Health and Disability Commissioner
*Te Toihau Hauora, Hauātanga*

**Waitaki District Health Service Limited, a doctor and two nurses breached the Code following the death of a baby with meningococcal septicaemia**
**20HDC00826**

Waitaki District Health Service Limited (WDHSL), a doctor and two nurses breached the Code of Health & Disability Services Consumer's Rights (the Code) following the death of a baby with meningococcal septicaemia.

The baby arrived at Oamaru Hospital, a rural hospital, with vomiting and fever. He was triaged by two registered nurses who allocated a triage score of three. Upon examination, one of the nurses identified a rash and dots on the baby's neck. The other nurse recognised the baby's triage score was higher than three and needed to be seen by the doctor immediately. She called to request the doctor attend but did not document the change in triage code.

The baby's Paediatric Early Warning System (PEWS) score was not calculated (the PEWS is calculated from objective vital sign measures such as oxygen requirements, heart rate and blood pressure, the more abnormal the vital signs, the higher the score).

The doctor arrived within a minute and was immediately concerned the baby had meningococcal disease or meningitis and that he was dehydrated and experiencing septic shock. The doctor ordered a test and the baby was given fluids and antibiotics. When the doctor was comfortable the baby's situation had stabilised, he organised handover to a larger hospital and an ambulance was ordered to transfer him to a larger hospital.

Against the advice of other staff present, the doctor made the decision to use an ambulance to transfer the baby, as opposed to a helicopter, and the request for an ambulance, by one of the nurses, was noted as an "ASAP inter-hospital transfer" not an "emergency transfer", which resulted in a delay of 40 minutes.

A nurse was tasked with caring for the baby during transit to the larger hospital in the ambulance. She was given inappropriate equipment to monitor the baby's vital signs and so was unable to do so adequately during the transfer.

While a paediatric doctor at the larger hospital had verbally accepted the baby's transfer, the emergency department (ED) at the larger hospital was not notified and was not expecting the baby's arrival. ED staff did not expect the baby to be so unwell on presentation, or that he would deteriorate significantly during his transfer. Sadly, the baby deteriorated further at the larger hospital, and died six days later.

Deputy Commissioner Dr Vanessa Caldwell found Waitaki District Health Service Limited breached Right 4(1) of the Code for failing to provide services with reasonable care and skill. She found that a PEWS chart was not used to document vital signs appropriately, there was no guidance in place for adequate objective observations or criteria to support decision-

making on the mode of transfer, and staff communication was inadequate. She also criticised the lack of appropriate equipment at the hospital.

Dr Caldwell also found the doctor in in breach of Right 4(1) because he failed to reassess the baby's response to treatment and provide further treatment, his decision on the mode of transfer between hospitals was inappropriate, While the transfer by air may not have been quicker, the baby would have received monitoring en route. Dr Caldwell also criticised the doctor's handover discussion with the receiving hospital and inadequate documentation.

The first nurse was also found in breach of Right 4(1) of the Code for failing to calculate a PEWS score and for not providing adequate documentation, including adequate information on the ambulance request form.

Dr Caldwell found the second nurse in breach of Right 4(1) for failing to monitor and document the baby's vital signs during transfer, for failing to recognise the baby's worsening condition and seek support, and for inadequate documentation.

WDHSL told HDC it has taken the oversights in care provided to the baby very seriously and has worked hard to improve its systems and processes, including adopting the Paediatric Early Warning Score, delivering training to staff members using observation equipment during transfer, and devised an ambulance transfer flowchart.

Dr Caldwell acknowledged the changes made by WDHSL and noted that it has taken seriously the responsibility it has to provide all staff the necessary equipment and robust guidance to assist their decision-making. She made a number of recommendations, including that WDHSL undertake an audit of paediatric monitoring equipment available for all potential patient transfers and an educational comment on improving the quality of communication by the paediatric doctor at the larger hospital.

28 August 2023

ENDS

***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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