Decision 21HDC00993
10 March 2026

HEALTH & DISABILITY COMMISSIONER
TE TOIHAU HAUORA, HAUĀTANGA

Care provided to man who died of heart failure

1. On 4 May 2021, the Health and Disability Commissioner (HDC) received complaints from Mrs D (mother), Mrs A (wife), and Ms B (sister) about the care provided to Mr A by Health New Zealand | Te Whatu Ora (Health NZ). The complaint concerns the failure to escalate worsening heart failure. Sadly, Mr A died in hospital one day after presenting to the public hospital Emergency Department (ED). I extend my sincere condolences to Mr A's family for their loss.

Information gathered

2. Mr A had a history of high blood pressure and cardiac problems from the age of 23, when he was fitted with a pacemaker that was later removed.[1] Mr A was under the care of his general practitioner (GP) and had presented to hospital with chest pain, shortness of breath, and leg swelling in February and November 2020. He was also due to see a rheumatologist for a constellation of symptoms that Mr A and his family thought may have indicated an autoimmune disease such as lupus (systemic lupus erythematosus).

3. On day1 March 2021, Mr A, who was 42 years of age at the time, presented to the public hospital ED due to abdominal pain, breathlessness, and lower leg swelling. Mr A was assessed by an ED House Officer (junior doctor) at around 8.13am. The clinical notes state that Mr A had a fast heart rate of 162bpm (tachycardia), was short of breath, had pitting oedema to his shins[2] and reported having felt unwell for months. The House Officer told HDC that he was concerned that Mr A was in heart failure, so he arranged an electrocardiogram (ECG), a chest X-ray (which showed fluid build-up in the lungs), and blood tests. The House Officer discussed his findings with the ED senior medical officer (SMO).[3]

4. At 9.39am, an ECG was conducted, and Mr A had a recorded heart rate of 150–160bpm. Initial treatment to get Mr A's heart rate under control was commenced. Mr A had an Early Warning Score (EWS)[4] of 5, and conversations were had with the general medicine service as to the appropriate treatment pathway for Mr A. The general medicine SMO on duty over the weekend was Dr C. Two junior general medicine House Officers were also on duty, one of whom told HDC that there was no general medicine registrar on duty at the time, so the expectation was that House Officers would consult directly with the SMO.

5. The ED House Officer discussed Mr A's care via telephone with Dr C. The House Officer told HDC that he advised Dr C of Mr A's condition and the treatment provided up to that point,

[1] In response to the provisional opinion, Mrs A told HDC that Mr A had a pacemaker fitted in his 20s because of his slow resting heart rate (bradycardia). She said that, as far as she is aware, he did not experience a fast heart rate until 2021.
[2] Swelling caused by fluid accumulating in the tissues.
[3] A consultant emergency physician.
[4] A scoring system that assists with the recognition of and appropriate response to a patient at risk of clinical deterioration. The EWS increases as vital signs become increasingly abnormal.

and Dr C provided general treatment advice, including that, if Mr A's heart rate settled, he could be discharged. At around 2.05pm, Mr A's oxygen saturation[5] was 90%. The ED House Officer contacted Dr C again, and she agreed to admit him under the care of general medicine. The ED House Officer told HDC that Dr C asked a general medicine House Officer to review Mr A. At 3pm, Mr A's EWS was 6, and his heart rate had decreased to 98bpm. The general medicine House Officer reviewed Mr A and documented his impression as atrial fibrillation[6] and cardiomegaly[7] with fluid overload. The House Officer discussed Mr A's condition with Dr C, who provided further treatment guidance. There is no documentation to suggest that the House Officer asked Dr C to review Mr A at that time, and Dr C told HDC that there was no need for her to review Mr A as he was haemodynamically stable (meaning that his vital signs were within normal limits).

6. At 4pm, Mr A's EWS was 8. The general medicine House Officer told HDC that, at around 5.30pm, he received a phone call from the ED House Officer, who raised concerns about Mr A's condition, particularly that Mr A had significant abdominal pain (at that time, Mr A was still in the ED despite being under the care of general medicine). The general medicine House Officer reviewed Mr A at around 6pm and noted both his pain and his increasing oxygen requirement. He told HDC that he called Dr C requesting that she come in to review Mr A. The House Officer told HDC that Dr C did not consider it necessary and instead suggested that the House Officer consult with the general surgery registrar in case there was some intra-abdominal issue that they were missing. Dr C said she has no recollection of this conversation with the general medicine House Officer. The conversation was not documented in the clinical notes. In response to the provisional opinion, Dr C told HDC that if she had been asked to review Mr A at that time, she would have done so.

7. A CT scan showed no surgical abnormality in the abdomen, and Mr A was then admitted to the Critical Care Unit (CCU) because of his escalating oxygen requirements. The general medicine House Officer said that he texted Dr C to advise that Mr A had been transferred. Dr C reviewed Mr A in person for the first time at 8.25pm. The general medicine House Officer told HDC: 'I was relieved that [Dr C] had seen Mr A and outlined a plan'. Dr C did not refer Mr A for specialist input at that time, as he had not received a 'full trial of current treatment'.

8. Dr C said that, although she was aware that Mr A would require cardiology input, she interpreted his vital signs, including the high EWS scores, and clinical findings to be a result of medication administered previously. In response to the provisional opinion, Dr C further told HDC that she considers she medically managed Mr A's heart failure appropriately at the first review, given the information available to her. She said that she also took Mr A's

[5] Oxygen saturation refers to the percentage of haemoglobin in the blood that is saturated with oxygen, and normal levels typically range from 95% to 100%.

[6] A common heart rhythm disorder causing an irregular and often rapid heartbeat because of problems with the heart's electrical system.

[7] Enlarged heart because the heart is working harder than usual.

decreasing EWS into account.[8] Dr C said that there was no information in the system regarding any previous echocardiogram reports or cardiology consultations to guide her.

9. At 1.37am on day2 March, a House Officer called Dr C because Mr A's oxygen saturation levels were deteriorating below 92% while on oxygen, he had increased work of breathing,[9] and his liver and renal function were declining. The House Officer told HDC that she was concerned about pulmonary embolism,[10] so she discussed this with Dr C, who agreed that Mr A should undergo a CT pulmonary angiogram [11] and recommended intravenous furosemide, which the medication chart shows was charted and given at 2am. The House Officer said that she then asked the CCU nurses to contact the on-call anaesthetist and ask him to review Mr A as he was not maintaining sufficient levels of oxygen in his blood. The on-call anaesthetist said that he received a call to review around 3.30am and he did so immediately, which a retrospective nursing note confirms. The House Officer said that Mr A was started on a noradrenaline infusion as per hospital protocol, because of his deteriorating systolic blood pressure. The retrospective nursing notes indicate that the infusion was started at 5am. In response to the provisional opinion, Dr C said that it was not her that recommended the commencement of the noradrenaline infusion, which is supported by the clinical notes.

10. The House Officer told HDC that she called Dr C again sometime between 5am and 6am and specifically asked her to review Mr A in person immediately and discuss his care with the tertiary hospital Intensive Care Unit, as he had been on noradrenaline with minimal improvement in his blood pressure and worsening blood parameters. The House Officer told HDC: 'I felt this man was too unwell to remain in the local public hospital and required more specialised input. I also informed her that the anaesthetist on call was still present. She… [said she] would review [Mr A] at 8am'. The House Officer also said that Dr C recommended that Mr A be started on a dobutamine infusion. A retrospective nursing note states: 'As per [anaesthetist] started dobutamine infusion … increased by Dr C'; however, it is unclear from the clinical record or the medication chart at what time the commencement or increase of the dobutamine infusion began.

11. Although there is no contemporaneous documentation of this discussion, a clinical note written retrospectively (timed at 6.42am) records the House Officer's discussion with Dr C, consistent in part with the House Officer's recollection of this phone call – including that Dr C recommended the initiation of dobutamine and that she would review Mr A at 8am. The medication chart also shows that dobutamine was charted, but it is unclear what time it was given. However, the retrospective note does not record the House Officer's request for Dr C to attend. A retrospective nursing note also records that, at some point, the 'consultant' (assumingly Dr C) was phoned by the House Officer with 'nil action', although it is unclear

[8] 8 at 4pm, 8 at 4.22pm, 9 at 5.25pm, 5 at 6pm, and 7 at 7pm.
[9] Work of breathing refers to the energy expended to inhale and exhale.
[10] A life-threatening blockage in a lung artery, usually caused by a blood clot that travels from another part of the body.
[11] A medical imaging test that uses a CT scanner and a contrast dye to create detailed images of the pulmonary arteries.

what time this took place. Dr C told HDC that she does not recall being asked to review Mr A at that time.

12. Around 6am, the House Officer documented that she called Dr C again, requesting her immediate attendance, after which Dr C came in to review Mr A. In response to the provisional opinion, Dr C reiterated that she only recalls being contacted once (when she was asked to attend) and that she immediately attended shortly after 6am. However, the House Officer's recollection is that, between 1.37am and 6.30am, she called Dr C three times.

13. Dr C told HDC that she was unaware of the events that had taken place earlier that morning as she was not called to attend. She said that staff knew to call her if they had any concerns. She stated that, when she reviewed Mr A in person, he had deteriorated, so she called a cardiologist at a tertiary hospital, who accepted him for transfer. In response to the provisional opinion, Mrs A told HDC that she was told around 2.30am that Mr A was going to be transferred to a tertiary hospital. However, when she arrived back at the hospital, she was informed that the weather was too bad for the plane to leave. She said: 'To then see with the HDC report as well as the hospital report, the tertiary hospital had not even been contacted until 6.30am, I feel deceived about this'.

14. At 9.34am, Mr A went into cardiac arrest. Sadly, he could not be resuscitated.

15. Mrs A raised concerns that, as Mr A did not undergo an autopsy, there was no Coronial investigation into the underlying cause of his death. Health NZ told HDC that the Coroner was informed of Mr A's death but did not accept jurisdiction. Dr C told HDC that, if the cause of death is unclear, the SMO calls the Coroner to discuss the circumstances of the death and then faxes a completed form to the Coroner, who decides whether an autopsy is required. Dr C said that she discussed Mr A's case with the Coroner, and the Intensive Care Unit nurse emailed the completed form.

16. A 'Hospital Record of Death' form was sent to the Coroner on the morning of day2 March and was returned by the Coroner at 10.42am the same day.

17. Dr C said that she does not recall speaking to Mr A's family about the Coronial process, and she was not aware of the family's concerns in this respect. In response to the provisional opinion, Mrs A told HDC: 'It should not be normal for a 42-year-old man to pass away and with the fast decline he experienced at the hospital and then to not even have a [Coroner's] report'.

Further information

Health NZ

18. Health NZ conducted an internal chart review of the care provided to Mr A. The review found that the appropriate specialties were consulted in a timely manner; that Dr C did not see Mr A in person until 12 hours after his presentation to ED and did not seem to appreciate how

unwell Mr A was; that diltiazem and bisoprolol[12] were administered despite Mr A being in heart failure; and that the House Officer on duty overnight called Dr C for advice on two occasions and she came in when required to do so at 6am.

19. Health NZ said that an SMO would be expected to escalate a patient's care when the expertise of a tertiary centre or specialty area is required or if the presenting issue is outside the SMO's routine practice. It said that on-call SMOs are expected to be available for advice and support and to attend in person if required. Health NZ told HDC that other specialties are available to provide support.

20. Health NZ said that, since these events, it has discussed Mr A's care at the general medicine team meeting, reinforced that House Officers should request a review by an SMO if they feel it appropriate, presented the case at a peer review meeting, and sent a memo to staff regarding the need for clear documentation of phone conversations with SMOs.

Dr C

21. Dr C told HDC that it was difficult to determine the severity of Mr A's condition, and the EWS must be considered in the context of each patient. She said that she considered Mr A to be moderately unwell and that his condition was likely to improve after further treatment. Dr C said that, during her first assessment of Mr A, she did not consider a specialist referral was required, but his condition had changed when she reviewed him again the following morning, so she consulted a cardiologist at the tertiary hospital.

22. Dr C said that she has reflected extensively on Mr A's case and accepts, with the benefit of hindsight, that she should have sought cardiology advice earlier and that she is mindful of the importance of good communication, especially with junior doctors. In response to the provisional opinion, Dr C said that, while she accepts that in hindsight an earlier referral was indicated, she does not consider it unreasonable to have proceeded as she did.

Responses to provisional opinion

Mrs A

23. Mrs A was given the opportunity to comment on the 'information gathered' section of the provisional opinion. Where relevant, her comments have been incorporated into this report. Mrs A questioned why she was not told about Mr A's heart failure until 6pm on day1 March. In addition, she told HDC:

> 'My children have lost their father. [Mr A] also does not get to be in their lives as they grow up … Life has altered drastically for my family and for the negative. [Mr A] was a

[12] Diltiazem is a calcium channel blocker used primarily to treat hypertension (high blood pressure) and angina (chest pain). It works by relaxing the blood vessels and reducing the heart's workload. Bisoprolol is a beta-blocker commonly prescribed for heart conditions, including hypertension and heart failure. It helps to lower heart rate and blood pressure by blocking the effects of adrenaline on the heart. Diltiazem and bisoprolol can be used together, but caution is advised because of potential interactions that may increase the risk of side effects such as bradycardia and hypotension.

very loved husband, father and son. He was a pillar both in my family and also the wider community […] Each and every day is different with him not being with us.'

Mrs D

24. Mrs D was given the opportunity to comment on the 'information gathered' section of the provisional opinion. Where relevant, her comments have been incorporated into this report. In addition, Mrs D told HDC:

> 'The sad thing is, no investigation, no reports change the outcome for us. [Mr A] is gone, my beautiful son is now a wonderful but also sadly a painful memory … [Health NZ […]] needs more cardiology input and care'.

Dr C

25. Dr C was given the opportunity to comment on the provisional opinion. Where relevant, her comments have been incorporated into this report. In addition, Dr C told HDC:

> 'I have reflected at length on this case. As a result, my practice changed, and I continue to be more inclined to seek advice from a tertiary centre/cardiology specialist at an earlier stage. I am, and have always been, mindful of the importance of good communication, especially with junior doctors and encourage them to not hesitate to request SMO assessment. I am responsive to the same'.

26. With respect to the disputes about whether or not she was asked to attend overnight, Dr C stated:

> 'The fact of a phone call occurring, and a request within the same for SMO attendance is material, relevant and important information to include in the written clinical record. This is 'drilled' into junior doctors. The lack of any record of the proposed and relevant requests to attend should resolve the factual dispute in my favour or at least preclude the HDC from making a definitive factual finding either way'.

27. Dr C told HDC that, at the time, she was working a 72-hour weekend call shift and an additional eight-hour regular shift on a Monday. Dr C told HDC:

> 'Sleep deprivation and exhaustion was the norm. I would like to point out that we were in the midst of the COVID 19 pandemic, we were working in teams, with reduced staff, and all sorts of other restrictions. There was no option of calling a colleague to step in when feeling fatigued … So, it was not an option in this case. I could not just leave, that would be abandonment of duty, in my opinion'.

Health NZ

28. Health NZ was given the opportunity to respond to the provisional opinion. Health NZ accepted the recommendations made in the provisional opinion.

Opinion

29. As part of my assessment of this complaint, I obtained independent clinical advice from a general medicine specialist, Dr Denise Aitken (Appendix A).

30. I acknowledge that, in my assessment and analysis of the care provided to Mr A, I must guard against the bias that comes with hindsight and knowing the outcome. I have given careful consideration to the contemporaneous clinical record and the statements of the various doctors who provided care to Mr A.

Dr C – breach

Escalation of care

31. Dr C's involvement in Mr A's care began when she accepted him under the care of general medicine at approximately 2.50pm on day1 March. Dr C reviewed Mr A in person for the first time at 8.25pm, after he was transferred to the CCU.

32. Dr Aitken advised that several factors indicated that Mr A was critically ill by the time Dr C reviewed him in person, including that his oxygen saturation level was significantly below normal (91%) despite receiving 15 litres/minute of oxygen, he was cold to the touch, his urine output was low despite fluid replacement, he was drowsy and lethargic, and he had unresolved abdominal pain. I also note Mr A's particularly high EWS between 4pm and 5.25pm. Prior to Dr C's review, Mr A's EWS readings were 8 at 4pm, 8 at 4.22pm, 9 at 5.25pm, 5 at 6pm, and 7 at 7pm. I acknowledge Dr C's comments that she took into account Mr A's improving EWS during her assessment at 8.25pm, and I note that Mr A's EWS did seem to improve slightly between 6 and 7pm. However, I do not consider a brief dip in EWS score at 6pm, which I note rose again at 7pm, to represent an improving clinical picture. Dr Aitken advised that she would have expected a specialist physician to recognise that Mr A was critically ill at that point, with evidence of cardiac and respiratory failure, and to escalate Mr A's care at that time. However, this did not occur until around 6.30am the following morning, when Dr C consulted with the tertiary hospital Cardiology.

33. I have considered Dr C's response to these matters but, noting the clinical information available to her at the time, I accept Dr Aitken's advice that Dr C's failure to escalate Mr A's care constitutes a moderate departure from accepted standards.

Oversight and support of junior doctors

34. Dr Aitken advised that there is evidence that all junior doctors involved in Mr A's care appropriately escalated their clinical concerns to the relevant SMOs, and I agree. I consider it clear from the documentation and the statements provided by those involved that junior staff were aware of the need to contact the SMO should they require senior oversight, and it appears that they did so on each occasion that they became concerned about Mr A's deteriorating condition.

35. However, the accounts between the junior doctors and Dr C about the number of times that she was contacted on day1 and day2 March are conflicting, which has necessitated a close analysis of the clinical records and statements made in order to draw factual conclusions.

36. The general medicine House Officer said that he called Dr C at around 6pm on day1 March and requested that she review Mr A in person, but she declined because she did not consider it necessary at that stage. The House Officer said that Dr C told him to consult with the general surgery registrar instead, which he did. Dr C told HDC that she has no recollection

of this conversation, and this discussion is not documented in the clinical notes. Notwithstanding the lack of documentation in the clinical records, there is a direct statement from the House Officer given close in time to the events in 2021 about this call, and he in fact escalated to the surgical registrar as requested, which in my view, is corroborative of his evidence. I therefore accept his statement (noting also that there is no evidence to suggest it lacks reliability and credibility) and find that this call did occur.

37. The overnight House Officer told HDC in a statement dated 1 July 2021 that she called Dr C sometime between 5am and 6am on day2 March and asked her to contact the tertiary hospital and review Mr A immediately. The House Officer told HDC that Dr C declined to review Mr A immediately and said that she would review him at 8am. The statement is clear and unequivocal. Dr C told HDC that she does not recall this conversation or being asked to review Mr A in person. As outlined above, there is a retrospective clinical note written by the House Officer that is corroborative of her statement that this call was made (and other clinical records, including a retrospective nursing note and the medication chart, also identify action taken in response to this call).

38. In my view, the weight of evidence satisfies me that Dr C was contacted by the House Officer around 5–6am prior to, and separately from, the phone call at around 6am where she agreed to attend, and that Dr C was at least aware (prior to 6am) of the need to attend Mr A at some stage, due to the House Officer documenting that Dr C would review at 8am.

39. Dr Aitken was critical that Dr C either declined to review Mr A in person or deferred attendance to junior doctors, concluding this to be a departure from the standard of care. I have treated this conclusion with some caution, noting that the opinion was based on broad factual conclusions about the junior doctor's requests, which did not have the specificity that I have now determined. However, I have not completely dismissed Dr Aitken's opinion in this respect.

40. I accept the evidence of the House Officers that they sought Dr C's support and in-person review, noting in particular that, independently, the two doctors provided similar evidence close in time to the events of Dr C declining to attend, or deferring attendance, on two separate occasions. However, I am mindful that the exact content of the conversations cannot be established with certainty, and it is important to consider the contextual information Dr C has provided about her fatigue and the stresses of the COVID-19 environment in which the team was working. Accordingly, I have allowed for the possibility that Dr C did not fully comprehend that she was being asked to attend Mr A in person.

41. That said, Mr A was a seriously unwell and deteriorating patient, in the care of very junior doctors, where there were no intermediate-level registrars to provide them support. I am critical that, particularly overnight, care was escalated on three occasions before Dr C agreed to come in (on the last call). SMOs in such circumstances must have a low threshold in the interests of patient safety to ensure that they understand the clinical picture and what is being asked of them by junior staff and to provide the support that junior doctors need. I am therefore critical that Dr C deferred her attendance on the occasions discussed above.

42. Right 4(1) of the Code of Health and Disability Services Consumers' Rights (the Code) states that every consumer has the right to have services provided with reasonable care and skill. In my view, by failing to recognise Mr A's critical condition and not appropriately escalating his care to a specialist earlier than 6.30am on day2 March, and by not appropriately responding to the escalating concerns of junior staff, Dr C failed to provide services to Mr A with reasonable care and skill and breached Right 4(1) of the Code.

Documentation and communication – educational comment

43. Mr A's family raised concerns that Mr A did not undergo an autopsy and that there was no Coronial investigation into the underlying cause of his death. Dr C told HDC that she discussed Mr A's death with the Coroner and that a nurse sent the completed form, as per the usual process, but that the Coroner did not accept jurisdiction. I also note that a 'Hospital Record of Death' form was sent to the Coroner on the morning of day2 March, and returned at 10.42am, which verifies that the Coroner was contacted about Mr A's death. I also acknowledge Dr C's comments that she was unaware at the time of Mr A's family's concerns in this respect. Accordingly, I accept that the correct process was followed by Dr C in contacting the Coroner about Mr A's death and note that it is not my role to assess whether or not the Coroner should accept jurisdiction.

44. However, Dr Aitken advised that there was no record in the clinical notes of Dr C's discussion with the Coroner, and there is no evidence that clinicians discussed the Coronial process with Mr A's family. Dr Aitken advised that there is an expectation that significant communication should be documented. I agree. It is understandable that Mr A's family is concerned that further investigations into his death did not occur, given the tragic and unexpected circumstances. Accordingly, I remind Dr C of the importance of documenting important discussions with other parties, such as the Coroner, and of communicating openly with families when such concerns arise.

Health NZ – other comment

Supervision of junior doctors and documentation

45. Dr Aitken advised that the doctors involved in the daytime care of Mr A were first-year doctors in the first three months of their career, the overnight doctor was a second-year doctor, and the general medicine junior doctors were supervised directly by Dr C (the SMO) with no involvement from an 'intermediate' doctor such as a registrar. Dr Aitken advised that, despite this, the junior doctors involved in Mr A's care appropriately escalated their clinical concerns, and I agree. However, I do consider that having several layers of experience within a department is important to foster appropriate escalation pathways and support for junior doctors, and so I encourage Health NZ to reflect on my comments and those of Dr Aitken. I also remind Health NZ of the importance of clinicians documenting important conversations with other staff, particularly if those staff have asked for assistance but it has not been actioned.

Recommendations and follow-up actions

46. I recommend that Dr C provide a written apology to Mr A's family for the failings identified in this report. The apology is to be sent to HDC within three weeks of the date of this report, for forwarding to Mr A's family.

47. I recommend that Health New Zealand | Te Whatu Ora ensure that SMOs, particularly in the context of having responsibility for supervision of very junior doctors, be adequately reminded of the importance of providing appropriate support and responding to requests for input. Health NZ should provide evidence that this has occurred, within three months of the date of this report. I also recommend that Health New Zealand | Te Whatu Ora review the medical staffing levels at [the local public] hospital to ensure an adequate mix of skills and capacity to meet acuity of demand. The outcome of the review, and details of any changes made as a result, are to be provided to HDC within three months of the date of this report.

48. A copy of the sections of this report that relate to Dr C will be sent to the Medical Council of New Zealand.

49. A copy of this report with details identifying the parties removed, except my independent advisor, will be placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

Morag McDowell
Health and Disability Commissioner

Appendix A: Independent clinical advice to the Commissioner

The following independent advice was obtained from Dr Denise Aitken, general medicine specialist:

'05 April 2023

Health & Disability Commissioner

Complaint: Mr [A] (Dec) [Health New Zealand] | Te Whatu Ora
Your Ref: C21 HDC 00993

My name is Denise Aitken. I have been asked to provide an opinion to the HDC on case number **C21 HDC 00993**.

I have read and agreed to follow the Commissioner's guidelines for independent advisors, and I am not aware of any conflict of interest.

I am a Specialist Physician with the qualification of Fellow of the Royal College of Physicians (FRACP), awarded in 1997. I have practised in general medicine at a provincial hospital since 1997. I have previous experience providing reviews of medical services, credentialing department for District Health Boards, and reviews of training for the RACP. I have previously provided advice for the HDC.

I have been asked to review the case, in particular to comment on –

1. The overall appropriateness of [Mr A]'s clinical management on [day1] and [day2] March 2021;
2. If not discussed above, whether there was timely and appropriate escalation of care, including involvement of local senior clinicians and remote advice from Specialist Physicians at [the tertiary] [h]ospital;
3. Any comment on [Mr A's local public hospital] clinicians' involvement in the Coronial process on this occasion, including advice provided to [Mr A's] family that an autopsy could not be performed, and death certification; and
4. Any other matters that you consider warrant comment.

For each question, I have been asked to advise:

a) What is the standard of care/accepted practice?

b) If there has been a significant departure from the standard of care or accepted practice, how significant a departure (mild, moderate, or severe) do you consider this to be?

c) How would it be viewed by your peers?

d) Recommendations for improvement that might help to prevent a similar occurrence in future.

In addressing the issues, I have reviewed all the clinical documents provided to me. I have discussed this case anonymously with a senior colleague to benchmark my opinion. Regarding referral to the Coroner, I had to refer to guidance [from another Te Whatu Ora district] and previous presentations given by Coroners that I have attended.

My opinion is primarily based on my experience as a clinician and the understanding of standards of practice.

The overall appropriateness of clinical care

Reports from junior staff at [the public hospital] outlined that [the public] [h]ospital is medically staffed in the Department of Medicine by junior doctors and senior consultants. Although reference is made in the reports provided and notes to an Emergency Department Registrar and Surgical Registrar, there is no comment on involvement of a Medical Registrar (year 3 or more clinical experience doctor). Thus, the medical staff involved in the daytime care of [Mr A] were first-year doctors in the first three months of their working career. The overnight junior doctor was a second-year doctor. Both these separate doctors were directly supervised by a Specialist Physician, [Dr C], with no intermediate-level doctor involved (or registrar).

Appropriateness of Clinical Management – day1/day2 March 2021

The junior doctors' reports provided and the clinical notes indicate that, at all times, the junior doctors appropriately escalated clinical concerns, initially to the Emergency Department senior and then to [Dr C], the physician on call. This was documented in both the medical notes and their subsequent report.

An Emergency Department specialist was involved in the initial care of [Mr A]. He used intravenous diltiazem for control of heart rate and comments on this himself. The use of this drug was described in the New Zealand Formulary [and] is relatively contraindicated in heart conditions with poor pump function. The information regarding [Mr A]'s cardiac function was not available to the treating Emergency Department doctor at the time that the decision was made. Diltiazem is used in New Zealand Emergency Departments for this indication.

Following the emergency care of [Mr A], [Dr C] was advised about [Mr A]'s clinical condition and accepted him under her care at approximately 1550 on [day1] March 2021. She was requested to attend to review him initially at approximately 1800 hours that day. The House Officer report records that she 'did not think it necessary' and gave advice. The House Officer who requested this review describes serious concerns and contacted the consultant, [Dr C], again by text message, who [then] agreed to come and review.

This review at 2025 hrs was conducted by [Dr C], being the consultant on call. The review is described in the clinical notes. Salient features recorded in the clinical record are an Early Warning Score of 8/8/9 at 1600/1622/1725 hours.

Early Warning Scores of 8–9 are described on the scoring sheet as 'likely to deteriorate rapidly'. An Early Warning Score of 10 indicates immediate life-threatening critical illness. At the time that [Dr C] reviewed [Mr A], his blood pressure had been, for a sustained period of time, below 100mmHg systolic in the afternoon, although it had risen slightly at the time she saw him.

He had a continuous increase in his oxygen requirement through the afternoon.

The context of this review was a relatively young man in his first presentation to hospital with a new diagnosis of decompensated heart failure and atrial fibrillation. At the time of assessment, he was receiving 15 litres/minute of oxygen, with oxygen saturating significantly below normal at 91%. He was described as peripherally shut down, that is, he was cold to touch. His urine output since admission was only 600ml (despite fluid replacement of 1000ml) with no output recorded since 1100 hours in the morning. He was described as drowsy and lethargic. He had undiagnosed severe abdominal pain.

Based on the information described above, I would expect a Specialist Physician to recognise that [Mr A] was critically ill at that point, with evidence of cardiac failure, respiratory failure, and progressive respiratory failure, and that it was appropriate to escalate care.

Whether there was timely and appropriate escalation

In my opinion, it was appropriate at this time to escalate his care, and consideration should have been given to discussion with a senior colleague at the regional centre. Failure to recognise the severity of his situation and to escalate care was a moderate failure of care. I have discussed this with a peer, who concurs. It may be useful for clear guidelines regarding which patients should be discussed with regional and other cardiology and other specialist services or physicians working at Te Whatu Ora […].

Following the review at 2025 hrs, junior doctors on call [became] increasingly concerned [and] requested doctor attendance from [Dr C] on two further occasions. The SMO declined or deferred attendance, according to junior doctor reports. This resulted in [the junior doctor] seeking assistance from a specialist in another discipline to assist when [Mr A]'s respiratory failure became critical.

This failure to respond in a timely manner [to] two requests from junior staff is a departure from standards of care expected. Junior doctors should expect support from the seniors for whom they act on behalf. Failure to respond to requests for assistance is a serious departure from expected practice. I have discussed this with a peer, who agrees. It may be useful for clear documentation for Te Whatu Ora […] SMOs regarding the requirement to attend at [a] junior doctor's request so that expectations are clarified.

Coronial Process

There is no documentation available to me regarding Te Whatu Ora clinician involvement in the Coronial process, other than [Dr C]'s subsequent written statement. 'The Coroner was contacted by me and after discussion, the Coroner decided this was not a case for autopsy'.

Nursing notes record that the medical daytime staff, Dr […] and RN […], on [day2] March in the morning informed family about the likely poor outcome. In an initial note by [RN] at 1115 [hrs] on [day2] March 2021, entitled nurse, records a 'family meeting', but there is [no] further detail regarding this.

It is not clear if clinicians discussed the Coronial process for family wishes regarding an autopsy after [Mr A]'s death.

There was no record in the clinical notes of [Dr C]'s discussion with the Coroner.

The Coroner in New Zealand has jurisdiction to investigate death where there is a significant family concern as to the cause of death. I do not know if [Dr C] has been fully oriented to the New Zealand Coronial process. The significant family history obtained by clinical staff prior to [Mr A]'s death would suggest that family concerns regarding a clear diagnosis were likely and entirely reasonable.

Information regarding the New Zealand Coronial processes should be provided for non-New Zealand-trained doctors, or they should be advised to seek advice from a colleague familiar with the process, when entering into discussions with the Coroner where there is any complexity around the decision-making regarding Coronial jurisdiction.

It may be useful for [Mr A's] family if a referral is made to a Specialist Cardiologist for review of [Mr A]'s full clinical record, including his echocardiogram images and that [of other family]. This may be helpful for the family if it provides advice regarding the appropriateness of further assessment and/or screening and follow-up of [Mr A]'s children.

Denise Aitken
SPECIALIST PHYSICIAN
FRACP, CLINIC DIP PALLIATIVE MEDICINE'

The following further independent advice was obtained from Dr Denise Aitken:

'I have reviewed the documentation provided in the link.

I will respond by email to facilitate an expedited response, being aware that considerable time has elapsed since the whānau contacted the HDC.

I did not have access to the clinical notes for this review.

[Dr C]'s response does not change my original view.

With regard to the assessment at 2025 [hrs] on [date], the EWS is clearly recorded between 16.00 and 18.00 as 8, 8, 9. It improves somewhat between 1800 and 1900 [hrs] to 5 and 7.

These recordings are cause for significant concern and, in the context of the physical findings at that review, should have prompted further action or escalation.

Subsequently, EWS recording is discontinued in the CCU as far as I am able to tell. During this time, [Mr A]'s oxygen requirement rose to 15 L/min, and then he required BiPAP, indicating further deterioration in respiratory function.

[Dr C]'s inability to recall conversations or identify text messages is non-contributory. There is clear documentation from junior staff, as I recall in the clinical notes and statements that this occurred and there is no reason to doubt these.

It is not possible to comment on discussions with family or the Coroner as there is not sufficient documentation to make comment.

Health NZ comment that Orientation to Coronial process is not useful. More relevant is whether [Dr C] received this orientation and when, and what does the orientation consist of?

I consider that there is an expectation that documentation of significant communication should occur. This should consist of an indication (at the least) of the recorder's understanding of the content of those conversations. This, in my opinion, applies to significant discussions with family and external advice such as the Coroner. In my view, the need for clear documentation of important conversations is already explicit in the health care environment.

I further comment that Health NZ says that, if staff feel fatigue is compromising care, they have the option to call in sick. Did [Dr C] know this, and was it a realistic option in the staffing environment at the time? I note that the junior staff report her as saying sleep was an issue, but she herself does not refer to this.'