Mr and Mrs A.

b) Provide training to junior doctors on the assessment and escalation of red flag symptoms, including persistent fever and tachycardia (rapid heart rate), in children. A copy of the training records, including an outline of the content, is to be provided to HDC within six months of the date of this report.

c) Undertake an audit of 20 paediatric discharge summaries, covering the most recent 12-month period, for compliance with provision of appropriate safety netting advice. A report on the audit results and any corrective actions is to be provided to HDC within three months of the date of this report.

d) Provide HDC with a copy of evidence of completed recommendations from the systems analysis review dated 12 June 2024, including the guideline developed for children with persistent gastrointestinal symptoms. Evidence is to be provided within three weeks of the date of this report.

[1] Inflammation of the stomach and intestines caused by viruses, bacteria, or parasites and resulting in nausea, vomiting, diarrhoea, abdominal pain, and fever.
[2] A burst or torn appendix, usually caused by appendicitis, which can release infected material into the abdomen and lead to serious infection.
[3] A surgical procedure that involves bringing the end of the small intestine (ileum) to the surface of the abdomen to create a stoma, allowing waste to exit the body into an ileostomy bag.
[4] Right 4(1) states 'Every consumer has the right to have services provided with reasonable care and skill.'

Names have been removed (except Health New Zealand | Te Whatu Ora Capital, Coast and Hutt Valley and the clinical advisor on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

e) Audit a sample of 15 paediatric charts for the frequency of Paediatric Early Warning Score (PEWS)[5] observations against accepted local guidelines. Audit results and any corrective actions are to be provided to HDC within three months of the date of this report.

f) Consider reviewing the admission process to encourage early engagement with Play Specialists to reduce interventional distress, enable examinations, and enhance the ability to observe developmental behaviours in response to illness.

Background

4. Miss A was two years old at the time of these events. On Saturday 9 July 2022, she developed a fever and was taken to the local medical centre where her parents were told that she had a viral infection, most likely influenza. A general practitioner (GP) conducted a physical examination of Miss A, which did not show any clear signs to suggest a cause other than flu-like illness, which was prevalent at the time. The GP who examined Miss A told HDC that appendicitis is difficult to diagnose in the early stages and rare in children of Miss A's age. The GP did not order a blood test because they did not consider it useful or appropriate and because no laboratory services were available at the local medical centre on the weekend, so the family would have had to transfer to Wellington Hospital. Miss A improved significantly after receiving ibuprofen for fever and pain and was discharged home.

Wellington Hospital

5. The next day, after Miss A's parents contacted Healthline for advice, she was admitted to a paediatric ward at Wellington Hospital and had a nasogastric tube[6] inserted to facilitate fluid intake. Her symptoms, as noted in the Emergency Department (ED) clinical record, consisted of a four-day history of cough, inflammation of nasal mucous membranes, fevers, and a two-day history of reduced oral intake, episodes of loose bowel motions, and abdominal discomfort. Miss A was diagnosed with a viral illness and dehydration.

6. A paediatric consultant reviewed Miss A on the morning of 11 July 2022. Her abdomen was soft and she was noted to be crying during the abdominal examination. Clinical documentation records that Miss A had frequent loose malodorous bowel motions during the day. She did not have a fever but had been administered paracetamol and ibuprofen throughout the day. That evening, a paediatric registrar examined Miss A, who was very reluctant to be examined because of her abdominal pain. The registrar documented a clinical impression of possible gastroenteritis. The nursing documentation notes Miss A as being 'miserable,' requiring regular pain relief (paracetamol and ibuprofen), and being unable to lie flat.

7. At 4am on 12 July 2022, Miss A woke up miserable and with a high temperature of 38.1°C. The paediatric registrar reviewed her at 11am and noted that she was miserable, lethargic, and dehydrated. A plan was made to increase nasogastric fluids. The registrar considered the possibility of a urinary tract infection. This is supported by clinical documentation

[5] System designed to identify paediatric patients at risk of deterioration and to help staff know when to escalate for clinical assistance.

[6] A thin, flexible tube inserted through the nose into the stomach to deliver nutrition or medications or to remove stomach contents.

directing nursing staff to obtain a 'clean catch' urine sample if possible. However, there is no record of this sample being obtained.

8. In an internal review after the events, Health NZ acknowledged that, at this point, Miss A's clinical path began to diverge from the typical gastroenteritis picture as she had not improved after 48 hours, had a high heart rate, and had fevers again. Miss A's blood tests were normal but did not include a full blood count or C-reactive protein (CRP)[7] test. In response to my provisional decision, Mr and Mrs A state that a full blood count and/or CRP should have been ordered at that stage, rather than limiting the investigation to a blood test, which primarily assesses kidney function, hydration, and electrolyte balance.

9. That evening, Miss A was noted as having a tight, distended abdomen, and this was discussed with the paediatric registrar. In response to my provisional decision, Mr and Mrs A said they had expressed real concern that Miss A's abdomen was firm to the touch and very distended. The nurse caring for Miss A on the afternoon shift told them that the doctor was coming to see them. The doctor did not arrive that evening; after making further enquiries, Mr and Mrs A were told that Miss A would be reviewed in the morning.

13 July 2022

10. On the morning of 13 July 2022, the locum[8] paediatric registrar, Dr B, reviewed Miss A because the registrar who had examined her the day before was covering staffing gaps at another hospital. Dr B stated that Miss A had been seen by different doctors each day of her admission, which she believes affected the continuity of care. In contrast, Health NZ stated that it does not consider inadequate staffing to be a factor, as the ward was adequately covered with a locum registrar, and it noted that it is not unusual for a different resident medical officer (RMO) to review patients from one day to the next, although – where possible – the same RMO will review the patient throughout admission.

11. The handover information was that Miss A had been diagnosed with gastrointestinal illness, and Dr B was asked to determine whether Miss A was well enough to be discharged.

12. Dr B completed a full physical examination during this review. Miss A was still receiving nasogastric fluids and had been sipping water orally. Her abdomen was soft and generally tender (meaning the tenderness was not limited to a specific area). Dr B recalls Mrs A asking her whether Miss A's abdomen looked distended; Dr B did not think it was. After examining Miss A, Dr B did not feel she was well enough to be discharged as she had not been eating and drinking. Mr and Mrs A dispute that Dr B completed a full physical examination and state that a conversation about discharging Miss A occurred before any examination took place. Mrs A thought it was unusual to discuss discharge when there were concerns about Miss A's distended abdomen.

[7] CRP is released into the blood in response to inflammation or tissue damage, so a high CRP result can indicate inflammation and infection.

[8] A locum covers temporary vacancies such as during annual leave, sick leave, and recruitment for permanent staff.

13. The clinical record notes that Miss A was 'spiking' temperatures overnight and had an increased heart rate. The PEWS chart records Miss A's temperature at over 38°C and her heart rate at 168 at 8.40am that morning. On occasion, the PEWS is only documented in the clinical record by nursing staff as a score with no individual components. Miss A's blood pressure was recorded only once during her inpatient stay, which did not allow for monitoring trends or accurate scoring, and there is no + sign in the scoring column on the chart to indicate that observations are incomplete.

14. Miss A was distressed by the interventions, miserable, and difficult to examine. Laboratory results confirmed that Miss A did not have rotavirus, but the results of faecal tests for gastrointestinal bacteria, viruses, and parasites were still pending. Dr B asked the nursing staff to stop using the nasogastric tube and to offer food and fluid orally. She planned to review Miss A that afternoon and discussed the plan with the on-call paediatric consultant. Miss A was to be given paracetamol and ibuprofen for fevers and misery.

15. For context, before going to work, Dr B had returned a negative RAT test and was unaware that she was developing COVID-19, which she tested positive for the next day.

16. Health NZ stated that, by 13 July 2022, it was clear that Miss A's clinical path had diverged from what would be expected of viral gastroenteritis and that a full blood count and CRP should have been done. Results from these tests probably would have shown that Miss A's white cell count and CRP were elevated, prompting further investigation.

17. Dr B saw Miss A again on the afternoon of 13 July 2022, but there is no clinical documentation of a review. At 2.48pm, the faecal test result was reported as negative for all illnesses. Nursing documentation notes a PEWS of zero and no fever, but this is not documented on the PEWS chart, and the individual vital sign recordings are not specified in the documentation. The nurse documented that Miss A was alert and interactive but miserable at times and had been given regular pain relief.

18. Mr and Mrs A stated that, before Miss A was medically reviewed, they were told that Miss A was to be discharged and that the doctor walked into the room and said 'Right, let's get her home. Everything we are doing, you can do at home. If you have any problems, don't come back to ED, see your GP.' Mr and Mrs A felt that Miss A was still unwell and that her high fevers were still unmanaged even though paracetamol was reducing them.

19. Dr B recalls observing Miss A from the end of the bed at around 1pm and that she appeared brighter, was moving around freely, was drinking, and had eaten some lunch. Dr B explained that Miss A could be discharged because she no longer required the nasogastric tube and the hospital was not offering anything that could not be done at home. In response to my provisional decision, Mr and Mrs A noted that a review did not take place at this time.

20. Dr B felt that Miss A's parents agreed she was more herself and felt comfortable with the plan. During an internal review process, Health NZ acknowledged that Mr and Mrs A had not felt comfortable with the plan and apologised for not listening to their concerns. Dr B did not re-examine Miss A but stated that she would not have refused to do so if requested. She did not suggest further blood tests as Miss A had improved over the day and had a

working diagnosis of a viral illness. Health NZ's review found that Miss A should not have been discharged home based on the limited review that took place.

21. Return advice noted on the discharge summary includes instructions to seek a medical review with Miss A's GP if she does not improve, has ongoing fevers, starts refusing oral intake again, or deteriorates in any way. Dr B offered to send the discharge documentation to Miss A's parents by mail rather than have them wait until it was complete, as they had a long drive home.

22. No return advice is specifically documented on the discharge summary. The section for 'advice to patient' does not include any safety netting instructions. Dr B acknowledged that her documentation contains errors and gaps, particularly on the discharge summary, which had been prepared earlier in the week by a colleague. She did not follow her usual process of updating the discharge summary with clinical improvement, findings of the afternoon review, and the return advice provided to the family. Dr B did add that return advice had been provided to the family to continue to encourage oral fluids. Dr B also acknowledged that, on reflection, there was a missed opportunity to more thoroughly re-evaluate or question Miss A's diagnosis.

23. On 18 July 2022, Miss A's GP re-referred her to hospital. She had not improved and was complaining of a sore abdomen. Miss A was diagnosed with a ruptured appendix and required surgery to remove part of her bowel. She remained in hospital until 1 August 2022 but was readmitted a few days after discharge with a bowel obstruction. Miss A required further surgery to form an ileostomy and was eventually discharged on 18 August 2022.

Responses to provisional decision

24. Mr and Mrs A were provided with a copy of the background section of my provisional decision. Their comments have been incorporated into this report where relevant, including a summary of the impact these events have had on Miss A and her family. Mr and Mrs A state that Miss A has experienced ongoing stomach issues since these events, the most recent on 19 April 2026 when she was admitted to Wellington Children's Hospital for small bowel obstruction. Miss A is on a two-year recall as she is likely to require further surgery on the scar as her stomach grows.

25. Miss A is also on a waitlist for trauma therapy as a result of what happened in 2022, and her parents have sought therapy to manage their own trauma. Mr and Mrs A are unable to take Miss A into any healthcare setting without her having a panic attack. She needed to be sedated for medical interventions, such as inserting an intravenous line, during her recent admission. The repercussions of these events have significantly affected Miss A's family.

Analysis

26. To assist my decision-making regarding whether Miss A was provided with care of an appropriate standard, I have considered independent clinical advice from paediatrician Dr Heidi Baker (**Appendix A**).

27. Dr Baker advised that there were moderate departures from the accepted standard of care when Miss A did not improve within 48 hours after admission, and her vital signs did not

normalise as would be expected for a child with gastroenteritis. The Starship Gastroenteritis Guideline advises that, for children with a diagnosis of gastroenteritis who have abdominal pain that continues for more than 24 hours, alternative diagnoses need to be considered and investigated for, consultant review is required, and surgical intervention may be required.

28. I accept Dr Baker's advice that, although the initial clinical assessment was appropriate, further investigations for an alternative diagnosis did not occur when Miss A's clinical pathway deviated and she continued to have fevers and a high heart rate. Miss A did not improve as expected. Her clinical pathway deviated from expected on 12 July 2022 when the registrar considered an infective cause for her symptoms and requested a urine sample. I accept Dr Baker's advice that further investigations, including full blood count and CRP, should have been ordered, especially as Miss A's laboratory test results had not identified a viral cause for her illness.

29. Miss A's record notes that she was miserable at times on 13 July 2022 when she was discharged and, although she appeared more herself in the afternoon, no vital signs were recorded on her PEWS chart. There is evidence throughout Miss A's admission of spiking high temperatures, and her heart rate remained elevated or within the upper limits of physiological parameters. The clinical record documents a PEWS score of zero but does not specify how this was calculated. In my view, one set of observations in isolation does not indicate a trend of improvement.

30. Dr Baker advised that tachycardia appears to have been accepted and noted that it would be unusual for a patient to be discharged with tachycardia. Dr Baker further advised that persistent fever several days after presentation and on discharge without any confirmed cause is unusual. It is not clear whether the pain relief given on 13 July 2022 contributed to the lack of fever that afternoon or whether this was considered before discharge. Noting that Miss A was too young to verbalise how she was feeling and how swiftly related conditions can deteriorate in young children, I am critical of the decision to discharge Miss A without clearly determining whether there was another cause for her symptoms, whether those symptoms had fully resolved, and whether her perceived improvement in the afternoon of 13 July 2022 was sustained. I am also concerned that, given these factors, an evaluation from a senior medical officer (SMO) was not sought to support the decision to discharge.

31. I accept that Dr B discussed return advice with Miss A's parents and that this advice included seeking medical review from Miss A's GP if they had any concerns. However, no safety netting advice is documented in Miss A's discharge summary or clinical record. I would be concerned if Miss A's parents were discouraged from bringing Miss A to the ED if she became acutely unwell, and I am critical of the absence of clear instructions in Miss A's discharge summary about when it would be appropriate to seek GP advice and when it would be better to come to the ED.

32. Dr B tested positive for COVID-19 the day after Miss A's discharge. She acknowledged that her clinical documentation, particularly Miss A's discharge summary, contains gaps and that

there was a missed opportunity to re-evaluate Miss A's diagnosis. I accept that the early stages of COVID-19 infection may have contributed to the deficits in the care Dr B provided.

33. Dr Baker has commented on the potential impact of short staffing on clinical review and continuity of care. Miss A was seen by a different registrar each day she was in hospital, and this limited the registrars' ability to obtain an overall picture of Miss A's progress from admission to discharge. Health NZ disagrees that staff rotating out of the hospital to cover sick leave affected clinical care, as the ward Miss A was on had sufficient staff, and its internal review did not identify that staff were unable to perform allocated tasks because of short staffing or high acuity. Dr Baker advised that a lack of continuity of care increases a risk of not appreciating changes in the clinical state and affects relationships with the family. I note that Health NZ endeavours to ensure the same registrar reviews patients where possible, and I consider that, in this instance, Miss A would have benefited from being reviewed by the same doctor throughout her admission. I do agree with Health NZ that, although it is preferable to have the same doctor throughout an admission, this is difficult to sustain. Further, it was not the rotation of doctors that affected the quality of care but rather the diagnostic anchoring on a viral illness as a cause of the symptoms and a lack of attention to the whole picture being presented over the four-day admission in light of the persistent red flag symptoms for infection. However, I would be concerned about staffing levels if this was a factor in the decision not to seek an SMO consultation for discharge.

Conclusion

34. Miss A was admitted to hospital with a suspected diagnosis of gastroenteritis. When she did not improve as expected, a paediatric registrar considered whether another cause for her symptoms was possible and asked nursing staff to obtain a urine sample if possible; however, no blood tests specific for inflammatory markers were requested. The next day, Miss A was seen by a different doctor and discharged without a urine test or further investigations, which, had they had occurred, would have indicated that Miss A's symptoms were not caused by gastroenteritis.

35. Miss A was unwell on the morning of her discharge from Wellington Hospital and noted to be miserable with recent fevers and a high heart rate, both red flag symptoms for infection. She did not recover as expected and did not have a blood test to rule out infection as a cause of her symptoms. During her stay, Miss A was seen by a different doctor each day, which did not allow any one registrar to have a full picture of Miss A's progression. PEWS observations were inconsistent, leading to incorrect impressions based on incorrectly calculated scoring. Discharge documentation was inadequate, and safety netting advice was insufficient. For the above reasons, I find that Health NZ did not provide services with reasonable care and skill, in breach of Right 4(1) of the Code.

Distribution

36. A copy of the final report with details identifying the parties removed, except Health New Zealand | Te Whatu Ora – Capital, Coast and Hutt Valley, and the clinical advisor on this case, will be placed on the HDC website, www.hdc.org.nz, for educational purposes.

Dr Vanessa Caldwell
Deputy Health and Disability Commissioner

Appendix A: Independent clinical advice to the Commissioner

The following independent advice was obtained from paediatrician, Dr Heidi Baker.

'Complaint laid by [Mr and Mrs A] regarding care of their daughter, [Miss A], at Wellington Hospital between 10 and 13 July 2022.

[Miss A] was initially diagnosed with viral gastroenteritis. She ultimately underwent laparotomy and resection with formation of ileostomy for perforated appendix on her second hospital visit.

The complaint refers to her initial presentation to Wellington on 10–13 July 2022. It does not refer to her subsequent surgical stay. The family were complimentary of the care she received during the second stay.

1. Complainants:

[Mr and Mrs A's] complaint specifies concerns about three main areas:

a) misdiagnosis at first presentation
b) parents felt not listened to
c) request for repeat clinical examination of abdomen prior to discharge not met.

[Mr and Mrs A] identify the mental, physical, short-term, and long-term distress for [Miss A] and their family. They describe financial distress as a result of the prolonged hospital stay and complications.

2. Provider: Three responses were received from providers.

a) Dr […]— [local medical centre], where [Miss A] was first assessed on 9 July 2022. Note that the complaint does not specifically refer to this period. Dr […] responded with an explanation of her care and decisions and had provided the family with follow-up advice, which was followed.

b) Dr […] – SMO Wellington Hospital – responded to both [the local medical centre] care (met standard of care) and to hospital care. He makes a statement that the initial standard of care was met at Wellington Hospital on admission but that care deviated from 11 July when [Miss A] remained febrile and tachycardic. The family state that they asked for further investigations and raised concerns about [Miss A]'s distended abdomen. This has been documented in the notes but not any clear thinking behind the next steps. The documentation is that the nurse advised that doctors said it was no longer needed.

c) Dr [B] – Paediatric Locum Registrar – responded regarding care on 13 July 2022, the day of discharge. Dr [B] had seen and examined [Miss A] on the morning of the 13th and recognised she needed a longer period of observation. She discussed the case with her SMO and then reviewed [Miss A] that afternoon. She has documented that [Miss A] appeared brighter, had lunch, and was moving around. She did not recall the family

specifically asking for a further examination and would not typically deny that. Dr [B] did acknowledge that she had provided a discharge summary that had been prepared by someone earlier in the week without making amendments. The family recall being advised to not come back to hospital. Dr [B] states this would be unusual advice for her to give.

Dr [B] also notes that she tested positive for COVID-19 shortly after [Miss A] was discharged.

3. Clinical notes

These have been written on all dates in question. While a PEWS chart was provided, the final recordings prior to discharge were documented only in the written, clinical notes, not on the PEWS chart.

The initial examination, diagnosis and plan has been documented.

There is documentation around review on the date of concern – 11–12 July – and the possibility of urinary tract infection is raised. No further differential diagnosis is documented; it is difficult to know if these were considered based on this.

The discharge documentation did not include specifics of final examination.



Question 1: Whether the clinical assessments made between 10 and 13 July 2022 were full and adequate and included investigations as appropriate.	
List any sources of information reviewed other than the documents provided by HDC:	NIL
Advisor's opinion:	[Miss A]'s initial presentation and assessment were consistent with viral illness (including gastroenteritis) when she first presented. July 12: her clinical presentation deviated from typical. Between 12 and 13 July (discharge), there was an opportunity to perform blood tests, including FBC [full blood count] and CRP, which may have been elevated and alerted staff to an alternate diagnosis.

What was the standard of care/accepted practice at the time of events? Please refer to relevant standards/material.	Initial assessment was consistent with standard of care. When her clinical path deviated, this failed to trigger further appropriate investigations.
Was there a departure from the standard of care or accepted practice? • No departure; • Mild departure; • Moderate departure; or • Severe departure.	Moderate departure. Ongoing fever and tachycardia warranted further investigation for sepsis or an alternative diagnosis.
How would the care provided be viewed by your peers? Please reference the views of any peers who were consulted.	Ongoing fever and tachycardia would typically trigger further investigation or observation rather than discharge. However, note comments made that [Miss A] had improved between the morning ward round and the afternoon review prior to discharge.
Please outline any factors that may limit your assessment of the events.	Observation in paediatrics is a powerful tool but one that is difficult to capture in words in notes or discharge letters.
Recommendations for improvement that may help to prevent a similar occurrence in future.	LOCAL: guidelines on assessment and escalation of persistent fever, tachycardia and review of SEPSIS guidelines. SYSTEMIC: review of staffing, sick notice relief and rotation of staff.

Question 2: Provide comment on the differential diagnoses considered and whether these were sufficient.	
List any sources of information reviewed other than the documents provided by HDC	NIL
Advisor's opinion	Viral illness was initial focus and became bias. Note viral swab panel was negative. Bacterial urinary tract infection was considered but not an alternate source of bacterial infection. Surgical cause for presentation was not mentioned during the 10–13 July admission.

What was the standard of care/accepted practice at the time of events? Please refer to relevant standards/material.	Treatment of fever, tachycardia, and pain with antipyretics and analgesia. Fluid rehydration – orally, if unsuccessful nasogastric, if needed IVF [intravenous fluids]. Deviation from typical pathway – exploration of other diagnosis.
Was there a departure from the standard of care or accepted practice? • No departure; • Mild departure; • Moderate departure; or • Severe departure.	Moderate departure: when not improving, review of diagnosis should have been considered. Rotating staff, sick staff resulting in staff rotating out of hospital impacted clinical review and time.
How would the care provided be viewed by your peers? Please reference the views of any peers who were consulted.	Typically, further senior evaluation would have been considered when the presentation deviated from expected.
Please outline any factors that may limit your assessment of the events.	Limited to information in notes and summary.
Recommendations for improvement that may help to prevent a similar occurrence in future.	Senior doctor review when deviating from usual pathway. Consideration for FBC, CRP when not improving. Clear documentation of abdominal examination. Adequate staffing of paediatric trainees and SMO.

Question 3: Whether sufficient regard was paid to ongoing symptoms of fever, tachycardia, and lethargy and responsiveness to treatments provided.	
List any sources of information reviewed other than the documents provided by HDC	NIL
Advisor's opinion	Note was made of these symptoms and some work-up (urine and electrolytes) was done. A 'scan' was mentioned but not followed through with. Unclear why. Tachycardia appears to have been accepted. Note: mention made of PEWS (Paediatric Early Warning Score) had returned to 0 prior to departure by doctor/nurse but not on chart.

What was the standard of care/accepted practice at the time of events? Please refer to relevant standards/material.	Deviation from usual – tachycardia – if remained present on discharge is unusual.
Was there a departure from the standard of care or accepted practice? • No departure; • Mild departure; • Moderate departure; or • Severe departure.	Moderate: expect vital signs to normalise and [to have a] consistent period of this.
How would the care provided be viewed by your peers? Please reference the views of any peers who were consulted.	Phase 1 (early) appropriate. Phase 2 (12 July–) would raise concerns about examination of vital signs and limited investigations in light of duration of illness.
Please outline any factors that may limit your assessment of the events.	Notes only.
Recommendations for improvement that may help to prevent a similar occurrence in future.	Ensure PEWS charts completed and the pattern noted over duration of stay, ie, swinging fevers, persistent tachycardia. Ensure one-off resolution of symptoms following use of Pamol and ibuprofen is observed for a period (4 hrs minimum).

Question 4: Provide comment on whether there was a missed opportunity to diagnose abdominal pathology earlier.	
List any sources of information reviewed other than the documents provided by HDC	NIL
Advisor's opinion	Blood tests (FBC, CRP) could have been performed on 12 or 13 July when the pathway was deviating. Repeated, clear abdominal examination, lying supine and relaxed required. Abdominal X-ray or ultrasound when concerns raised about bloating.

What was the standard of care/accepted practice at the time of events? Please refer to relevant standards/material.	Persistent symptoms not fitting with expectant pathway would trigger further evaluation.
Was there a departure from the standard of care or accepted practice? • No departure; • Mild departure; • Moderate departure; or • Severe departure.	Mild/moderate Short staffed Unwell doctor, early prodrome of COVID-19
How would the care provided be viewed by your peers? Please reference the views of any peers who were consulted.	Deviation from usual pathway would trigger further investigations.
Please outline any factors that may limit your assessment of the events.	Notes only.
Recommendations for improvement that may help to prevent a similar occurrence in future.	Pathway for senior review and/or bloods when pathway deviating, ie, persistent tachycardia.

Question 5: Comment on the ongoing assessments and monitoring of physiological condition during inpatient admission.	
List any sources of information reviewed other than the documents provided by HDC	
Advisor's opinion	Assessment and monitoring should always be documented in notes and on charts if relevant.
What was the standard of care/accepted practice at the time of events? Please refer to relevant standards/material.	No departure.

Was there a departure from the standard of care or accepted practice? • No departure; • Mild departure; • Moderate departure; or • Severe departure.	No departure, though documentation in nursing notes prior to discharge rather than on observation chart should be reviewed.
How would the care provided be viewed by your peers? Please reference the views of any peers who were consulted.	Consistent with general level of practice until deviation, then assessment should have included further investigations.
Please outline any factors that may limit your assessment of the events.	Notes only.
Recommendations for improvement that may help to prevent a similar occurrence in future.	Ensuring PEWS charts are completed prior to discharge.

Question 6: Provide comment on the standard of documentation.	
List any sources of information reviewed other than the documents provided by HDC	NIL
Advisor's opinion	Apart from PEWS chart immediately before discharge – adequate (note, these observations were in the nursing notes).
What was the standard of care/accepted practice at the time of events? Please refer to relevant standards/material.	Documentation adequate, though note discharge summary done in advance led to findings prior to departure by examining doctor not being included.
Was there a departure from the standard of care or accepted practice? • No departure; • Mild departure; • Moderate departure; or • Severe departure.	No

How would the care provided be viewed by your peers? Please reference the views of any peers who were consulted.	The person discharging the patient should review the discharge notes and add personal comment.
Please outline any factors that may limit your assessment of the events.	Notes only.
Recommendations for improvement that may help to prevent a similar occurrence in future.	Final review comment in discharge notes by doctor who discharges patient.

Question 7: Please comment on the discharge advice given.	
List any sources of information reviewed other than the documents provided by HDC	
Advisor's opinion	Adequate written advice in notes. "return advice given" is often used but lacks specificity.
What was the standard of care/accepted practice at the time of events? Please refer to relevant standards/material.	Last documented observations on chart were febrile and tachycardic. Makes advice to return if patient has a fever contradictory.
Was there a departure from the standard of care or accepted practice? • No departure; • Mild departure; • Moderate departure; or • Severe departure.	Persistent fever on discharge would be unusual. Mild–moderate departure. Temperature on its own is not a vital sign we would take in isolation. It is taken in the context of the whole child. However, temperature this many days after presentation is unusual.
How would the care provided be viewed by your peers? Please reference the views of any peers who were consulted.	Unusual to discharge a child home who is febrile if they have been an inpatient for 4 days without clear cause.

Please outline any factors that may limit your assessment of the events.	Notes only.
Recommendations for improvement that may help to prevent a similar occurrence in future.	Ensure PEWS charts are completed before discharge. Discharge notes are reviewed by clinician discharging patient.

Question: Any other matters in this case that you consider warrant comment.	
List any sources of information reviewed other than the documents provided by HDC:	
Advisor's opinion:	SYSTEMIC ISSUES: staffing. Lack of staffing and no sick notice relief placed strain on staff; rotated to peripheral hospital, locum cover, and no one repeatedly saw the patient from one day to next.
What was the standard of care/accepted practice at the time of events? Please refer to relevant standards/material.	NO: asking staff to cover external hospitals and therefore leave local (Wellington) services stretched places additional stress on all staff, with implications for patient care. Lack of continuity of care increases the risk of not appreciating changes in the clinical state and not establishing a relationship with the family.
Was there a departure from the standard of care or accepted practice? • No departure; • Mild departure; • Moderate departure; or • Severe departure.	Moderate to severe
How would the care provided be viewed by your peers? Please reference the views of any peers who were consulted.	Inadequate staffing – trainees and SMO – results in junior staff, unfamiliar with patients (+ environment), and reduced senior oversight of decision-making.

Please outline any factors that may limit your assessment of the events.	Unclear what the bed pressures were at the time of discharge. This may have influenced decision-making clarity. Unclear of accessibility of SMO to daily patient reviews.
Recommendations for improvement that may help to prevent a similar occurrence in future.	Increased junior and senior doctor staffing. Establish sick notice relief roster to ensure staffing is adequate, rather than stretching current staff.
By signing this report, I agree to HDC correcting any formatting, spelling, or grammar issues on the proviso that the substance of the report and any quoted material remains unchanged.	
Signature:	
Name: Dr Heidi Baker	
Date of Advice: 5 August 2024	