Paediatrician / Crown Health Enterprise

Report on Opinion - Case 96HDC3043

Complaint

The complainants complained about the process undertaken by the paediatrician and the Crown Health Enterprise ("the CHE") where, following a visit to accident and emergency department in mid-August 1996, the non-accidental injury of their three month old son, the consumer, was suspected.

In particular, the complainants complained that appropriate procedures were not followed by the paediatrician and the CHE and that the consumer and his mother were detained in hospital without adequate explanation or information for four days in mid-August 1996.

Investigation

The complaint was received on 25 February 1997. An investigation was commenced on 7 April 1997. During the investigation the complainants identified an unresolved concern about the consumer's mother's relationship with the CHE's mental health service and a psychiatrist. This matter was referred to Advocacy on 26 March 1998. Further to the investigation, information was obtained from the following:

The Consumer's Mother/the Complainant
The Consumer's Father/the Complainant
The Paediatrician
The Child Protection Co-ordinator at the CHE
Clinical Practice Group Manager Newborn, Child and Youth Health at the CHE
Clinical Practice Group Manager Child and Community Health Services at the CHE

Continued on next page

Paediatrician / Crown Health Enterprise

Report on Opinion - Case 96HDC3043, continued

Investigation, *continued*

The following documents were obtained and viewed:

The CHE Statement of Policies and Guidelines on Child Abuse - dated April 1995
Draft Policy Statement in relation to Child Abuse/Child Protection - dated 18 July 1997
Good Practice Guidelines in relation to Child Protection - dated January 1998.

Information for the CHE's Clinical Staff - Care and Protection Investigations and Proceedings for Children and Young Persons/Information sharing with NZ Children Young Persons and Their Families Service and the Police - revised February 1998.

Information Gathered During Investigation

In mid-August 1996 the complainants took their son, the consumer, to the accident and emergency department at a public hospital where they advised staff that he had fallen from a bouncinette which had been placed on the kitchen bench.

The complainants informed the Commissioner that while in the accident and emergency department they drew staff attention to a swelling in the back of the consumer's head which they had noted five days earlier. In addition, the consumer's father discovered an injury under the consumer's tongue and drew the attention of the paediatric registrar to this. The paediatric registrar then became concerned that the injuries may have been non-accidental and discussed his concern with the on-call paediatric consultant. The entry in the clinical record by the paediatric registrar stated, "*DW* [discussed with] [on-call paediatric consultant]. *Admit as will need observation re feeding, ? skeletal survey tomorrow."*

No information was given to the complainants in regard to any concerns staff members held over the suspected non-accidental injuries of the consumer. The consumer was admitted to hospital with his mother as a boarder. The consumer's mother's understanding at that time was that the consumer was being admitted because of feeding difficulties associated with the oral injury.

Continued on next page

Paediatrician / Crown Health Enterprise

Report on Opinion - Case 96HDC3043, continued

Information Gathered During Investigation, *continued*

The next morning the paediatrician interviewed the consumer's mother and examined the consumer. He agreed with the paediatric registrar that the consumer may have sustained non-accidental injuries.

The paediatrician informed the Commissioner that he then told the parents of his concern that the injuries could be non-accidental and explained to them that it was his obligation to inform the Children and Young Persons Service ("CYPFS") of this suspicion. The paediatrician advised the Commissioner that he told the complainants that it would be necessary for the consumer to stay in hospital over the weekend.

The consumer's mother advised the Commissioner that a brief discussion and medical examination of the consumer occurred in the presence of other medical staff early that morning. The consumer's mother reported that she and the consumer's father were not informed during this consultation about staff concerns regarding the suspected non-accidental injuries.

It was later in the morning that the paediatrician and the charge nurse met with the complainants to advise of these concerns. This discussion was recorded in the clinical notes by the paediatrician at 10.45am on the day after the consumer was admitted to hospital.

The consumer's mother was not informed by hospital staff about any support available, in particular the option of a Maori support person. When CYPFS staff saw the family in the afternoon they asked if the consumer's mother wanted a Maori support person. She responded that she did and a CYPFS staff member then contacted a Health and Disability Consumer Advocate, who arrived prior to the departure of CYPFS staff.

The paediatric registrar obtained information relating to the consumer's mother's mental health history. The paediatrician's opinion was that the consumer's mother's history of depression was seen to be a possible contributory factor to the suspected non-accidental injury of the consumer. There was no consultation at this time with the mental health service in relation to the suspected non-accidental injury.

Continued on next page

Paediatrician / Crown Health Enterprise

Report on Opinion - Case 96HDC3043, continued

Information Gathered During Investigation, *continued*

The consumer's father had taken the consumer to their general practitioner three days before the consumer was taken to the accident and emergency department in regard to the swelling on the back of the consumer's head. He had been reassured by the general practitioner that there was no reason to be concerned. The consumer's mother advised the Commissioner that despite this reassurance she requested a referral to see a paediatric consultant (who was also the on-call paediatrician when the consumer was taken to the accident and emergency department). A referral letter from the general practitioner to the paediatric consultant, dated the day after the consumer was taken to the accident and emergency department, is now on the consumer's file, though this would not have been available at the time of the initial consultation.

The CHE Statement of Policies and Guidelines on Child Abuse, section E 10, states that staff who make notifications to CYPFS must inform the child protection co-ordinator in the paediatric department of the hospital and complete the notification report for the co-ordinator. The Children, Young Persons and Their Families Act does not require that any notification to CYPFS under section 15 be in writing but the child protection co-ordinator advised that it was usual practice to send a written assessment or evaluation report to CYPFS on discharge.

The paediatrician did not notify the CHE's child protection co-ordinator and complete the notification report required by the CHE's protocol, nor did he send a written report to CYPFS during the admission or on discharge. The paediatrician informed the Commissioner that when he returned to the hospital four days after he saw the consumer, the consumer had been discharged the day before by another consultant and a written report to CYPFS seemed not to be relevant.

The failure to provide a written report was confirmed by a letter dated mid-September 1996 from a CYPFS social worker to the paediatrician, which stated, "*we do not normally forward our conclusions until we have received a written report from the hospital.*"

Continued on next page

Paediatrician / Crown Health Enterprise

Report on Opinion - Case 96HDC3043, continued

Information Gathered During Investigation, *continued*

On the day after the consumer was taken to the accident and emergency department and admitted to hospital, x-rays of the consumer, including skeletal x-rays, were taken and dental and eye examinations were carried out. An entry in the clinical record states that the paediatrician briefly reviewed the x-rays in the afternoon with no fractures being seen. No test results were communicated to CYPFS at this stage despite the paediatrician being in the hospital all that day.

Following further assessment and an ultrasound four days after the consumer had been admitted to the hospital, the consumer and his mother were discharged by a second paediatric consultant. The paediatrician who had been on leave on the day the consumer was discharged saw the consumer as an outpatient two days after he had been discharged and following this there was a further meeting with him in late August 1996. The paediatrician advised the Commissioner that, during the first meeting after the consumer had been discharged, he remained concerned that the consumer's injuries may have been non-accidental.

Current Situation

The CHE has now reviewed their guidelines for staff in regard to child protection issues. The Good Practice Guidelines in relation to Child Protection, dated January 1998, include the following information for staff:

Cultural input

It is important that there is early determination of cultural identification of child/family and the obtaining of appropriate cultural support for child/family/clinicians. …We need to work alongside cultural advisors and advocates in providing services to family.

Support for child and family

… Parents/caregiver need to be kept fully informed and fully involved in care decisions consistent with the safety of child. There should be an identification of support outside family eg, Patient Advocates.

Also contained in this document are guidelines for staff about their role in relation to the statutory role of CYPFS and the Police.

Paediatrician / Crown Health Enterprise

Report on Opinion - Case 96HDC3043, continued

The Code of Health and Disability Services Consumers' Rights

RIGHT 1
Right to be Treated with Respect

...

3) Every consumer has the right to be provided with services that take into account the needs, values, and beliefs of different cultural, religious, social, and ethnic groups, including the needs, values, and beliefs of Maori.

RIGHT 4
Right to Services of an Appropriate Standard

...

2) Every consumer has the right to have services provided that comply with legal, professional, ethical, and other relevant standards.

...

5) Every consumer has the right to co-operation among providers to ensure quality and continuity of services.

Opinion: Breach – the Paediatrician

In my opinion the paediatrician has breached Right 4 (2) and Right 4 (5) of the Code of Health and Disability Services Consumers' Rights.

Right 4(2)
The paediatrician failed to complete the notification report and advise the child protection co-ordinator as required by the CHE's policy. This meant that the co-ordinator was not in a position to ensure an overview of the management of this case.

In addition, the paediatrician did not ensure that test results available on the afternoon of the day after the consumer was admitted to hospital were collated and passed on to CYPFS in a timely manner. Further to this, the paediatrician did not provide a written report for CYPFS, following the discharge of the consumer, summarising the outcome of the medical assessment and tests.

Right 4(5)
The paediatrician did not consult with the mental health service or the consumer's mother's general practitioner as part of the initial assessment process. In not contacting other providers involved with the care and treatment of the consumer and his mother, the paediatrician failed to access information which could have further assisted his management of the admission of the consumer and the reporting of a suspected non-accidental injury to CYPFS.

Paediatrician / Crown Health Enterprise

Report on Opinion - Case 96HDC3043, continued

Opinion: Breach - the CHE

In my opinion the CHE has breached Right 1(3) and Right 4(2) of the Code of Health and Disability Services Consumers' Rights.

Right 1(3)

The CHE did not have appropriate systems in place to ensure that the consumer and his mother's Maori ethnicity was identified on admission and to ensure the family was given information about the availability of a Maori support person and the advocacy service. It was left to the staff from CYPFS to advise the consumer's mother about the availability of a Maori support person and to contact Health and Disability Consumer Advocacy Service on her behalf.

Right 4(2)

At the time of these events the CHE did not have in place adequate training or guidelines for staff in relation to child protection issues. In particular, there were no guidelines for staff on informing parent(s)/caregiver(s) of concerns about suspected non-accidental injury and any action to be taken by staff, or for ensuring staff understood their role in relation to the role of CYPFS.

If the clinicians had concerns about a possible non-accidental injury, where they believed hospital admission and further investigation was required, the appropriate course of action would have been to contact the CYPFS duty social worker. It would then have been the responsibility of CYPFS to make a decision about a place of safety for the consumer. Instead, the consumer was admitted under the pretext of being observed for feeding difficulties and staff commenced their own investigation into the suspected non-accidental injuries without informing the parents or CYPFS until some time later.

Paediatrician / Crown Health Enterprise

Report on Opinion - Case 96HDC3043, continued

Actions

I acknowledge the process undertaken by the CHE in relation to this complaint and, in particular, the review of child protection processes and guidelines as demonstrated by information and documentation provided by the CHE during the investigation. I am therefore not requesting any additional action on the part of the CHE as to their current protocols.

However, I would ask that both the paediatrician and the CHE apologise in writing to the complainants for their breaches of the Code. These apologies are to be provided to the Commissioner by the paediatrician and the CHE and will be forwarded to the complainants.

In addition, I recommend that the CHE pay the complainants $1,500.00 as reimbursement for the time and effort given by the complainants in meeting with the CHE and assisting the review process following these events.

A copy of my report will be sent to the complainants.