Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

Delayed diabetes diagnosis
20HDC02300

Two general practitioners breached the Code of Health and Disability Services Consumers' Rights (the Code) in their care of a four-year-old girl.

The young girl was seen by the two doctors over two consecutive appointments. In both consultations, the girl's abnormal urine results, obtained by triage nurses, were overlooked. The girl presented to another doctor a few days later and was diagnosed with type 1 diabetes and referred to hospital for treatment. The delayed diagnosis caused significant stress for the girl's family.

Dr Caldwell found that by failing to appropriately review and act on the abnormal urine results both doctors breached Right 4(1) of the Code, which gives consumers the right to services of an appropriate standard.

"The accepted practice is for a GP to review triage observations as part of patient assessment," said Dr Caldwell. "I am critical that both doctors overlooked the urine results during their appointments with the girl. In my view, the doctors' omissions led to a delay in the girl being diagnosed with type 1 diabetes."

Dr Caldwell noted that while the medical centre is also responsible for providing services in accordance with the Code, the deficiencies in the doctors' care were individual clinical failures. However, she did make an adverse comment about the company's triage guidelines.

"I am concerned that the triage guidelines in place at the time were not sufficiently clear to guide nursing staff to appropriately respond to a child at risk," Dr Caldwell said.

"Nonetheless, guidelines should not replace clinical judgement and critical thinking. Regardless of the adequacy of the guidelines in place at the time, I am most concerned that two doctors at the centre failed to look at the urine test results, despite the results being available for their perusal."

Dr Caldwell recommended that both doctors provide a written apology to the family for the breaches in care. She also made a number of recommendations to the medical centre, including that they provide HDC updates regarding changes to triage resources and the effectiveness of those changes and that they use the HDC report to share lessons and educate staff.

"I acknowledge that the medical centre, and the doctors have altered their practice (including introducing a Paediatric Early Warning Score) to prevent any further

omissions, and have created new policies and tools to better identify risk to its younger patients," Dr Caldwell said.

26 June 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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