Coordination of care of toddler with suspected non-accidental injury
16HDC00134, 27 March 2019

District health board ~ Fracture ~ Non-accidental injury ~ Rights 4(1), 4(5)

A sixteen-month-old boy presented to a public hospital on four occasions. At each presentation he was not weight-bearing on his left leg. The boy was diagnosed with a spiral tibial fracture, and during the course of the presentations the possibility of non-accidental injury also became a key diagnosis.

A few days later, the boy and his mother presented to the emergency department (ED) of the public hospital. The boy had not been weight-bearing on his left leg for approximately 36 hours. He was assessed by a number of ED staff, and an X-ray of his left leg was taken. No fracture was identified on the imaging, and the boy was transferred to the paediatric department, where further assessments were carried out and the X-ray re-reviewed. Again, no fracture was seen, and the boy was discharged home with analgesia and advice to return immediately if he deteriorated. There is no record in the clinical notes that non-accidental injury was considered specifically, but it was noted that the cause of injury was unknown. The paediatric consultant on this shift acknowledged that the clinical documentation for the presentation was incomplete, and attributed this to considerable pressure on the ward, with days being long and busy.

The boy and his mother re-presented to the paediatric department. In the context of a busy clinic, the paediatric consultant on this shift carried out a concise and focused assessment of the boy's left foot, and an X-ray of the foot was taken. No abnormalities were identified. The boy's presenting issue was documented as a deep soft tissue injury, and although the paediatric consultant considered inflicted injury, he acknowledged that this was not captured in the documentation. The boy was discharged home for monitoring and follow-up review in the paediatric ward if symptoms persisted.

Two days later the boy and his mother presented to the paediatric ward, and the boy was reviewed by a senior house officer. The paediatric consultant on this shift requested that the boy remain on the ward, and an orthopaedic opinion be sought. An orthopaedic registrar attended and recommended an MRI scan. The paediatric consultant advised that he attended the ward later that day with the intention of carrying out a child protection assessment. However, when he arrived on the ward, he was advised that the boy had gone home. An MRI scan was scheduled.

When the boy presented to the orthopaedic ward to undergo the MRI under general anaesthesia, a pre-anaesthetic checklist noted that he had a broken tooth. A Paediatric Nursing Assessment Form documented faded bruises on his right forehead and cheek, a missing tooth, and two black fingernails on the right hand. According to the nurses who assessed the boy, these findings were passed on to the house officer on duty. Following the MRI, a bone scan was recommended. However, because of the difficulty in arranging this, the boy was transferred to another hospital.

The paediatric team at the second hospital reviewed the boy, and a repeat X-ray of his left leg confirmed a diagnosis of a tibial spiral fracture. Additional injuries were also documented, including two black fingernails, two damaged fingernails, a missing left bottom incisor, bruises around the hips and chest, and a light pink discolouration over the right lower quadrant of the abdomen. Given this, an Unexplained Injury Process was initiated. A

Report of Concern was sent to Oranga Tamariki, and a referral made to the Child Protection Team. A skeletal survey was also planned.

The boy was flown back to the first hospital for the skeletal survey and, following this, was discharged. The paediatric consultant on call for this shift advised that the boy was discharged without her knowledge. In addition, although the findings of the skeletal survey were discussed and forwarded on to Oranga Tamariki on the day it was carried out, it was not formally reported on until much later.

The boy sustained further injuries following discharge, and was found deceased.

Findings

It was considered that the DHB's systems did not encompass an adequate safeguard for the boy, and that the evidence overwhelmingly demonstrates a systemic failing on the part of the DHB. The DHB had sufficient information to diagnose the spiral tibial fracture and non-accidental injuries earlier, but a series of failings in assessment, communication, documentation, and coordination of care, and a failure to adhere to policies and procedures prevented this from occurring.

It was held that the DHB failed to provide services with reasonable care and skill, and therefore breached Right 4(1). The DHB also failed to ensure co-operation among providers to ensure quality and continuity of services, and breached Right 4(5).

Recommendations

It was recommended that the DHB:

a) Provide a written letter of apology to the boy's family.
b) Advise HDC on the outcome of the review of medical staffing levels and rostering practices in the paediatric and radiology departments.
c) Carry out an audit on the standard of documentation of 50 child presentations.
d) Carry out an audit, over a period of three months, on the reporting timeframes of paediatric skeletal surveys.
e) Report back on the protocol being developed around hi-tech imaging requests for children under the age of 12 years.
f) For the purpose of shared learning, disseminate the anonymised version of the Commissioner's report to clinical teams across all hospitals within the DHB, as well as on a national level at relevant meetings.

It was also recommended that the DHB continue to follow up with Oranga Tamariki and the New Zealand Police regarding a multi-agency meeting to discuss the findings from the DHB's serious adverse event report and the Commissioner's report.

The DHB was referred to the Director of Proceedings, who filed proceedings by consent against the DHB in the Human Rights Review Tribunal. The Tribunal issued a declaration that the DHB breached Right 4(1) and Right 4(5) of the Code by failing to provide services to the boy with reasonable care and skill, and failing to provide co-operation among providers to ensure quality and continuity of services.