HEALTH & DISABILITY COMMISSIONER
TE TOIHAU HAUORA, HAUĀTANGA

Systemic failures in the recognition, escalation, and transfer of deteriorating patient

1. On 13 December 2022, the Health and Disability Commissioner (HDC) received a referral from the Coroner on behalf of Ms A regarding the care provided to her late father, Mr B, at Wairarapa Hospital (Health New Zealand | Te Whatu Ora – Wairarapa)[1] between 25 and 27 January 2022.

2. On 25 January 2022, Mr B experienced severe epigastric[2] pain and collapsed. Mr B was admitted to Wairarapa Hospital and diagnosed with acute pancreatitis.[3] He deteriorated significantly over the following days and was transferred to the Intensive Care Unit (ICU) at Wellington Hospital (Health New Zealand | Te Whatu Ora – Capital, Coast and Hutt Valley) on 27 January 2022. Sadly, Mr B later passed away. I extend my sincere condolences to Ms A and to Mr B's family for their profound loss.

3. Ms A raised several concerns about the overall standard of care provided to her father after his admission to Wairarapa Hospital. In particular, she was concerned about the timeliness of the clinical response to his deterioration and the delay in transferring him to Wellington Hospital ICU on 27 January 2022. She also expressed distress at what she perceived to be inadequate pain management during his time in the Emergency Department (ED), Medical Surgical Ward (MSW), and High Dependency Unit (HDU) and poor communication from staff at Wairarapa Hospital.

4. This report focuses on the standard of care Health NZ Wairarapa provided to Mr B from 25 to 27 January 2022 by Health NZ Wairarapa. This report also comments on the coordination of care between districts in the Health NZ Central | Te Ikaroa region.

Information gathered

5. At approximately 9am on 25 January 2022, Mr B experienced a sudden onset of severe epigastric pain and collapsed at work. Mr B was transported to the local medical centre by private vehicle.

6. Upon Mr B's arrival at the local medical centre, general practitioner Dr C noted that he was experiencing severe epigastric pain radiating from his left flank (torso, between lower ribs and hip bone), was nauseous and had vomited. A bedside ultrasound scan identified a large gallstone, which Dr C considered was related to Mr B's pain. It remained difficult to control

[1] On 1 July 2022, the Pae Ora (Healthy Futures) Act 2022 came into force, which disestablished all district health boards. Their functions and liabilities were merged into Te Whatu Ora | Health New Zealand (now called Health New Zealand | Te Whatu Ora).
[2] Located in the upper abdomen just below the ribs.
[3] A sudden inflammation of the pancreas (a gland behind the stomach), causing swelling, pain, nausea, and vomiting.

his pain despite a fentanyl patch and ketamine infusion being provided for pain relief, so a decision was made to transfer him via ambulance to Wairarapa Hospital ED.

Admission to Wairarapa Hospital – 25 January 2022

7. Following admission to Wairarapa Hospital at 11.27am, Mr B underwent an assessment and investigations in the ED. A CT scan was suggestive of acute pancreatitis and identified possible early blood clots in the portal vein (a major blood vessel in the upper-right quadrant of the abdomen) and multiple areas in the gallbladder that could represent gallstones or small polyps. The Senior Medical Officer (SMO) general surgeon told HDC that it was unclear whether the inciting cause of Mr B's pancreatitis was gallstones or alcohol, as he had a significant alcohol history.

8. At approximately 4.30pm, Mr B was transferred to the MSW for monitoring and pain management. Over the next 24 hours, he underwent several reviews for uncontrolled pain and deterioration on the Early Warning Score (EWS) chart.

9. The EWS is a tool to assist clinical staff in determining appropriate actions to take when a patient deteriorates. It provides a score based on the patient's vital signs and describes how care should be escalated according to those scores. The higher the score, the more urgent the escalation pathway. A single vital sign parameter may also trigger escalation. For example, an EWS of 10+ or any vital sign in the 'blue zone' indicates an 'immediately life-threatening critical illness,' and staff must make a 777 Medical Emergency Team (MET) call, stay with the patient and manage immediate life-threatening issues, and inform the SMO and the patient's family.

10. The Health NZ Wairarapa 'Adult Vital Signs and Early Warning Score Measurement, Recording and Escalation' policy stated that:

> 'The escalation pathway is mandatory and must be followed for a patient with an EWS of 1 or more. Action must be taken at the time the triggering EWS is documented. If the mandated response does not occur within the time frame specified, escalation should proceed to the action specified in the next coloured zone.
>
> Details of actions taken to escalate care must be documented in the patient's clinical record.
>
> Anyone may place a rapid response call if they are seriously concerned about a patient, regardless of vital signs or EWS.'

26 January 2022

11. At 2.20am on 26 January 2022, a registered nurse requested a medical review of Mr B after his EWS increased to 5. At 3.30am, the on-call house officer reviewed him and documented rising blood pressure, respiratory rate, and heart rate; a distended and tender abdomen; and that he was experiencing pain 'everywhere', felt short of breath, and appeared uncomfortable. She documented that the plan was to adjust his pain relief and continue monitoring, and she asked to be contacted if there were concerns.

12. At 5.10am, a nurse documented that Mr B had slept poorly and that he remained uncomfortable because of pain (rated 6–8/10), for which pain relief (Sevredol and intravenous paracetamol) had been administered. At 6.30am, he continued to report severe abdominal pain, and further pain relief was provided.

13. Mr B's EWS chart reflects that, during his time in the MSW, his heart rate and respiratory rate were within the 'red zone', indicating that he was 'likely to deteriorate quite rapidly.'[4] However, Health NZ conducted a Clinical Event Investigation (CEI) after these events and found that the ward staff House Officer did not escalate the MET calls to the SMO as required by its policy, and it acknowledged that there was a failure in the response to the EWS score.

14. However, documentation (written annotations) on the EWS chart does not indicate that Mr B's EWS score was 10+ or that any vital sign parameter was within the blue zone at this time, which would have required an emergency (MET) response.

Transfer to HDU

15. At 8am, three general surgery SMOs reviewed Mr B and documented that his severe pancreatitis was worsening. They planned to transfer him to the HDU and initiate further interventions, including a fentanyl patient-controlled analgesia (PCA) pump, Foley catheter, and a nasogastric tube.

16. At 9.15am, Mr B was transferred to the HDU for fluids, monitoring, and pain management, with the documented plan being that any further deterioration would require transfer to the ICU at Wellington Hospital. Clinical notes indicate that the MET call was made at 9.46am, but this was not accurately recorded on the EWS chart.

17. Ms A raised concern that her father, rather than Health NZ staff, had to notify her that he was being transferred to the HDU for a peripherally inserted central catheter line[5] and pain management. She also reported that his arm was left in an 'absolute mess' after attempts at insertion and that Wellington Hospital staff appeared shocked when they saw it.

18. Over the afternoon and evening of 26 January 2022, Mr B continued to deteriorate (as reflected in his increasing EWS and worsening vital signs). At 7.20pm, a MET call was made because his respiratory rate was 40 breaths per minute, his heart rate was 130–140 beats per minute, and his pain had increased and was recorded as 9/10. From that point, every set of recorded observations on the EWS chart until Mr B's transfer to the ICU at 4.30pm on 27 January 2022 reached the criteria requiring a MET response.

19. The MET call was attended by an SMO, RMOs, and nursing staff. Mr B's family were also noted to have been in attendance during the call and were updated by the medical team. It was also documented that staff were unable to increase Mr B's fentanyl dosage on the PCA

[4] When a patient's score is in the red zone, staff are required to request immediate review by a Residential Medical Officer (RMO), call the SMO, and inform the nurse in charge.

[5] A long, thin flexible tube inserted through the upper vein and threaded to a large vein near the heart. It is used to administer intravenous medications and to take blood samples.

pump to 160mcg/h because it could not be programmed into the machine. The RMO was informed of this, and a fentanyl patch was charted.

Attempted transfer to Wellington Hospital ICU

20. At approximately 10pm, clinical staff reviewed Mr B and discussed possible transfer to Wellington Hospital ICU. The SMO general surgeon told HDC that the three general surgery SMOs had a 'high level of concern for [Mr B's] active decompensation';[6] however, they were initially told to attempt HDU management at Wairarapa Hospital and then told that Wellington ICU could not accept the transfer due to bed availability (they were at full capacity). As a result, an interim management plan was made for Mr B to remain in the HDU with increased fluids and pain relief and to commence antibiotics.

21. Overnight on 26–27 January 2022, the MET criteria were met every hour, indicating ongoing clinical deterioration. However, Health NZ acknowledged that the house officer did not escalate MET calls to the SMO in the HDU.

Further deterioration and transfer to Wellington Hospital ICU – 27 January 2022

22. At 7.45am on 27 January 2022, three general surgery SMOs reviewed Mr B and documented that his pancreatitis was not improving and that possible transfer to Wellington Hospital ICU was dependant on blood results. Although it was noted that Mr B's pain had subsided, the MET criteria continued to be met. Further blood tests were taken during the day and showed worsening results.

<u>Repeat CT scan</u>

23. A referral for a repeat CT scan was received at 8.30am, and the scan was completed by 11.59am, then reported and finalised at 12.57pm.

24. The results showed severe inflammation of the pancreas with areas of dead tissue. The portal vein looked compressed, but there was no clear blood clot. The scan also identified likely tissue damage in the liver due to reduced blood flow. Gallstones were present, but the scan could not clearly visualise the main bile duct to rule out a blockage, so an ultrasound was recommended. The scan also showed fluid around both lungs, which was causing parts of the lungs to collapse slightly.

25. In its CEI report, Health NZ acknowledged that the decision to await a CT scan contributed to an additional delay of approximately four hours before ICU consultation progressed. However, Health NZ told HDC that there was nothing on the referral to indicate that the scan was urgent (the radiologists who triaged the CT scan had written 'today please'), and a turnover time from referral to report of 4.5 hours was acceptable for a same-day request.

26. In the afternoon of 27 January 2022 (sometime between 2.35pm and 3.10pm; the exact time is unclear), a General Surgeon reviewed Mr B and spoke with Wellington Hospital ICU, and transfer was accepted. Mr B's family were documented as having been updated at this time.

[6] This refers to the rapid, often sudden, failure of a previously stable, chronically diseased organ system (usually the heart or liver) to function adequately.

27. The on-call intensive care specialist for Wellington Hospital stated that he received a call from the general surgeon at Wairarapa Hospital at 2.35pm requesting Mr B be transported to Wellington ICU for ongoing care for pancreatitis. Transfer was accepted, and an aeromedical (flight) retrieval was subsequently organised.

Transfer to Wellington Hospital ICU

28. At 4.30pm, the flight retrieval team arrived at Wairarapa Hospital. Mr B's further deterioration and difficulty with airway management required intubation[7] before transfer, and this was performed in the operating theatre.

29. At 8.20pm, Mr B arrived at Wellington Hospital ICU. The on-call intensive care specialist stated that, on arrival, Mr B required significant support for his breathing and blood pressure. He also noted that the CT scan showed areas of collapse within his lungs (contributing to his breathing difficulties) and that areas of his liver were suggestive of an infarction (tissue death) that was possibly due to the blockage of a portal vein. Staff commenced high-dose antibiotics, steroids (to assist with his low blood pressure), and dialysis (to remove acid from his blood).

30. At 10pm, the surgical team considered that Mr B was dying from severe pancreatitis and multi-organ failure and that no surgical treatment option was available.

28 January 2022

31. In the early morning of 28 January 2022, a family meeting was held, and the ICU registrar informed Mr B's family about Mr B's condition.

32. Throughout the day, Mr B continued to deteriorate despite receiving maximal support (the highest level of care for critically ill patients). It is documented that several family meetings were held to convey this information, and a decision was made to withdraw curative therapy and focus on providing palliative care.

33. Mr B passed away at 10.30pm on in late January 2022 with his family present.

Subsequent events

34. No post mortem was conducted because Mr B's family objected to this at the time. However, a doctor verified the death and opined that the cause of death was 'acute pancreatitis with subsequent organ failure.'

35. Mr B's family expressed concerns to ICU staff about the care Mr B received at Wairarapa Hospital and the timing of his transfer to Wellington Hospital. As a result, his death was referred to the Coroner.

CEI report

36. Health NZ Wairarapa completed a CEI report (dated May 2022). The review team concluded that the main issues were 'all centred around a failure of process and organisational culture rather than personal failures of any individual health care professionals involved in [Mr B's]

[7] A medical procedure involving the insertion of a plastic tube into a patient's body to secure an airway and manage breathing.

care.' It found that staffing acuity and workload was not a contributing factor to this incident.

37. The report acknowledged several issues in relation to the care provided to Mr B between 25 and 27 January 2022, including:

a. Observations were not consistently completed, and there were instances where EWS calculations were inaccurate or not totalled correctly. Despite Mr B meeting the MET criteria on an hourly basis overnight on 26–27 January 2022, escalation did not occur as required, and the SMO was not notified in either the MSW or the HDU.

b. There was no clear procedure for consultation, referral, and transfer of a patient to Wellington Hospital ICU. This lack of clarity contributed to limited visibility for the ICU team about the patient's clinical status and observations, and there was no formal documentation outlining the handover process or how to manage capacity issues during transfer attempts.

c. There was a lack of recognition of Mr B's pain score.

d. There was a general lack of clear policies and procedures relating to the transfer and monitoring of acutely unwell patients. In particular, a guideline specifying which patients should be admitted directly to the HDU was needed. The review highlighted that another patient with acute pancreatitis had been admitted to the HDU at the same time, indicating a lack of a clearly defined pathway for managing higher-risk patients, such as those with acute pancreatitis.

e. There was a delay in consulting with the ICU team and making a decision regarding transfer. This delay was compounded by the decision to wait for a CT scan, which added four hours before ICU consultation occurred.

38. The CEI made eight recommendations, including:

a. Audit and education on the paper-based EWS tool.

b. Implementation of an automated electronic system for EWS and MET call escalation (automatic SMO alerts).

c. Develop a guideline detailing consultation with and referral to Wellington Hospital ICU. This should clarify clinical responsibility and a process of documenting information and advice.

d. Consider remote monitoring and virtual review (by Wellington Hospital ICU) for patients remaining at Wairarapa Hospital after consultation.

e. Introduce a procedure/guideline defining where acute patients are admitted with Health NZ Wairarapa. This should include consideration given to producing a list of conditions that meet criteria to have direct admission to the HDU.

f. Consider auditing adherence to the national prescription chart and ongoing monitoring.

g. Develop a process for consultation or triage for CT scans of acutely unwell patients.

h. Consider how Health NZ Wairarapa could improve a culture of adherence to following established processes.

Responses to provisional decision

Ms A

39. Ms A was given an opportunity to respond to the 'information gathered' section of the provisional decision and did not provide a response.

Health NZ Wairarapa

40. Health NZ Wairarapa was provided with an opportunity to respond to the provisional decision and had no further comment to make.

Health NZ Central | Te Ikaroa

41. Health NZ Central | Te Ikaroa was provided with an opportunity to respond to the provisional decision. It stated that it accepted my educational comment in regard to the need to improve shared visibility of observations and has made changes to improve its practice since the events (discussed below). Further comments made by Health NZ Central | Te Ikaroa have been incorporated into this report where relevant.

Decision: Health NZ Wairarapa – breach

42. Under Right 4(1) of the Code of Health and Disability Consumers' Rights (the Code), consumers have the right to have services provided with reasonable care and skill. In the context of this case, Health NZ had a duty to ensure timely recognition of, and response to, clinical deterioration, appropriate escalation in accordance with the EWS system, and robust clinical governance that included clear procedures, accurate documentation, and reliable handover practices.

43. I acknowledge that Health NZ has conducted an internal review into this case and, as a result, made several changes in practice and improvements to its systems. Nevertheless, the care provided to Mr B by Health NZ Wairarapa between 25 and 27 January 2022 did not meet the appropriate standard, for the following reasons.

Recognition and response to deterioration

44. In its CEI report, Health NZ found multiple failures in recognition and response systems, including observations not consistently completed, EWS totals recorded inaccurately or not calculated, and a repeated failure to escalate care appropriately when MET criteria were met. For example, the house officer (junior doctor) failed to escalate the MET call to the SMO in both the MSW and the HDU (in particular, overnight between 26 and 27 January 2022, when hourly MET triggers were being met).

45. In my view, these are serious departures from accepted practice in a deteriorating patient and materially reduced the reliability of the safety net that the EWS system (including the

MET call response) is designed to provide. I also note Health NZ's finding that staffing acuity and workload (at Wairarapa Hospital) was not a contributing factor in this case, which I consider indicates an organisational need for greater awareness of and training on the mandatory escalation pathway.

46. I emphasise that successful implementation of the EWS system requires robust clinical governance, including clear leadership, staff training, and regular auditing to ensure timely recognition of, and response to, clinical deterioration.

Clinical governance

47. Health NZ identified that procedures for consultation, referral, and transfer to ICU were unclear, visibility of the patient's clinical status and observations during escalation attempts for the receiving ICU was limited, and no clear document existed governing handover and capacity issues. It also noted a general lack of clear policies and procedures for the transfer and monitoring of acutely unwell patients between hospitals, including the need for criteria for direct HDU admission for high-risk conditions such as acute pancreatitis.

48. In my view, the lack of clarity and absence of important procedures represent a failure at the governance level by Health NZ Wairarapa.

Consultation and transfer to ICU

49. Following an SMO review at approximately 10pm on 26 January 2022, transfer to Wellington Hospital ICU was discussed; however, the ICU was unable to accept Mr B because it was at full capacity at the time. Therefore, an interim HDU management plan was instituted.

50. I acknowledge Health NZ's comments that capacity constraints on the ICU service at the time of events prevented Mr B being transferred earlier. However, I consider that this increased the need for Health NZ to maintain close, proactive consultation with Wellington ICU and to re-escalate promptly as Mr B's condition deteriorated. In this case, Health NZ's CEI report found that the decision to await a CT scan added a delay of approximately four hours before ICU consultation progressed, with acceptance of transfer not occurring until the afternoon on 27 January 2022.

51. When considered alongside the unactioned MET triggers, I consider that the delay in actioning the CT scan and the absence of a clear and well-understood pathway for ICU referral and transfer between hospitals meant that the care provided to Mr B fell below the required standard.

Conclusion

52. In light of the repeated failures to complete and interpret observations accurately, the lack of timely escalation of care, the delays in consultation and transfer (including the CT scan-related delay), and the absence of clear policies, procedures, and handover processes for ICU referral and transfer, I find Health NZ Wairarapa in breach of Right 4(1) of the Code.

Decision: Health NZ Central | Te Ikaroa – educational comment

53. Health NZ Wairarapa (Wairarapa Hospital) and Health NZ Capital, Coast and Hutt Valley (Wellington Hospital ICU) are two districts within Health NZ Central | Te Ikaroa (one of the

four Health NZ regions). As previously outlined, Health NZ Wairarapa identified that visibility for the receiving ICU (Wellington Hospital – Health NZ Capital, Coast and Hutt Valley) was limited and handover during escalation attempts was unclear in this case.

54. Similar issues regarding intra-regional communication and the clarity of escalation pathways were highlighted in another HDC investigation (C21HDC02106), reinforcing that these challenges are not isolated to one event.

55. I take the opportunity to highlight to Health NZ that clearer regional escalation frameworks, shared visibility of observations, and defined handover procedures are necessary to ensure quality and continuity of services (as required by the Code[8]) when care spans more than one district. These measures are particularly essential when ICU capacity is constrained or transfer is delayed for other reasons.

56. As noted below, several changes have been made since these events to address these issues. I emphasise the importance of embedding these improvements consistently across the region to support reliable, safe, and coordinated escalation of care for acutely unwell patients in the future.

Changes made since events

Health NZ Wairarapa

57. Health NZ stated that it has made the following changes since the events:

a. Commissioned a multidisciplinary deteriorating-patient working group with Wellington ICU (August 2022), overseen by the Clinical Event Review Group and the Clinical Board. Its work includes EWS education and compliance, auditing of escalation responses, transition to electronic observations, implementation of the Health Quality & Safety Commission Te Tāhū Hauora Kōrero Mai (patient/whānau-initiated escalation), and a review of MET processes (including after-hours escalation pathways and pager responsibilities). The group has also clarified shared-care roles across specialties and strengthened afternoon handover processes. Health NZ Wairarapa conducts monthly EWS compliance audits, real-time targeted audits, and monthly review of 20 clinical files per area, with direct feedback to staff and educators.

b. Introduced 24/7 SMO cover for the ED to support RMOs and the establishment of a Patient at Risk nursing team to assist with recognition and management of clinical deterioration, including attendance at and follow-up for MET calls. A mandatory MET call audit process has been implemented to ensure escalation steps are reviewed and issues addressed.

c. Instituted a 4pm HDU handover to identify complex patients who may require consultation with Wellington ICU and to agree management plans in conjunction with the ICU.

[8] Right 4(5) of the Code states: 'Every consumer has the right to co-operation among providers to ensure quality and continuity of services.'

d. Updated and re-introduced the 'Adult and Paediatric Vital Signs and Early Warning Score' policy (August 2023), now covering adults, maternity, paediatrics, and newborns.

e. Expanded orientation and education to include Ko Awatea EWS e-learning, ALERT training, AARC, sepsis recognition and escalation training, a two-day onboarding programme for all new staff, and opportunities for Acute Services nurses to complete buddy shifts in Wellington ICU.

f. Implemented the Regional Radiology Information System, which provides electronic referral prompts and clearer urgency options for clinicians. However, the option remains for the referring doctor to directly contact radiology to fast-track imaging for critically unwell patients.

g. Standardised fluid balance recording with new A3/A4 charts and a patient/whānau fluid diary, supported by recurring nurse-educator training sessions throughout the year.

Health NZ Central | Te Ikaroa

58. Health NZ Central | Te Ikaroa told HDC that it has since reviewed, and confirmed, that only one avenue exists for escalation to regional intensive care, which requires local ongoing assessment of a patient's condition, recognition of deterioration, and escalation as needed. In addition, it noted the Health Quality & Safety Commission Te Tāhū Hauora overlay in sharing quality and safety measures (such as about EWS and in-hospital cardiopulmonary resuscitation) and monitoring at district, regional, and national levels.

59. Further, Health NZ Central | Te Ikaroa highlighted that a 10-year Health Digital Investment Plan was announced in November 2025, which involves a 10-year investment pipeline delivered in three phases (stabilising critical systems, modernising platforms to improve efficiency, and enabling innovative care models). It stated that this work is intended to improve the visibility of a patient's status, including between Health NZ districts. This will enable a wider group of clinicians to safely monitor patients where there is concern about their deteriorating condition and a potential need for ICU specialist oversight and input.

Recommendations

60. I recommend that Health NZ Wairarapa:

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

b) Confirm the implementation and review the effectiveness of the recommendations set out in the CEI report, within three months of the date of this report.

c) Provide HDC with a copy of its new/updated policies, including but not limited to EWS/MET escalation, inter-ward transfer and monitoring, HDU direct-admission criteria for high-risk conditions, and ICU consultation, referral, and transfer, within three months of the date of this report.

d) Undertake an audit of 10 recent cases of acute pancreatitis and/or comparable high-risk acute presentations at Wairarapa Hospital to assess EWS compliance, escalation timeliness, and ICU consultation timing. An outcome report, with any corrective actions to be implemented, is to be provided to HDC within three months of the date of this report.

e) Consider assessing current clinical governance structures, with reference to the Health Quality & Safety Commission Te Tāhū Hauora framework for clinical governance 'He mahi ngātahi kia kounga: He anga hei whakahaere whare haumanu.'[9]

Follow-up actions

61. A copy of this report will be sent to the Coroner.

62. A copy of this report with details identifying the parties removed, except Health NZ Wairarapa, Health NZ Capital, Coast and Hutt Valley, Health NZ Central | Te Ikaroa, Wairarapa Hospital, and Wellington Hospital, will be placed on the HDC website, www.hdc.org.nz, for educational purposes.

Dr Vanessa Caldwell
Deputy Health and Disability Commissioner

[9] Clinical governance framework | Health Quality & Safety Commission Te Tāhū Hauora