

**A Primary Health Organisation  
Health NZ | Te Whatu Ora Tairāwhiti**

**A Report by the  
Deputy Health and Disability Commissioner**

**(Case 21HDC00764)**



**HEALTH & DISABILITY COMMISSIONER**  
TE TOIHAU HAUORA, HAUĀTANGA



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*He hōnore he korōria ki te Atua, he maungārongo ki te whenua  
 He whakaaro pai ki ngā tāngata katoa  
 He kura i tangihia he maimai aroha  
 Ki a rātou te hunga kua moe  
 Ki a koe e Master A e moe  
 Moe iho rā koe i roto i te ngāwaritanga o te Atua  
 Moe mai, moe mai, moe mai rā*

## Complaint and investigation

1. The Health and Disability Commissioner (HDC) received a referral from the Coroner about the services provided by a Primary Health Organisation (PHO) and Health New Zealand | Te Whatu Ora (Health NZ) Tairāwhiti. The following issues were identified for investigation:
  - *Whether [the PHO] provided [Master A] with an appropriate standard of care in 2018.*
  - *Whether [Health NZ Tairāwhiti]<sup>1</sup> provided [Master A] with an appropriate standard of care in 2018.*
  - *Whether [Dr B] provided [Master A] with an appropriate standard of care in 2018.*
2. This report is the opinion of Dr Vanessa Caldwell, Deputy Health and Disability Commissioner, and is made in accordance with the power delegated to her by the Commissioner.
3. The parties directly involved in the investigation were:
 

Ms A	Consumer's mother
Mrs A	Consumer's grandmother
Dr B	Provider/GP
Dr C	Provider/GP
RN D	Provider/registered nurse
RN E	Provider/registered nurse
Dr F	Provider/paediatrician
PHO	Provider
Health NZ Tairāwhiti	Provider
4. Further information was received from an ambulance service provider and the Coroner.
5. Independent advice was obtained from rural medicine specialist Dr Jennifer Keys (Appendix A).

<sup>1</sup> 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).

## Information gathered during investigation

### Introduction

6. This opinion relates to the treatment provided to Master A, aged 23 months, at a community health centre, a rural hospital, and Gisborne Hospital during his multiple presentations over Day 1–Day 5.<sup>2</sup> Tragically, Master A passed away on Day 5. The pathologist’s final post-mortem report states that Master A died of sepsis and multi-organ failure secondary to left *Streptococcus pneumoniae* bronchopneumonia (a lower lung infection caused by bacteria).
7. Master A lived in a rural area, where the available primary care was at a community health centre, which is approximately 30 minutes’ drive from the rural hospital, both of which are operated by the PHO. The hospital is a further 90–120 minutes’ drive from Gisborne Hospital, which is operated by Health NZ Tairāwhiti.

### Day 1

8. Master A was normally a well child. His parents had chosen not to have him immunised.
9. On Day 1 Master A presented to the community health centre at around 2.21pm with fever and vomiting, but no diarrhoea or cough. RN D examined Master A and noted that he had a temperature of 39.9°C (normal is 37°C). RN D documented that after discussion with the on-call general practitioner (GP), an ambulance was called to transport Master A to Gisborne Hospital. The on-call GP prepared a letter of referral to the ED.
10. The ambulance service provider told HDC that a 111 call from the community health centre was received at 2.28pm requesting an ambulance for Master A as he had a fever, and staff were unsure of the cause. An ambulance was dispatched at 2.31pm, arriving at the community health centre at 2.50pm.
11. The ambulance service provider said that on arrival, the attending ambulance officer found Master A lying on the bed. It is documented that he was sleepy but quick to rouse and focus on the environment. His mother, Ms A, informed the ambulance officer that Master A had attended Kōhanga Reo that morning, and at that time he had been his normal self.
12. The attending ambulance officer assessed Master A and documented his vital signs as a heart rate of 165 beats per minute (bpm) (normal is 100–150bpm), a respiratory rate of 36 breaths per minute (normal is 25–35), an oxygen saturation level of 100%, and a temperature of 39.9°C.
13. The ambulance officer recorded that Master A had no skin rash or shortness of breath, but a slight redness was noted around his throat. Master A took sips of water offered by his mother.
14. The ambulance departed at 3.19pm, and no changes in Master A’s condition were noted in transit to Gisborne Hospital.

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<sup>2</sup> Relevant days are referred to as Day 1–Day 5 to protect privacy.

*Gisborne Hospital*

15. The ambulance arrived at Gisborne Hospital Emergency Department (ED) at 5.23pm. Master A's whānau<sup>3</sup> stated that they had to wait a long time in the ED before Master A was seen by a doctor and admitted to the children's ward (Planet Sunshine). They were critical that an unwell child was not given a higher priority for receiving timely medical attention, and also that no X-ray was undertaken, and no bloods were taken. Master A was treated with only Pamol, and they felt he should have been treated with antibiotics.
16. Health NZ Tairāwhiti stated that an ED Child Emergency Nursing Assessment Form was started at 5.25pm. The form recorded that Master A's presenting complaint was 'febrile' (feverish). He was triaged as triage 4, as he was stable on arrival (triage 4 is an indication that the patient should be seen by a medical professional within one hour, as per the Australasian Triage Scale).
17. Health NZ Tairāwhiti told HDC that Master A was cared for in the ED, and at 6.30pm the Paediatric house officer was informed of Master A's observations. The Paediatric house officer saw Master A at 7pm (ie, approximately 1.5 hours after arrival), and a plan of care was put in place. At 8pm he was transferred to Planet Sunshine. Health NZ Tairāwhiti stated that this is an acceptable timeframe for a triage 4 patient but noted that the triage level was assessed on presentation, and it would not reflect any subsequent deterioration that may have occurred in the ED.
18. It was documented that Master A had a likely diagnosis of non-specific viral illness. Health NZ Tairāwhiti stated that there was no apparent clinical indication that this was anything other than a virus, so there was no clinical indication to undertake further testing. Health NZ Tairāwhiti stated that Master A did not have an elevated respiratory rate or a cough, so there was no indication that he had a chest infection. His temperature was mildly elevated at times, with an associated mild increase in heart rate, but these settled. This is confirmed by the clinical notes. Master A was alert and showed no signs of meningism/meningitis. Health NZ Tairāwhiti said that consequently, there was no clinical indication that blood tests or a chest X-ray were needed, and the diagnosis of a viral illness was made.
19. In relation to not prescribing antibiotics, Health NZ Tairāwhiti stated that the Starship Guidelines on Fever Investigation and Management were followed and, as it was the first day of fever, which is usually viral, antibiotics were not prescribed. Health NZ Tairāwhiti said that antibiotics are not prescribed because they cannot kill viruses, and people tend to get better when the viral infection has run its course, unless there is a complicated or prolonged viral infection causing a secondary bacterial infection, in which case a doctor may prescribe an antibiotic. Health NZ Tairāwhiti said that at the time of this presentation, there was no clinical indication that antibiotics were required.

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<sup>3</sup> Information was provided to the Coroner and HDC by Master A's grandmother, together with Master A's mother.

## Day 2

### *Discharge from Gisborne Hospital*

20. The Gisborne Hospital records state that Master A was well overnight with no fever, and he was eating and drinking.
21. Paediatrician Dr F reviewed Master A at around 9.30am and made a plan for discharge home with paracetamol. RN G documented that Dr F was happy for discharge and that no follow-up was required. RN G noted: '[M]um advised to seek medical help if no improvement or symptoms worsen. Mum happy with same ...'
22. In contrast, Master A's whānau advised that when Ms A spoke to the discharging doctor, Dr F, her concerns were not listened to. They said that she told him that her son had not eaten anything that morning, had had only a little water, had vomited, and had had rigors during the night, but Dr F was dismissive of this information.
23. The whānau stated that there is a discrepancy between the medical notes, which record that Master A was eating and drinking, and what Ms A witnessed. The whānau believe that greater consideration should have been given to delaying the discharge in view of the rural isolation of the family and the difficulty they would have in accessing prompt medical attention once they had returned home.
24. There is no record of any conversation about this on the morning of Master A's discharge from hospital.
25. Dr F told HDC that while he does not specifically recall his conversation with the whānau, his practice when talking with parents about discharge home has always been to ensure that they understand what he believes is causing their child to be unwell, to discuss the treatment for the condition, and to provide them with time to ask questions. He considers the wishes of the family and the 'safety net' for the child should they not improve, and he also takes into consideration the distance the child and whānau reside from Gisborne Hospital.
26. Health NZ Tairāwhiti stated that its paediatricians take a cautious approach to remote rural families and generally, if there is the slightest concern, they will keep the child in hospital longer just to 'watch and see'. Alternatively, often whānau are asked whether they have somewhere to stay in town, so that it is not so far to travel should the child need to re-present.
27. Health NZ Tairāwhiti told HDC that RN G told the Reportable Event Review interviewer that she discharged Master A from Planet Sunshine, although she had had minimal contact with him prior to arranging his discharge. She said that she was present when Dr F spoke to Ms A.
28. RN G said that Dr F was very thorough in the information he gave to Ms A and stressed that if she became worried about Master A, she should contact the nearest doctor. RN G recalled that Master A was not completely well, but he seemed playful, and she remembers him smiling. She stated that Ms A did not request that Master A stay in hospital longer.

29. Health NZ Tairāwhiti acknowledged that Ms A's perception of whether she was listened to may have been different from that of staff. Health NZ Tairāwhiti stated that it is ensuring that staff are always mindful of using the Manaaki Tairāwhiti<sup>4</sup> Way of Working.
30. The discharge summary was not completed on the day of Master A's discharge, and it was not received by the community health centre until three days later, on Day 4. Health NZ Tairāwhiti noted that the discharge summary documents that Master A had not vomited, but the nurses had documented that he had had one cough-induced vomit. Health NZ Tairāwhiti apologised for having recorded on the discharge summary that Master A had not vomited.
31. Ms A was not given any written information, such as the fever leaflet, a written summary, or a letter to the parent that included details of a contact person, department, or service, such as the rural health nurse, practice nurse, or GP.
32. Ms A stated that she felt powerless to challenge the doctor's decision to discharge Master A, but she remained uneasy about it. She said that her fears were reinforced that evening when Master A's condition deteriorated.

*Ambulance service provider home visit*

33. On the evening of Day 2, Master A's grandmother, Mrs A, visited the local ambulance station asking if she could borrow a thermometer to check Master A's temperature, because the whānau were unsure whether the thermometer they had was reliable.
34. The ambulance service provider said that a paramedic and an ambulance officer volunteer decided not to lend a thermometer, and instead they accompanied Mrs A to her home between 7.30pm and 8pm and found Master A lying on a mattress on the floor in the lounge. In response to the provisional opinion, Mrs A clarified that Master A was lying with his mother on a bed made up with mattresses on the floor in the lounge, which was converted into a sick room for comfort and convenience. She stated that it was a healthy and nurturing set-up for Master A, and his mother and his grandmother were both watching over him.
35. The ambulance service provider said that Ms A told the officers that Master A had been sent home from hospital that morning, and she had been advised to manage Master A's fever with paracetamol, which they had been doing.
36. The ambulance service provider told HDC that the ambulance officers recall that they could rouse Master A easily, and he could drink fluid out of his cup and take the paracetamol. They assessed Master A briefly, and the paramedic recalls that he was not in respiratory distress, he had a respiratory rate of 32 breaths per minute and a temperature of 39°C, and he was well perfused.<sup>5</sup>
37. The ambulance officers told the provider that they recall advising the whānau to continue doing what they had been advised by the hospital staff, and to monitor Master A for any

<sup>4</sup> Manaaki Tairāwhiti is whānau ora based and understands that individuals are part of whānau; it views the whānau as the owner of their own lives and understands that the whānau is embedded in society and history.

<sup>5</sup> There was sufficient blood flow to the core and extremities.

changes. They also recall advising the whānau that if they remained concerned, or Master A's condition became worse, they should seek further help.

38. The ambulance officers made no record of the home visit.

The ambulance service provider internal incident review

39. Other ambulance service provider personnel became aware of the home visit only when Master A's family informed them of it at Master A's tangi. The incident was lodged as a reportable event shortly afterwards, and it was investigated further by the provider, who interviewed the paramedic.
40. The ambulance service provider told HDC that the provider provided clarification to all ambulance personnel within the region that no home visits were to occur without an ambulance incident being logged officially through the Ambulance Communications Centre, and that proper documentation (an ambulance patient report form) was to be completed for all such incidents.
41. The ambulance service provider stated that it was most unusual for ambulance personnel to attend a family home informally in the way they did. He said that they showed very poor judgement in not generating an ambulance incident via the Ambulance Communications Centre and not completing any associated documentation.
42. The ambulance service provider noted that when interviewed 17 days later, the paramedic was able to recall very detailed information such as Master A's exact respiratory rate and temperature from the evening of Day 2. The provider stated:

'In my experience it is remarkable to be able to recall such a level of detail 17 days later, and I have some doubts as to the level of accuracy of this information. However, what is clear to me is that [Master A] did not appear to ambulance personnel to be sufficiently unwell at that time to need to return to hospital, and taking into account that he had been discharged from hospital earlier that day with a presumed viral infection, it is my opinion that the advice provided by the ambulance personnel on the evening of Day 2 was appropriate at that time.'

43. During a meeting with Health NZ Tairāwhiti as part of the later reportable event investigation, the whānau spoke positively of the support the ambulance service provider provided.

**Day 3**

44. On the evening of Day 3 Master A's temperature increased. The whānau attempted to contact the ambulance service provider without success because the staff were already on a call-out. The family then tried to contact the rural health nurse.
45. Mrs A told the Coroner of her frustration at not being able to contact the rural health nurse and queried whether the PHO still provided this on-call service. She said that she tried desperately to contact the rural health nurse and went to her house and banged on her door, but no one was home.

46. The PHO told HDC that it is not contracted to, and does not, provide a rural health nurse on-call service. It provides a Level 2 (hospital-level) ED at the rural hospital for after-hours care. In response to the provisional opinion, Mrs A stated that she was aware that members of the local community had consulted the rural health nurse for medical assistance at the rural health nurse residence in the region (especially given that there was no resident doctor in the region) and often received some form of assistance from there.
47. RN E stated<sup>6</sup> that at approximately 9pm Master A's mother telephoned the local hospital ED stating that she was bringing in her child to see the doctor. RN E said that she immediately telephoned the on-call doctor, Dr C, who spoke to Ms A by telephone.
48. Dr C was employed by the PHO as a GP.
49. Dr C told the Coroner that during the call, Ms A told him that Master A had been in Gisborne Hospital and had been discharged in the morning after an admission overnight with fever. He said that he suggested that there was not much that could be done at the rural hospital, and that probably Master A needed to be seen at Gisborne Hospital, as the rural hospital had limited facilities to investigate a sick child. He said that Ms A suggested that he might be able to do something about Master A's breathing, which he agreed might be the case. He agreed to see Master A but suggested that they be prepared to travel onwards to Gisborne Hospital.
50. In response to the provisional opinion, Mrs A stated that they were reticent about attempting a two-hour drive in the night with an ailing Master A who appeared to have breathing difficulties. Rather than making a two-hour drive to Gisborne at night on an isolated highway they chose to make a 20-minute drive to consult with a doctor who could make observations, form an opinion and activate an emergency call for a helicopter. She said that prior to their arrival at the rural hospital they discussed that only a physician could make an informed and expert decision that would activate the despatching of a helicopter. She stated that they knew that Master A's symptoms had changed, they were frightened, and they needed a doctor to see him urgently to make that call.

#### *Review at rural hospital*

51. The whānau then travelled to the rural hospital, arriving at around 10pm.
52. The clinical records state that Master A had a high fever, a cough, and rapid breathing, which had started in the early evening. He had last had paracetamol at 2pm, more than six hours prior to his presentation, which was in keeping with the advice given to Ms A by Gisborne Hospital not to exceed four doses per day.
53. RN E stated that Master A looked unwell, and he was listless and felt very hot, but he was alert and looking around. The first temperature recording was 37.4°C, but RN E suspected that the thermometer was faulty. A new thermometer gave a recording of 39.8°C. RN E said that when Dr C arrived, she informed him that she was very concerned about the child and that in her judgement, Master A should go to Gisborne Hospital.

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<sup>6</sup> To the interviewer for the reportable event investigation.

54. RN E said that she knew Mrs A socially. RN E said that she told Ms A that Master A looked unwell and should go to Gisborne Hospital, but Ms A declined, stating: 'What for, just so they can give him more paracetamol?' In response to the provisional opinion, Ms A said that RN E's perceptions and opinion were incorrect. She said that RN E did not make such a statement to her, and she did not give that answer. Mrs A stated that they came to the hospital because they had noted a change in Master A's breathing, which had become more laboured, he was not getting any better, he was not eating, and he was barely drinking.
55. Dr C told the Coroner that on examination, Master A was hot and breathing rapidly. Dr C documented that Master A's heart rate was fast at 177bpm and he had a temperature of 40°C. Dr C said that the rest of the examination was nonspecific, with Master A's chest and abdomen appearing normal, and no neck stiffness or rash seen. Dr C documented that Master A's likely diagnosis was a viral illness. He said that he asked RN E to give Master A paracetamol to settle his fever, and then he went to the office to review his notes.
56. Dr C said that neither the Gisborne Hospital discharge summary nor any notes from the recent hospital admission were available at the rural hospital on Day 3 (the day after discharge from Planet Sunshine).
57. At 11.19pm Dr C called the on-call paediatrician at Gisborne Hospital, Dr F, to ascertain the nature of Master A's recent admission and determine a management plan for him. Dr C said that they agreed that this was likely to be a viral illness but, based on the history of prolonged fever and Master A's remote residence, he should be admitted overnight to Gisborne Hospital for further investigations and observation. Dr C said that at the time of his discussions with Dr F, he had no evidence that this illness was something more serious than a transient viral infection.
58. Dr C documented:
- '[D]iscussed with [Dr F] at [Health NZ Tairāwhiti]). Likely viral illness. Likely to settle with paracetamol but advised that child should be admitted overnight to [Gisborne Hospital] — given paracetamol.'
59. Dr C stated that he informed Master A's family of Dr F's advice. He said that Master A's mother asked him whether Gisborne Hospital would just keep Master A overnight again and discharge him the following morning, and he agreed that this was possible, but said that it was the appropriate precautionary approach to take in that situation. Dr C recorded: '[M]other and grandmother given option to go to hospital or to return home with ibuprofen.'
60. Dr C stated that when discussing a possible transfer to Gisborne Hospital, he asked whether they wanted him to order an ambulance or whether they wished to use their own car, and they preferred to use their own car. Mrs A stated that the reason for this preference was that if they travelled by ambulance, they would then be stranded in Gisborne with no transport home. She said that the previous ambulance trip had been very uncomfortable, and often the ambulance was single crewed. The whānau told the Coroner that it was then after midnight, and they were 'looking for leadership from the doctor', but they found this lacking. They said that Dr C left it up to the whānau to make the decision about going to Gisborne Hospital, but

at the same time he seemed to be minimising the seriousness of Master A's high temperature by referring to it as a virus. In response to the provisional opinion, they said that part of the discussion was around Master A's breathing. Dr C said that the laboured breathing was likely to be a secondary symptom of the virus and, as Master A's chest sounded okay, there was no concern.

61. The whānau found themselves faced with trying to determine the urgency for medical care at a time when they themselves were tired, stressed, and vulnerable.
62. Mrs A stated that she and her daughter were frightened about Master A's state and did not believe that they were really in the best position to make such a critical decision. They were relying on the doctor to make this decision for them.
63. The whānau told the Coroner that they were critical of Dr C for the following reasons:
- They had the impression that Dr C minimised their concerns about Master A's health. Mrs A told the Coroner that she felt especially affronted when she observed what she perceived as a 'snigger' from the doctor toward her and Master A's mother.
  - They insisted that Dr C call Gisborne Hospital, which he seemed reluctant to do. They felt that he contacted Gisborne Hospital only once he realised that they would not leave until he did so.
  - The whānau considered that Dr C should have made some arrangement for them to stay at the rural hospital overnight with Master A, rather than the whānau attempting the two-hour drive to Gisborne Hospital at 1am or driving back home.
  - The whānau considered that if Dr C really thought that Master A should be admitted to Gisborne as a precautionary measure, then he should have requested a helicopter (air ambulance).
  - The whānau had to ask Dr C to listen to Master A's chest, as this was not done during the initial assessment.
  - They asked Dr C whether Master A could have a 'spacer' to help with his breathing. This suggestion was declined, and Dr C commented that the breathing was a secondary symptom of the virus. They said that Dr C did not consider other reasons for Master A's laboured breathing.
64. Dr C told HDC that he is sorry that the whānau had the impression that he minimised their concerns, which he feels is an inaccurate representation of his response to the whānau. He said that he sought to understand the broader situation and family dynamics to provide safe and appropriate care for the child within this wider whānau context. He does not recall a 'snigger' or have any memory of any problems with his interactions. He said that this is not something he would do or that would make sense given the context.
65. Dr C said that he contacted Gisborne Hospital based on his own clinical judgement, as he considered it imperative that he understood what Master A's recent admission had entailed, as there was no discharge summary in the notes.

*Admission to rural hospital denied*

66. Master A's whānau asked whether Master A could stay in the rural hospital for the rest of the night, and Dr C stated that this was not possible, as they did not admit children overnight.
67. The PHO stated that at that time it did not have any written policy regarding the admission of children. It said that it was a long-standing position of the organisation that the admission of children be cautioned against, and a sick child should be admitted directly to Gisborne Hospital.
68. The rationale for this was that a child with a fever can deteriorate rapidly and require urgent medical attention from a more specialised paediatric service. In addition, if children required continuous observation, it was better to transfer them to Gisborne Hospital rather than admit them to a case-mix ward (a mix of aged care, respite care, disability support, palliative care, ED, and maternity care) at the rural hospital. Furthermore, the hospital has limited resources and is not equipped to manage seriously unwell patients.

*Helicopter transfer*

69. Dr C stated that helicopter transfers are reserved for the most acute patients needing urgent transfers. He said that Master A did not present as needing an urgent helicopter transfer on the evening of Day 3 and he noted that helicopter transfers can create problems for whānau in that the helicopters are limited in their capacity to carry more than one accompanying person, and they can leave whānau without a vehicle at the destination. He noted that it is important to use the most appropriate form of transport for hospital transfers, and it was his experience that helicopter transfers are not necessarily faster than a private car or an ambulance transfer. He said that adverse weather, which can include low clouds, and other tasking of the helicopter, can cause long delays, particularly at night.
70. Dr C stated: 'The most appropriate transport would have been for the family to drive directly from [the region] to Gisborne Hospital.' He said that he told this to Ms A when he spoke to her on the telephone before they came to the rural hospital.
71. Dr C said that when it became evident that the family were reluctant to spend a night in Gisborne Hospital, he asked whether there were relatives they could stay with who lived closer to Gisborne Hospital, so that they could get there rapidly if Master A needed further investigations and treatment. In response to the provisional opinion, Mrs A stated that driving to Gisborne late at night was an issue because of fatigue and fear of the unknown. They wanted an ambulance and requested an air ambulance. She stated that there was no issue with accommodation in Gisborne and that was never a factor that was discussed.
72. Dr C stated that Master A's mother and grandmother decided to take Master A home, so he gave them safety-netting advice to seek further assistance should Master A deteriorate. The advice included ringing 111, going to the community health centre, or taking Master A directly to Gisborne Hospital.
73. RN E said that she was present during this discussion, and Dr C explained to Ms A the red flags they should be aware of and what action to take, including that if Master A's temperature was still high in the morning then to have Master A seen by a doctor.

74. Dr C said that he re-examined Master A to reassure himself that he had not overlooked any clinical signs that might indicate that Master A should go directly to Gisborne Hospital. He documented that Master A's temperature had come down to 38°C and his breathing had slowed, and there was no neck stiffness or rash. Dr C said that Master A was taking water from a syringe and looking much improved. Dr C said that he provided the family with some ibuprofen for Master A to take later in the evening to avoid exceeding the recommended dose of paracetamol.
75. Master A left the rural hospital at around midnight on Day 4, approximately two hours after his presentation.
76. Dr F told HDC that he does not recall the specifics of his conversation with Dr C but clearly remembers that his advice was that Master A should return to Gisborne Hospital for repeat assessment and review. Dr F recalls this as he expected to be phoned by the ED overnight when Master A arrived and was surprised that Master A had not arrived at the hospital when he handed over to his colleague the following morning.
77. The PHO told HDC that Dr C and RN E were interviewed at a later date, and both interviews confirmed that the whānau were advised that Master A should be admitted to Gisborne Hospital. The PHO said that after the whānau declined taking him to Gisborne Hospital, RN E advised the grandmother that if Master A was still unwell in the morning, and they were concerned, then they should have him seen. RN E said that she anticipated that Ms A was unlikely to have a thermometer at home, so she told Mrs A that they should take Master A to the community health centre in the morning if he was still hot, and they should ask the practice nurse to take his temperature.

## Day 5

### *Community Health Centre*

78. At around midday on Day 5 Master A presented at the community health centre. RN D met Ms A and Master A in the reception area and took them through to the examination area. She noted that Master A was extremely unwell, and she stayed with him for a few minutes until the GP was available. RN D documented that Master A's respiratory rate was 64, his temperature was 38.9°C, his oxygen saturation was 87%, and his heart rate was 175–183.
79. At 12.13pm Master A was assessed by Dr B, who at the time of these events was working as a locum doctor in general practice. Dr B had been working for the PHO as a locum for approximately three weeks prior to these events.
80. Dr B told HDC that this was the only occasion on which she saw Master A, and he attended the community health centre at the region with his mother and grandfather. She stated that from the history she was given and from his clinical records, Master A had presented to Gisborne Hospital on Day 1, with vomiting and a fever. He had been diagnosed with a viral infection, possibly roseola<sup>7</sup> or similar. She said that upon discharge the following day, the family had been advised that Master A should be taken back to the paediatric ward at Gisborne Hospital if they had any concerns.

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<sup>7</sup> A childhood viral illness that presents with a fever and a rash.

81. Dr B told HDC that by the time she saw Master A, he had been unwell for at least five days. She said that Ms A informed her that Master A's temperature had been elevated, he had rapid breathing and was suffering from diarrhoea, and he did not want to be touched or moved.
82. Dr B recorded Master A's temperature as 38.9°C (45 minutes post the administration of paracetamol at home). He was accepting some fluids and was breathing with a slight indrawing of the intercostal spaces (the spaces between the ribs) but he had no wheezing. However, his hands and feet were cold, and he did not want to be moved, but he was not coughing.
83. Subsequently, Dr B told HDC that Master A was pale and jaundiced. She said that she asked Ms A if that was his normal colour, and she replied that it was not. Dr B stated that Master A was very unwell, and she discussed with the ED consultant at Gisborne Hospital 'in detail' that she had a child who looked very sick and might have sepsis. She said that the ED consultant agreed with her management.
84. Dr B said that her impression was that Master A looked very unwell, and he needed to be in hospital where he could have full investigations and be monitored closely. She said that she wanted Master A in hospital as soon as possible, but she considered his condition was not immediately life-threatening.

*Transfer to Gisborne Hospital*

85. Dr B said that she completed her clinical notes and referral letter then telephoned the ED consultant at Gisborne Hospital to inform them that she was sending Master A for admission. She said that she sent the ED electronic referral letter. Gisborne Hospital stated that the letter had no content of the assessment for that day, but it did contain GP notes from Day 1 and Day 3, which caused confusion.
86. Dr B said that she found out later that her clinical notes had not been transferred. She stated that at the time she did not realise that the current notes had to be saved first before they would transfer.
87. The whānau told the Coroner that Dr B did not mention the option of transporting Master A to Gisborne Hospital by helicopter, and they were advised to take Master A in their own car.
88. Dr B stated that she considered transporting Master A to Gisborne Hospital by helicopter, but the weather at the time was too dangerous for the helicopter to fly, with heavy rain and low cloud causing poor visibility. She said that she and RN D discussed with Ms A the option of Master A being transported to Gisborne by ambulance. Dr B stated that although she had been working at the PHO for only a few weeks, she had noted that often there was a significant delay in an ambulance arriving.
89. Ms A explained to Dr B that the ambulance trip they had taken the previous week had been an unpleasant experience that she did not want to repeat. She preferred instead to take Master A to Gisborne in her own vehicle, which her father-in-law would drive. RN D recalled the same discussion. Master A left the community health centre at 12.30pm, 30 minutes after presenting.

90. In response to the provisional opinion, Dr B stated that alternative travel arrangements were communicated to the family, but the weather did not permit the air ambulance to be operational, and the time an ambulance would have taken to get to the location to transport the baby would have added time to a situation that was becoming time critical. She said that the family elected to take the baby by private car, and she was not in a position to dictate to the family what method of transport they should take.
91. Dr B stated that in her assessment it was reasonable for Ms A to take Master A to Gisborne in her own vehicle. Dr B said that it is likely that they would have had to wait for the ambulance to get to the region before departing for Gisborne, delaying Master A's admission. She said that she advised Ms A that if Master A's condition deteriorated on the way, she should stop at one of the clinics on the way. Dr B documented: 'Mo[th]er prefer to drive, refused ambulance. Advised if he medically deteriorates on his way, to stop in other clinics. ED informed that they are coming.'
92. Dr B said that due to the urgency of the situation, she did not try to insert an intravenous (IV) line, as that would have taken time and would not have been ideal for the transportation by car. She said that as Master A was already having some sips of fluid orally, she thought the time would be better spent getting him to the hospital, where he could have attention from a more skilled team. She said that she discussed the plan in detail with the ED consultant, who agreed with it.
93. Dr B stated that she referred Master A to the ED at Gisborne Hospital, but on arrival the family went directly to the paediatric ward, which was what the paediatrician they saw on Day 2 had instructed the family to do if they had further concerns.

#### *Gisborne Hospital*

94. It is documented that during the drive from the region, Master A became yellow (jaundiced). It is noted that he had dark stool diarrhoea and bright yellow urine, and he is described as being lethargic. The whānau complained that the staff at Gisborne Hospital did not respond quickly in providing emergency care to Master A.
95. Master A was brought into the children's ward at Gisborne Hospital by his mother at around 3.30pm. The paediatrician told the Coroner that it was clear on arrival that Master A was unwell. The paediatrician noted that Master A had been having temperatures, he was lethargic and had difficulty breathing, and on that day he had also developed sudden jaundice.
96. The nursing notes document the admission, including Master A's observations and his grunting respirations. He was moved into a high dependency area and IV access was obtained with difficulty, as peripherally he was shutting down.
97. The records state that on examination Master A was 'yellow and grunting' with mildly increased work of breathing. He was warm centrally with a capillary refill time of under 2 seconds (capillary refill time is a measure of how fast blood returns into skin that has been blanched by 5 seconds of finger pressure. A time longer than 2 seconds indicates shock). Master A had a soft abdomen but he was tensing it. He had poor air entry to the left lung.

98. The differential diagnoses were viral hepatitis, sepsis caused by a respiratory infection (bloodstream infection), haemolytic uraemic syndrome (a blood and kidney disorder that can occur following infections), or disseminated intravascular coagulation (blood clotting throughout the body).
99. A chest X-ray showed a left lung collapse, but an ultrasound showed no effusion (a collection of fluid outside the lung). A broad-spectrum antibiotic (co-amoxicillin-clavulanic acid) was started, a senior doctor was asked to attend, and a discussion with a children's hospital was planned.
100. The blood results from a test taken at 3.42pm were slow to come back (reported at 5.02pm), which made it difficult to assess Master A and give the children's hospital accurate information. Health NZ Tairāwhiti told HDC that this did not delay Master A's transfer to the children's hospital, because there were logistical issues in mobilising the retrieval team.
101. Master A was anaemic with a low platelet count and an abnormal blood-clotting screen. The paediatrician attended and discussed Master A with the Paediatric Intensive Care Unit (PICU) at the children's hospital.
102. Anaesthetics was called and there was a further discussion with PICU regarding the additional results, including Master A's low sodium (salt), raised renal tests (indicating kidney problems), raised transaminases (indicating liver problems), and deranged blood clotting.
103. Given the problems in all these areas, a diagnosis of multi-organ failure was made. Transport to the children's hospital was arranged, and it was planned to administer blood products to try to correct some of the abnormalities. However, Master A deteriorated and then stopped breathing.
104. An 'intervention record' in the notes provides a timeline of events after Master A stopped breathing. The record documents the escalating requirement for low, then high flow oxygen delivery, and that fluid boluses were given for shock. At 7.15pm Master A suffered a respiratory arrest and was intubated. Chest compressions commenced and cardiopulmonary resuscitation continued until, sadly, it was determined that Master A had died.

#### **Clinical advice to Coroner**

105. The Coroner obtained clinical opinions from GP Dr H and paediatrician Dr I.

#### *Dr H*

106. Dr H reviewed the timeline of events. He said that infants are well known for their ability to recover quickly and also to deteriorate with minimal signs present until very late in a disease process. Dr H stated that while it is possible that there was a pneumonic process present when Master A was admitted to Gisborne Hospital on Day 1, there appeared to be no clinical chest signs to support that and, with clinical improvement, Master A was discharged home.

107. Dr H stated:

‘Without doubt the distances involved in this case play a part both consciously and sub-consciously in both medical and parental decisions to make long journeys with a child. There are both social and fiscal reasons why this is often very difficult. The mother’s reluctance to make a further ambulance trip to Gisborne is understandable. It is uncertain whether this would have made a material difference to the outcome. The rapid deterioration of the child is alarming but as I mentioned earlier is not an infrequent event in infants. I feel this case is a wake-up call to the difficulties that persons in remote areas face that we in larger centres with base hospitals minutes away do not.’

108. Dr H concluded that he could find no evidence of any medical deficiencies in the treatment of this case.

*Dr I*

109. Dr I stated that his expertise is in secondary-level hospital paediatrics, and he is not a qualified GP and has never worked in primary care. He noted that Master A had not been immunised, placing him at higher risk of vaccine-preventable infections, including bacterial infections such as Pneumococci sepsis.

110. Dr I noted that at multiple points during Day 1 and overnight on Day 1/Day 2 it was specifically noted that Master A had a normal rate of breathing, was not coughing, and was not working hard to breathe. Dr I concluded that there were no apparent signs of a chest infection at that stage. Dr I noted that aside from very minor points, such as an entry not being timed, the documentation is complete and thorough.

111. Dr I advised that the initial management and decision to admit to hospital on Day 1 appears appropriate, and the initial admission overnight clearly documents normal observations over an appropriate period of time.

112. Dr I said that on Day 3 the only documented finding that may have suggested that Master A had developed a respiratory problem was his fast breathing rate. Dr I advised that in isolation, this may not have indicated a definite need for hospitalisation, and it was clearly felt to be reducing with the improvement of Master A’s fever.

113. Dr I was not critical of Dr C on the basis of that finding alone and noted that medical practitioners cannot ‘make’ a patient attend hospital if recommended, with the only recourse being to involve Police if a child is felt to be in imminent danger, which was clearly not felt to be the case, and Dr C considered it reasonable for Master A’s family to continue to monitor Master A at home. Dr I noted that although he is not a GP, he felt able to comment that Dr C’s actions in advising a clinical review in person, discussing the case with a paediatrician, advising re-admission, and providing safety advice given that the family did not return to hospital, were all appropriate.

114. Regarding the presentation on Day 5, Dr I advised that on that day Master A is documented for the first time as having increased work (effort) of breathing. Clearly Master A was unwell, and he was sent to hospital. Dr I said that it is difficult to ascertain whether Master A deteriorated during the 90-minute journey to hospital, but by the time he arrived at the

hospital he was clearly very unwell, with medical and nursing staff recognising his respiratory distress and jaundice.

115. Dr I said that imaging and blood investigations were performed, all of which showed significant abnormalities, giving rise to a picture of multi-organ failure. Senior medical staff were involved rapidly, and they discussed the case with a children's hospital before all results were available. Master A's condition deteriorated rapidly, with a cardiorespiratory arrest. Senior medical and anaesthetic staff responded to this with standard care, but the situation was irrecoverable by that stage.
116. Dr I stated that, tragically, it appears that Master A was very unwell and deteriorated rapidly, and rapid escalation of medical therapy was not enough to stop his further deterioration and subsequent death.
117. Dr I concluded that the actions taken on Day 5 were appropriate, including transferring Master A to hospital, and the rapid escalation of care to high dependency and planned intensive care. Dr I stated:

'I do not consider from the notes available to me that there appear to be any other actions that could have been taken on ... [Day 5] that could be said to be likely to have prevented [Master A's] death ... I do not think there is fault in either of the Hospital admissions in terms of the care [Master A] received.'

### Reviews

118. Two reviews were completed — the Child Health Unit Clinical Case Review and the Reportable Event Investigation — and these made findings and recommendations.

#### *Child Health Unit Clinical Case Review*

119. The Child Health Unit Clinical Case Review was undertaken by the Health NZ Tairāwhiti paediatric ward and included health professionals from the PHO and Gisborne Hospital who were involved Master A's care. The review identified several issues or queries that arose as a result of the care provided, and planned actions in response.
120. Comments in the Child Health Unit Clinical Case Review included the following:
- Initial management (Day 1–Day 2) was in line with recommended management guidelines.
  - No fever handout was given on discharge, which may or may not have influenced whānau decision-making.
  - Regarding the whānau's concerns that the Gisborne Hospital discharge summary from Day 2 was inaccurate, the review acknowledged that it can be difficult when resident medical officers (RMOs) are writing discharge summaries for patients with whom they have had no contact. The review noted that often RMOs have many discharge summaries to write, and limited time. However, the review states that RMOs still have a duty of care for accuracy. It was recommended that patients should be encouraged to report any inaccuracies or concerns to Planet Sunshine.

- The community health centre had indicated that there was no adequate referral/communication process. The staff had no knowledge that Master A had been discharged from hospital on Day 2 or that he had presented to the rural hospital after-hours GP clinic on Day 3. Gisborne Hospital ED doctors have now been asked to give discharge summaries to patients before discharge from ED, particularly those patients from the region.
- The review identified the need for improved communication pathways between the PHO clinics, and between Gisborne Hospital and the PHO.
- The review states that worried whānau re-presenting, especially late at night, should be an alarm to all health practitioners. The review noted that often parental anxiety can be a criterion for admission and/or assessment. The paediatric admission policy now states: 'All children seen in ED between 2400 and 0600hrs should be offered the opportunity for admission to the ward for observation and Paediatric review in the morning.'
- On Day 5 the blood test results were slow to come back, which made it difficult to assess Master A and difficult to give the children's hospital accurate evidenced information. The children's hospital had asked that staff 'phone back when results available', which caused a potential delay in the children's hospital accepting the need for retrieval. Upon receipt of the samples in the lab, the correct procedures for processing urgent samples were not followed, as the receiving staff did not identify that this was an urgent request and, as a result, these were processed with a large batch of routine samples.

#### *Reportable Event Investigation*

121. The Reportable Event Investigation was undertaken jointly with Health NZ Tairāwhiti and the PHO. The findings included the following:

- The initial viral diagnosis set the scene for the subsequent interactions.
- Information on the Gisborne Hospital discharge on Day 2 was not available in a timely manner (the discharge summary arrived three days later).
- The discharge summary states to 'return if concerns' but does not state where to return to.
- Neither Ward 4 (Planet Sunshine) at Gisborne Hospital nor the rural hospital ED provided a fever pamphlet on discharge.
- Master A was not referred for follow-up by primary care following his discharge from Gisborne Hospital on Day 2 or after the presentation on Day 3 at the rural hospital.
- On Day 3 Dr C did not advise the whānau strongly enough to take Master A to Gisborne Hospital as advised by the paediatrician. The advice Dr C gave to Master A's mother was not sufficient for her to make an informed decision. The whānau were given a choice of whether or not to be transferred, when they were seeking leadership, and they reported that they felt as if they were being overly dramatic.
- The PHO policy was not followed during the Day 3 presentation, which clearly identifies unexplained fever as requiring transfer to Gisborne Hospital.

- The rural isolation and distance from the hospital may have contributed to the decision-making by Master A's mother and Dr C on Day 3.
- There was no community follow-up on Day 4 following the Day 3 presentation.
- When Master A presented on Day 5, Dr B did not call an ambulance/helicopter to take him to Gisborne Hospital. The ambulance service provider should have been called as a helicopter may have been operational, although the weather conditions may have impacted on the decision not to call the helicopter.
- On Day 5 Dr B did not call Paediatrics at Gisborne Hospital. The paediatrician may have been able to offer advice, for example to administer antibiotics, IV fluids, intramuscular (IM) antibiotics, and/or oxygen prior to leaving the region.
- On Day 5 the whānau took Master A to Ward 4 (Planet Sunshine), where the staff were unaware that he would be arriving. Dr B had notified the ED that Master A would be arriving, but the whānau did not present to ED.
- Dr B did not realise that the current notes had to be saved first before they would transfer.
- Being stranded in Gisborne without a vehicle is a problem for families being transferred to Gisborne Hospital via ambulance from the region.
- The weather conditions affect the mode of transport from the region to Gisborne Hospital.
- The practice of not allowing children to stay for observation for up to six hours at the rural hospital is problematic.

### Recommendations

122. The review made the following recommendations:

#### PHO TRIAGE POLICY

- Review the triage policy.
- The triage policy to include GPs in other coastal clinics and not be limited to the rural hospital's ED.
- Educate both nurses and doctors on the triage policy.
- Include the triage policy in the new clinical staff orientation process.
- To include a section to contact Paediatrics if there are concerns.
- Work with the ambulance service provider for a clearer process for transporting people (helicopter/ambulance).
- Consider the impact of the person being stranded in Gisborne following ambulance/helicopter transfer.
- If recommendations are refused, determine the reasons for this and establish how the concerns can be overcome.

## PHO PAEDIATRIC ESCALATION PROTOCOL

- The rural hospital contract allows for children to be admitted. Explore the option to keep children overnight on the ward if there is a late presentation and there are concerns.
- Consider the language used: if the child/person requires admission then family is strongly advised as opposed to being given the choice.
- Include contacting Paediatrics for advice.
- Consider the impact of isolation and distance to travel.
- Implement the children's hospital guidelines.

## FOLLOW-UP PROCESS

- Gisborne Hospital to ensure that the discharge letter goes home with the patient and is available on Medtech on discharge.
- The PHO to implement a process to notify practices/rural health nurse/GP after hours, to follow up unwell children or adults of concern and book into a clinic or follow-up by rural health nurse the next day if appropriate.
- The PHO to develop a fever pamphlet.
- The PHO staff to receive education in Medtech documentation.

**Cultural competency**

123. The whānau told the Coroner that they consider there to be a need for GPs to have a better understanding of the community in which they are practising. They stated that as part of a doctor's orientation, there should be a conversation with kaumātua and kuia.
124. In response, the PHO stated that it has had kaumātua on staff for many years, who support staff being welcomed into the organisation and community.
125. The PHO stated that the orientation also provides an opportunity for new doctors to provide feedback and recommendations regarding the orientation pack. It said that cultural competency is mandatory training for all staff.

**Responses to provisional opinion**

126. The PHO made no comments about the provisional opinion.
127. Health NZ Tairāwhiti made no comments about the provisional opinion.
128. Dr C made no comments and accepted the recommendations in the provisional opinion.
129. Comments were received from Master A's whānau and Dr B. These have been incorporated into the 'information gathered' section as appropriate. In addition, the following comments were received.

*Master A's whānau*

130. Master A's whānau said that they sought leadership, professional support, and expertise from doctors and trained medical personnel who they believed would make the best medical

judgements for Master A. They believe that over the course of five days they did everything in their power to access and acquire the best possible medical care and advice that was available to Master A.

131. They stated that they pleaded to stay at the rural hospital and tried to reason with both the doctor and nurse, as it was after midnight, and they were exhausted. They asked for a helicopter to transport them to Gisborne, but Dr C refused and instead he gave them the option to drive to Gisborne, which they declined because they did not want to make the hour-and-a-half drive whilst fatigued and without medical assistance.

*Dr B*

132. Dr B submitted that her assessment of Master A was adequate because she realised that it was appropriate to get Master A to hospital as soon as possible. She said that she communicated that to the family and made arrangements for Master A to get to hospital. She communicated with the ED doctor about the transfer and Master A's condition, as the ED doctor was to be the first point of call in Master A's admission to hospital.
133. Dr B conceded that consultation with a paediatrician prior to Master A's transfer to hospital would have been beneficial but noted that she did consult the ED doctor. She stated that standard practice when referring patients to the hospital is that the GP consults with the ED doctor, who then consults with the appropriate department within the hospital if needed.
134. Regarding whether any interventions were indicated prior to Master A's transfer to Gisborne Hospital, Dr B stated that there were limitations in that IV fluids were unable to be administered due to Master A being very sick and his veins not easily accessible, antibiotics could not be administered orally as he was vomiting, and oxygen could not be administered as the family had elected to take him to hospital via private car.
135. Dr B agreed that she should have given clearer instructions to the family on where to go at Gisborne Hospital, in order to get them to the appropriate department more efficiently.
136. Dr B acknowledged that she made an error when saving the medical notes on a system that was new to her, but she said that she relayed Master A's details verbally to the ED doctor. In addition, the ED had her contact details, and if there had been any confusion, they could have contacted her directly for clarification.

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## Opinion: Introduction

137. E te whānau ka mihi aroha ki a koutou i tō tino mamae, tō pōuritanga o tō tamaiti ātaahua kua whetūrangitia. Kāore he kupu, he whakaaro hei whakaora te ngaro ka waenganui a koutou. Nō reira ka tuku a mātou nei aroha, a mātou nei rangimārie ki a koutou katoa — Mauri Ora.
138. It is clear that Master A's whānau made every attempt to ensure that Master A received the care he needed, but their rural location added to the challenges they faced. Master A's

whānau sought assistance for him from the community health centre, the ambulance service provider, the rural health nurse, the rural hospital, and Gisborne Hospital. However, a lack of documentation and poor communication resulted in the full picture not being apparent when needed. In particular, the repeated presentations should have been a red flag.

139. In addition, in my view there was an element of confirmation bias such that clinicians continued to believe that Master A had a viral illness even when he failed to improve after several days and developed a cough, a high temperature, and fast breathing.
140. In considering the care provided to Master A, I have been guided by the advice provided by rural specialist Dr Jennifer Keys.

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## **Opinion: Health NZ Tairāwhiti — breach**

### **Discharge on Day 2**

141. On Day 2 the Gisborne Hospital records state that Master A was well overnight, that he was eating and drinking, his mother was comfortable with a discharge home, and that she had been advised to return if she had any concerns (but not where she should return to). I am concerned about the discharge processes that occurred on Day 2.
142. Ms A said that she told Dr F that Master A had had rigors during the night and had vomited, and that Master A had not eaten anything that morning and had had only a little water, but Dr F was dismissive of this information.
143. Dr F does not specifically recall his conversation with the whānau, but he said that his practice when talking with parents about discharge home has always been to ensure that they understand what he believes is causing their child to be unwell, to discuss what the treatment is for the condition, and to provide them with time to ask questions. He said that he considers the wishes of the family and the ‘safety net’ for the child should they not improve.
144. RN G said that Dr F was very thorough in the information he gave to Ms A.
145. In addition, RN G said that Ms A did not request that Master A stay in hospital longer, and Dr F told Ms A that if she became worried about Master A she should contact the nearest doctor. I am unable to make any findings about what exactly was said but I acknowledge that Ms A may have found it difficult to challenge Dr F’s decision to discharge Master A, despite her concerns. As she was told that it was likely that Master A’s symptoms were caused by a virus and he was treated only with Pamol, it is understandable that she questioned the benefit of returning to Gisborne Hospital when Master A’s symptoms persisted and then worsened.
146. The whānau stated that greater consideration should have been given to delaying the discharge in view of the rural isolation of the family and the difficulty they would have in accessing prompt medical attention once they had returned to the region. They noted that Master A was discharged over the weekend.

147. Health NZ Tairāwhiti stated that its paediatricians take a cautious approach to remote rural families and generally, if there is the slightest concern, they will keep them in hospital longer just to 'watch and see'. Alternatively, often whānau are asked whether they have somewhere to stay in town so that it is not so far to travel should the child need to re-present.
148. There is no record of any discussion with Ms A about a longer hospital stay or remaining in Gisborne on the morning of Master A's discharge from hospital.
149. RN G discharged Master A from Planet Sunshine even though she had had minimal contact with him prior to arranging his discharge. No discharge summary was completed on the day of Master A's discharge — it was completed by a house officer and the GP practice received it three days later. As a result, when Master A represented to the rural hospital on Day 3, Dr C had no information about the previous hospital admission.
150. The discharge summary states to 'return if concerns' but does not state where to return to. It appears that Ms A was given conflicting advice regarding whether she should go to the GP or re-present to Gisborne Hospital if Master A remained unwell. In addition, it was unclear whether a re-presentation to hospital should be via the ED or directly to Planet Sunshine.
151. Furthermore, Ms A was not given any written information such as the fever leaflet, a written summary, or a letter to inform her of the details of a contact person, department or service, or information about contacting the rural health nurse, practice nurse, or GP.
152. Master A was also not referred for follow-up by primary care following his discharge from Gisborne Hospital on Day 2.
153. I note that Dr I concluded that on Day 5 the transfer of Master A to hospital and the actions taken at Gisborne Hospital were appropriate, including the rapid escalation of care to high dependency and the planned intensive care. However, the blood results were slow to come back, which made it difficult to assess Master A and give the children's hospital accurate information. Potentially this could have delayed the children's hospital accepting the need to retrieve Master A, and his actual transfer. I accept that in the event the slow blood results did not delay the transfer, and that this occurred because of other events. Nonetheless, I am critical that the laboratory staff did not follow correct procedures for processing urgent blood samples.
154. Having considered the information received, I adopt and accept the findings of the Child Health Unit Clinical Case Review and the Reportable Event Investigation. Overall, I consider that the discharge process on Day 2 was inadequate and did not provide sufficient follow-up or support services for Ms A and Master A.
155. I have carefully considered the extent to which the failings in Master A's care occurred as a result of individual staff action or inaction, as opposed to systemic and organisational issues. I have concluded that because the failures involved multiple staff members, a lack of staff awareness in relation to the difficulties faced by patients from remote communities and the need for follow-up and support, this is reflective of systemic and organisational issues at Health NZ, for which it is responsible at a service level. Accordingly, I find that Health NZ

Tairāwhiti breached Right 4(1) of the Code of Health and Disability Services Consumers' Rights (the Code).<sup>8</sup>

### Opinion: Dr C — adverse comment

156. On Day 3 Master A's whānau became concerned when his condition deteriorated and he developed a high fever, cough, and rapid breathing. The whānau unsuccessfully sought assistance from the ambulance service provider and the rural health nurse, so they then travelled to the rural hospital, where they saw Dr C.
157. On examination, Master A was hot and was breathing rapidly. His heart rate was 177bpm and his temperature was 40°C. No Gisborne Hospital discharge summary or notes from Master A's hospital admission on Day 1/Day 2 were available to Dr C.
158. At 11.19pm Dr C called Dr F at Gisborne Hospital. Dr C and Dr F agreed that this was likely to be a viral illness, but because of Master A's prolonged fever and the whānau's remote locality, Master A should be admitted to Gisborne Hospital overnight for further investigations and observation. Dr C documented: '[D]iscussed with [Dr F] at [Health NZ Tairāwhiti]. Likely viral illness. Likely to settle with paracetamol but advised that child should be admitted overnight to HT — given paracetamol.'
159. Dr Keys advised that Dr C's assessment of Master A was consistent with current practice and guidelines and that no further tests were indicated at the rural hospital on Day 3. I accept this advice.
160. Dr C stated that he told Master A's whānau about the advice that Dr F had given him, and Master A's mother asked whether Gisborne Hospital would just keep Master A overnight and discharge him the following morning (as had happened during the admission on Day 1/Day 2), and Dr C agreed that this was possible but said that it was the appropriate precautionary approach to take in that situation. However, Dr F clearly remembers that his advice was that Master A should return to Gisborne Hospital for repeat assessment and review. I acknowledge that Master A's mother had questioned the usefulness of taking Master A back to Gisborne Hospital, and Dr C's advice was given in light of that information. However, in my view, Dr C should have advocated strongly for hospital admission given Dr F's advice and explained that the PHO policy was that an unexplained fever required transfer to Gisborne Hospital, and Dr C should have discussed the risks of returning home.
161. Dr C recorded: '[M]other and grandmother given option to go to hospital or to return home with ibuprofen.' Dr C stated that Master A's mother and grandmother decided to take Master A home, so he gave them safety-netting advice to seek further assistance should Master A deteriorate. The advice included ringing 111, going to the community health centre, or taking Master A directly to Gisborne Hospital.

<sup>8</sup> Right 4(1) states: 'Every consumer has the right to have services provided with reasonable care and skill.'

162. RN E said that she was present during this discussion, and Dr C explained to Ms A the red flags they must be aware of and what action to take, including that if the temperature was still high in the morning, then to have Master A seen by a doctor.
163. In my view, it was essential for Dr C to provide sufficient information to enable Master A's mother to make an informed decision on whether to go to hospital.
164. The whānau said that it was then after midnight and they were 'looking for leadership from the doctor' but found this lacking. They said that Dr C left it up to the whānau to make the decision about going to Gisborne Hospital, but at the same time he seemed to be minimising the seriousness of Master A's high temperature by referring to it as a virus. They found themselves faced with trying to determine the urgency for medical care at a time when they themselves were tired, stressed, and vulnerable.
165. When discussing a possible transfer to Gisborne, Dr C asked the whānau whether they wanted him to order an ambulance or whether they would use their own car to get to Gisborne, and they told him that they preferred to use their own car because if they travelled by ambulance, they would then be stranded in Gisborne with no transport home. In addition, they said that the ambulance trip on Day 1 had been very uncomfortable, and often the ambulance was single crewed. The whānau consider that if Dr C had really thought that Master A should be admitted to Gisborne as a precautionary measure, then he should have requested a helicopter.
166. Dr C stated that helicopter transfers are reserved for the most acute patients needing urgent transfers, and Master A did not present as needing an urgent helicopter transfer on the evening of Day 3. However, Dr C did not discuss this option or his reasoning with the whānau.
167. The whānau asked whether they could stay at the rural hospital for the remainder of the night rather than undertaking the long drive to Gisborne at night or the return journey home. Dr C told them that this was not possible, as they did not admit children overnight. The PHO did not have a written policy regarding the admission of children, but the long-standing position was that the admission of children should be cautioned against, and a sick child should be admitted directly to Gisborne Hospital because a child with a fever can deteriorate rapidly and require urgent medical attention from a more specialised paediatric service. In my view, this should have been discussed fully with the whānau.

### **Other comment**

168. The whānau considered that Dr C was dismissive and gave them the impression that they were overreacting ('drama queens'). I am unable to make findings about Dr C's manner, and I am mindful that Dr C was working with a diagnosis of a virus and may have been attempting to allay their concerns. However, I remind Dr C that whānau concerns should be taken seriously and that whānau should be treated with respect.

**Opinion: Dr B — breach**

169. On Day 5 at around midday Master A re-presented at the community health centre, where he was seen by Dr B. By that time Master A had been unwell for five days. Ms A told Dr B that Master A's temperature had been elevated, he was suffering from diarrhoea and rapid breathing, and he did not want to be touched or moved.
170. Dr B recorded Master A's temperature as 38.9°C (45 minutes post the administration of paracetamol at home) and noted that he was accepting some fluids and was breathing with slight indrawing of the intercostal spaces but he had no wheezing. However, his hands and feet were cold, and he looked pale and jaundiced. Dr B said her impression was that Master A looked very unwell, and he needed to be in hospital where he could have full investigations and be monitored closely. She said that she wanted Master A in hospital as soon as possible, but she considered that his condition was not immediately life-threatening.
171. Dr Keys advised that Dr B's assessment of Master A was not adequate. Dr Keys noted that apart from recording Master A's temperature, Dr B's note does not include other nursing observations or note how alert Master A was, although his heart rate and respiratory rate were very high and his oxygen saturation was low (suggesting either hypoxia or very poor peripheral circulation). Dr B did not record that Master A was jaundiced, although she did note this subsequently. Dr Keys said that the paediatric admission note states that there was minimal air entry in Master A's left lung, but Dr B's record states that Master A's chest was clear. Dr Keys advised that there was sufficient information available (from a combination of history, nursing observations, and Dr B's assessment) to understand that Master A was very unwell and that there was a significant likelihood that he had bacterial sepsis and should be treated as such.
172. Dr Keys concluded: 'It is clear from [Dr B's] note and her actions that she understood that [Master A] needed hospital treatment, but not that [Master A] was very significantly compromised.' I accept this advice.
173. The whānau complained that Dr B did not mention the option of transporting Master A to Gisborne Hospital by helicopter. Dr B said that she did consider transporting Master A to Gisborne Hospital by helicopter, but she concluded that the weather was too dangerous for the helicopter to fly. The serious event review report states that the ambulance service provider should have been called, as a helicopter may have been operational. I agree and consider that this was not an appropriate decision for Dr B to make.
174. Dr B discussed with Ms A the option of Master A being transported to Gisborne by ambulance. Ms A explained that the ambulance trip the previous week had been an unpleasant experience that she did not want to repeat. She preferred instead to take Master A to Gisborne in her own vehicle, which her father-in-law would drive.
175. Dr B stated that in her assessment it was reasonable for Ms A to take Master A to Gisborne in her own vehicle. Dr B said that it was likely that they would have had to wait for the ambulance to get to the region before departing for Gisborne, delaying Master A's admission. However, Dr B did not call the ambulance service provider to check the timing of the availability of an ambulance or whether an ambulance would be double crewed. There is no

evidence that she discussed with Ms A the potential for a child to deteriorate suddenly, the symptoms to watch out for, or the risks to Master A of travelling that distance by car. However, Dr B said that she advised Ms A that if Master A's condition deteriorated on the way, she should stop at one of the clinics on the way to Gisborne. I find it concerning that Dr B thought that Ms A had sufficient clinical knowledge to assess Master A's condition and know when help was needed.

176. Dr Keys advised that she would consider family transfer of such a sick child only if all other options had been investigated and were not possible or would be very delayed or had been declined by the family (after an explanation of possible outcomes). I accept that advice.

177. Dr B did not contact the Gisborne Hospital paediatric service. The serious event review report noted that a paediatrician may have been able to offer advice, for example to administer IV fluids, antibiotics, and/or oxygen prior to Master A leaving the region. I agree that she should have discussed Master A's condition with a paediatrician.

178. Dr Keys commented that although the PHO's guideline states that a paediatrician should be informed prior to a paediatric transfer, she considered that calling an emergency medicine specialist would also be good practice.

179. Dr Keys advised that several interventions were indicated prior to and/or during Master A's transfer to Gisborne Hospital. She stated:

'I would not expect that [Dr B] would have initiated these interventions without appropriate consultation ... Even if the doctor did not have the skills or experience to treat a very sick child with likely sepsis a discussion with an appropriate specialist in Gisborne should have included possibilities for treatment prior to leaving [the region] and/or during transport.'

180. I am unable to make findings as to the extent of Dr B's discussion with the ED specialist at Gisborne Hospital. Her clinical note states that she told the ED that Master A was coming, whereas subsequently she stated that she had a conversation in detail with the emergency medicine specialist, who agreed with her management. Dr Keys commented:

'On balance, it seems unlikely that an Emergency Medicine Specialist would have agreed with this management plan if they had been aware of how sick [Master A] was and/or if help or advice had been requested.'

181. Dr B completed her clinical notes and sent the ED electronic referral letter and then telephoned the ED consultant at Gisborne Hospital to inform staff that she was sending Master A for admission. Gisborne Hospital stated that Dr B's letter had information about the assessment that day, but it contained only GP notes from Day 1 and Day 3, which caused confusion. Dr B said she found out later that the clinical notes from that day were not transferred because the current notes had to be saved first before they would transfer.

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182. When the whānau arrived at Gisborne Hospital they took Master A to Planet Sunshine, where the staff were unaware that he would be arriving. In my view, Dr B should have told Ms A what she should do once she arrived at Gisborne Hospital.
183. Overall, I am left with the impression that Dr B provided minimal support to Master A's whānau, failed to think critically, and failed to seek advice from the paediatric service at Gisborne Hospital. Dr Keys advised that there was a moderate departure from accepted standards in that Dr B failed to understand how sick Master A was; failed to consult appropriately with either an emergency specialist or a paediatrician at Gisborne Hospital prior to transfer; and failed to consider appropriate transport options.
184. I acknowledge that Dr B had been working as a locum at the PHO. However, she was an experienced doctor. In my view, she should have sought advice in light of her lack of experience in this remote area.
185. For the above reasons, I find that Dr B failed to provide services to Master A with reasonable care and skill and breached Right 4(1) of the Code.
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### **Opinion: Community health centre — adverse comment**

186. On Day 3 Master A's whānau asked whether Master A could stay in the rural hospital for the rest of the night, and Dr C told them that this was not possible because they did not admit children overnight.
187. At that time, the PHO did not have a written policy regarding the admission of children to the rural hospital, but the long-standing position was that the admission of children should be cautioned against, and a sick child should be admitted directly to Gisborne Hospital. The rationale for this was that a child with a fever can deteriorate rapidly, requiring urgent medical attention provided by a more specialised paediatric service. In addition, if children require continuous observation, it is better for them to be transferred to Gisborne Hospital than to be admitted to a mixed ward, and the rural hospital has limited resources and is not equipped to manage seriously unwell patients.
188. I am also concerned that Master A was not referred for follow-up by primary care following his presentation at the rural hospital on Day 3. I agree with the need for the PHO to implement a process to notify the relevant medical practice, the rural health nurse, or the after-hours GP about a child's presentation, and the next day follow up unwell children of concern and book them into a clinic or to be followed up by the rural health nurse.
189. Both Dr C and Dr B made their own assessments as to whether transfer of Master A to Gisborne Hospital by car was appropriate. They also decided whether transfer by helicopter was possible in the weather conditions. Dr B also concluded that waiting for an ambulance would delay the transfer. However, neither doctor contacted the ambulance service provider to discuss the most appropriate mode of transfer in the particular circumstances. In my view, better communication between the PHO staff and the ambulance service provider is required.

## Changes made

### Health NZ Tairāwhiti

190. Health NZ told HDC that all the Child Health Unit Clinical Case Review recommendations regarding Planet Sunshine have been implemented.
191. Gisborne Hospital has developed a nursing discharge letter for nursing staff to complete and give to whānau. This has been designed as a back-up should additional information be required, or if for any reason the discharge summary cannot be completed and given to the whānau prior to them leaving.
192. RMOs have been directed to type the following in all discharge summaries: 'If you have any questions or concerns regarding the content of this discharge summary, please contact Planet Sunshine on 06 8690500 extn 8037/8038.'
193. There has been a commitment from the Planet Sunshine paediatricians to complete discharge summaries on children from the region prior to them leaving the hospital, so that this information goes with the whānau and is sent to the GP practice electronically.
194. Gisborne Hospital now telephones the GP clinics on Monday mornings to inform them of patients who were admitted over the weekend.
195. Planet Sunshine has developed an audit tool to monitor the discharge information given to whānau, such as the discharge letter, patient information, and documentation of follow-up. This is used for all weekend discharges of patients living in remote, rural, and out-of-town communities.
196. Gisborne Hospital is looking at ensuring that a manual defibrillator arrives at paediatric crash calls.
197. Health NZ Tairāwhiti is exploring several options to support the rural hospital. These include establishing a direct video link from the rural hospital to the ED at Gisborne Hospital.
198. A reminder to provide the fever handout has been emailed to nurses, and paediatricians are more conscious of ensuring that appropriate and available handouts are given.
199. Istat<sup>9</sup> training has been provided for paediatric staff and will be repeated if necessary.
200. Calcium gluconate has been added to the paediatric resuscitation trolley.

### PHO

201. The PHO has established a new role, which aims to support and manaaki staff by inducting them into the culture of its organisation and the community.

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<sup>9</sup> A bedside point-of-care whole blood analysis system with real-time results.

202. A name change of the rural hospital is being considered because it does not meet many criteria that may be expected to be present in a hospital, and it operates more as an after-hours GP clinic.
203. The PHO has reviewed its Handover Policy and Triage Policy, implemented the paediatric escalation procedures, improved follow-up processes, and developed a fever pamphlet for families. The PHO said that there is now a clearer protocol for staff to follow regarding the care of paediatric patients.
204. The PHO has developed a new policy within primary care — the Families/Whānau at Risk Support Pathway Primary Care Community Health Centre.

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## Recommendations

205. I recommend that Health NZ Tairāwhiti, the PHO, and Dr B each separately apologise to Master A's whānau for the criticisms outlined in this report. The apologies are to be sent to HDC within three weeks of the date of this opinion, for forwarding. Dr C has provided an apology to Master A's whānau.

### PHO

206. I recommend that within six weeks of the date of this opinion, the PHO:
- Review the changes made since this event and report to HDC on the outcome.
  - Report to HDC on the steps taken regarding the role of the rural hospital, the policies regarding overnight stays by children, and the training of staff on the steps to be taken when unwell children present at night.
  - Engage with the ambulance service provider to develop an agreed process/policy to determine whether an air transfer is appropriate and the time frames for ambulances. The process is to be provided to HDC.
  - Provide training to staff on the processes if a consumer requires hospital admission, including the information to be provided to the consumer or whānau in order for them to make an informed choice. The content of the process and the training is to be provided to HDC.
  - Provide staff training on handover policies, in particular requiring GPs to contact a paediatrician for advice before transferring unwell children. Details of the content and training are to be provided to HDC.

### Health NZ Tairāwhiti

207. I recommend that within six weeks of the date of this opinion, Health NZ Tairāwhiti:
- Conduct an audit of the Gisborne Hospital paediatric service to ascertain whether discharge letters go home with the patient and are available on Medtech on discharge and report the outcome to HDC.

- Review the effectiveness of the Planet Sunshine audit tool to monitor the discharge information given to whānau and report the outcome to HDC.
- Advise HDC of the steps taken to improve communication and engagement with the PHO.

#### **Dr C**

208. In response to the recommendations in the provisional opinion, Dr C provided evidence that he had completed the HDC online modules for further learning ([www.hdc.org.nz/education/online-learning/](http://www.hdc.org.nz/education/online-learning/)).
209. I recommend that within three months of the date of this report, Dr C provide evidence that he has undertaken additional education on person-centred care and effective communication with healthcare consumers.

#### **Dr B**

210. I recommend that within three months of the date of this report, Dr B complete the HDC online modules for further learning ([www.hdc.org.nz/education/online-learning/](http://www.hdc.org.nz/education/online-learning/)). Evidence of attendance at related training and completion of online modules is to be provided to HDC.
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### **Follow-up actions**

211. A copy of this report will be sent to the Coroner.
212. A copy of the sections of this report that relate to Dr B will be sent to the Medical Council of New Zealand.
213. A copy of this report with details identifying the parties removed, except Health NZ Tairāwhiti, Gisborne Hospital, and the independent advisor on this case, will be sent to the Medical Council of New Zealand and the ambulance service provider and placed on the Health and Disability Commissioner website, [www.hdc.org.nz](http://www.hdc.org.nz), for educational purposes.

## Appendix A: Independent clinical advice to Commissioner

The following independent advice was obtained from rural health GP Dr Jennifer Keys:

'I have been asked to provide clinical advice to HDC on case number 21HDC00764. I have read and agree to follow HDC's Guidelines for Independent Advisors.

I am not aware of any personal or professional conflicts of interest with any of the parties involved in this complaint.

I am aware that my report should use simple and clear language and explain complex or technical medical terms.

<p>Qualifications, training and experience relevant to the area of expertise involved:</p>	<p>I qualified MBChB in 1991 from the University of Dundee, Scotland. My postgraduate qualifications are MRCP(UK), MRCPGP, MSc (Remote Healthcare), Master of Public Policy and FDRHMNZ.</p> <p>I worked as a Rural Hospital Specialist at Lakes District Hospital, a rural hospital in Queenstown, for 14 years (from 2009 to 2024), during which time I was Clinical Director for four years. In addition, I was Chair of Council of the Division of Rural Hospital Medicine for four years. In this capacity I attended board meetings of the Royal New Zealand College of General Practitioners.</p> <p>I am currently working as a locum in Rural Hospital Medicine, including for a remote healthcare organisation in the Far North.</p>
<p>Documents provided by HDC:</p>	<p>Referral from Coroner dated 1 April 2021.</p> <p>[The PHO's] responses dated 26 May 2021 and 27 July 2022, including statements from staff.</p> <p>Clinical records from [the PHO] covering the relevant period.</p> <p>Relevant policies from [the PHO].</p> <p>Response and notes from Health NZ Tairāwhiti.</p> <p>Response and notes from [the ambulance service provider].</p> <p>Please note that as per our usual process, for your initial review we have not included the serious adverse event review and clinical case reviews that occurred.</p>
<p>Referral instructions from HDC:</p>	<p>Whether the care provided by [Dr C] on [Day 3] ... met accepted standards of care. In particular:</p>

	<p>Whether his assessment of [Master A] was adequate.</p> <p>Whether any further tests or interventions were indicated during this assessment.</p> <p>Whether the decision to discharge was reasonable in the circumstances, or whether alternative arrangements were indicated.</p> <p>Whether the care provided by [Dr B] on [Day 5] ... met accepted standards of care. In particular:</p> <ul style="list-style-type: none"> <li>— Whether her assessment of [Master A] was adequate.</li> <li>— Whether it was reasonable in the circumstances for her to allow [Master A's] whānau to transport him to Gisborne Hospital themselves, or whether alternative arrangements were indicated.</li> <li>— Whether she should have consulted a paediatrician prior to [Master A's] transfer to Gisborne Hospital.</li> <li>— Whether any interventions were indicated during her assessment and prior to [Master A's] transfer to Gisborne Hospital.</li> <li>— Whether the information provided to Gisborne Hospital about [Master A's] transfer was appropriate.</li> </ul> <p>Any other matters in this case that you consider warrant comment.</p>
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**Factual summary of clinical care provided complaint:**

<p>Brief summary of clinical events:</p>	<p>... [Day 1]. [Master A] was a healthy 23 month old boy who became unwell with a fever. He was known to be unimmunised. He was assessed by a Registered Nurse (RN) at [the community health centre], [the PHO]. The RN discussed with a General Practitioner and [Master A] was referred to the Paediatric department at Gisborne Hospital, where he spent one night and was discharged with a diagnosis of likely viral infection.</p> <p>... [Day 3]. In the evening [Master A] became more unwell. He continued to be febrile and had a cough and shortness of breath. He was seen for around two hours at 10pm at [the rural hospital],</p>
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[the PHO] by [Dr C], ... and thought to be likely to have a viral infection. After discussion with a paediatrician the GP gave advice to the whānau to return to Gisborne Hospital but they were not keen to return. After discussion of other options [Master A's] family elected to return home with him. He was re-examined prior to departure and his observations were trending downwards. The GP thought it was reasonable that he go home and asked that [Master A] be taken to [the community health centre] the following morning ... if he was still unwell.

Whilst the general descriptions of the consultation by the GP and [Master A's] whānau are broadly similar the exact details and the tone of each description varies. In particular:

- The GP describes a complete examination but whānau describe that he had to be asked to listen to [Master A's] chest.
- The GP describes that he chose to call the paediatrician but whānau say that he did so only after being asked to.
- The GP says that he discussed the opinion of the paediatrician, that [Master A] should be readmitted to Gisborne Hospital but the family believed that it was left to them to make a decision about whether to go to Gisborne Hospital. The GP notes that he believed the whānau were reluctant to go to Gisborne again as there was a chance that they would be admitted and discharged again with no change in diagnosis. The RN present believes that the family were given sufficient information to make a decision, which the GP felt was a reasonable one.
- The whānau do not believe that they were taken seriously or that their concerns were listened to. The GP denies that this was the case.

[Day 5]. [Master A] became more unwell and was taken to [the community health centre], where he was assessed by [Dr B], a locum doctor ... It was noted by the RN that [Master A's] temperature was 38.9, his heart rate was 175–183, respiratory rate was over 60 and that his oxygen saturation was 87 (on room air), but that observations were difficult to get. The doctor noted that he was febrile but taking small amounts of fluid, that his temperature was 38.9 degrees, his chest was clear and that he had some indrawing of intercostal spaces. She does not comment on [Master A's] level of consciousness. The doctor states in her

	<p>clinical note that the mother preferred to drive and that she informed the Gisborne Emergency Department that [Master A] was coming.</p> <p>I note discrepancies between the 2018 clinical note and the 2022 letter to HDC.</p> <p>In a letter to the Health and Disability Commissioner in July 2022 the doctor describes [Master A] as having been pale and jaundiced and that his hands and feet were cold. She states that he was very unwell and that she discussed with the Emergency Department consultant at Gisborne Hospital “in detail” that she had a child who looked very sick and may have sepsis. She states that the ED consultant agreed with her management. In the same letter she says that she considered helicopter transfer but that the weather was poor. She does not state that she discussed this decision with anyone. She says that ... at [the PHO] she had noted that there was often a significant delay to an ambulance arriving.</p> <p>At 1230 the family took [Master A] by car to Gisborne Hospital.</p> <p>I note a discrepancy between statements by the doctor, the RN and the family with regard to transport.</p> <p>[Master A’s] family noted that they were advised to take [Master A] themselves to Gisborne Hospital. They were aware of potential delays to ambulance transport and had considered helicopter transport but did not mention this to the doctor.</p> <p>The doctor’s clinical note states that the mother preferred to drive. In her subsequent (2022) letter she states that she was aware that an ambulance could be significantly delayed. She also says that she considered a helicopter but that the weather was poor. No mention is made (in her clinical note or 2022 letter) that she discussed this decision with either the RN or the Emergency Department consultant.</p> <p>In a later note the RN present states that the family were offered the option of using an ambulance to get to Gisborne Hospital, but that the ambulance was often single crewed. The RN notes that the use of a helicopter was not discussed.</p> <p>On admission to Gisborne Hospital, at around 1530, [Master A] was noted to have a temperature of 40.5 degrees, heart rate of 180 and oxygen saturations of 89%. He was yellow, cool peripherally and grunting, with minimal air entry to the left side of</p>
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	<p>his chest. Chest x-ray showed consolidation of the left lung. Blood tests showed that he was very anaemic, his platelets were low, his bilirubin was 315 and his coagulation was abnormal.</p> <p>[Master A] was found to have sepsis secondary to pneumonia. He deteriorated rapidly and despite resuscitation died that evening.</p>
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<p><b>Question 1:</b> Whether the care provided by [Dr C] on [Day 3] ... met accepted standards of care. In particular:</p> <ul style="list-style-type: none"> <li>— Whether his assessment of [Master A] was adequate.</li> <li>— Whether any further tests or interventions were indicated during this assessment.</li> <li>— Whether the decision to discharge was reasonable in the circumstances, or whether alternative arrangements were indicated.</li> </ul>	
<p>List any sources of information reviewed other than the documents provided by HDC:</p>	<p>BPAC (Best Practice Advocacy Centre) “Identifying the risk of serious illness in young children with fever” guideline (2024), which directs users to the NICE (National Institute for Clinical Excellence) “Fever in under 5s: assessment and initial management guideline” (2019, updated 2021) and “Suspected sepsis: recognition, diagnosis and early management” (2016, updated 2024).</p>
<p>Advisor’s opinion:</p>	<p>In my opinion [Dr C’s] assessment of [Master A] was consistent with current practice and guidelines.</p> <p>No further tests were indicated at [the rural hospital] on [Day 3] ...</p> <p>The lowest risk intervention would have been to transfer [Master A] to Gisborne Hospital, as advised by the paediatrician. I believe that [Dr C] shared that advice with [Master A’s] whānau but that, as it was clear that the family did not want to return to Gisborne Hospital, a discussion took place which considered other options, all of which would have lowered [Master A’s] risk, but none of which, including staying closer to Gisborne, were followed. Discharge occurred with an understanding that early review would take place if [Master A] was not better in the morning</p>

	(clinical note refers to safety-netting). [Dr C] considered that the family would follow this advice.
What was the standard of care/accepted practice at the time of events? Please refer to relevant standards/material.	<p>The standard of care is in keeping with that described in BPAC (Best Practice Advocacy Centre) “Identifying the risk of serious illness in young children with fever” guideline (2024), which directs users to the NICE (National Institute for Clinical Excellence) “Fever in under 5s: assessment and initial management guideline” (2019, updated 2021) and “Suspected sepsis: recognition, diagnosis and early management” (2016, updated 2024).</p> <p>I have been unable to locate the versions of these guidelines which were available in 2018 but I don’t believe that accepted generalist practice has changed significantly over the time since this case.</p> <p>Accepted care is to assess the febrile child for a) high risk features and b) potential sources of infection with a focus on identifying children who are likely to (either or both) be very unwell or have bacterial infections.</p> <p>Usual generalist practice, if there are clinical features of concern, is to discuss with an appropriate specialist.</p> <p>Usual generalist practice, if a patient wishes to do something other than that which is advised, is to negotiate the safest possible alternative and to “safety-net” by providing details of symptoms which would be of concern.</p>
<p>Was there a departure from the standard of care or accepted practice?</p> <p>No departure; Mild departure; Moderate departure; or Severe departure.</p>	In my opinion there was no departure from accepted practice.

How would the care provided be viewed by your peers? Please reference the views of any peers who were consulted.	I believe that my peers would view [Dr C's] consultation and notes as consistent with good practice.
Please outline any factors that may limit your assessment of the events.	Notes from [Master A's] whānau consider that [Dr C's] attitude was dismissive and that he left them to make a decision about whether or not to go to Gisborne Hospital. It is not possible to retrospectively understand the dynamics of a consultation, however, the Registered Nurse present believes the family were given adequate information.
Recommendations for improvement that may help to prevent a similar occurrence in future.	If system capacity allows, consideration could be given to lowering the threshold for proactively (the following day) calling whānau of children who have chosen an alternative to hospital admission.

<p><b>Question 2:</b> Whether the care provided by [Dr B] on [Day 5] ... met accepted standards of care. In particular:</p> <ul style="list-style-type: none"> <li>— Whether her assessment of [Master A] was adequate.</li> <li>— Whether it was reasonable in the circumstances for her to allow [Master A's] whānau to transport him to Gisborne Hospital themselves, or whether alternative arrangements were indicated.</li> <li>— Whether she should have consulted a paediatrician prior to [Master A's] transfer to Gisborne Hospital.</li> <li>— Whether any interventions were indicated during her assessment and prior to [Master A's] transfer to Gisborne Hospital.</li> <li>— Whether the information provided to Gisborne Hospital about [Master A's] transfer was appropriate.</li> </ul>	
List any sources of information reviewed other than the documents provided by HDC:	BPAC (Best Practice Advocacy Centre) "Identifying the risk of serious illness in young children with fever" guideline (2024), which directs users to the NICE (National Institute for Clinical Excellence) "Fever in under 5s: assessment and initial management" guideline (2019, updated 2021) and "Suspected sepsis: recognition, diagnosis and early management" (2016, updated 2024).

<p>Advisor's opinion:</p>	<p>My understanding is that [Dr B] (as per notes from [the PHO]) was registered in a general scope of practice ... I would expect that recognition of an unwell child to fall within a general scope of practice. I would not anticipate that the skills to manage such a child would be included in a general scope of practice but that appropriate consultation would occur and that advice would be taken to manage a very sick child in such a resource limited environment.</p> <p><u>Whether her assessment of [Master A] was adequate.</u> In my opinion [Dr B's] assessment was not adequate.</p> <p>[Dr B's] note does not (apart from temperature) include other nursing observations or note how alert [Master A] was, although his heart rate and respiratory rate were very high and his oxygen saturation was low (suggesting either hypoxia or very poor peripheral circulation). She notes that he was peripherally cold. She does not note that [Master A] was jaundiced although she does state that she noted this in her letter to the HDC of 2022. The paediatric admission note states that there was minimal air entry left lung but her lung examination note only states that chest was clear. It is clear from her note and her actions that she understood that [Master A] needed hospital treatment, but not that [Master A] was very significantly compromised.</p> <p>There is sufficient information available (from a combination of history, nursing observations and [Dr B's] assessment) to understand that [Master A] was very unwell and that there was a significant likelihood that [Master A] had bacterial sepsis and should be treated as such.</p> <p><u>Whether it was reasonable in the circumstances for her to allow [Master A's] whānau to transport him to Gisborne Hospital themselves, or whether alternative arrangements were indicated.</u> I believe that [Dr B's] inadequate understanding of how unwell [Master A] was and newness to this position led her to inadequately consult local services with regard to appropriate transport.</p>
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	<p>Transport options were road ambulance, helicopter or family transport.</p> <p>Such transport decisions are nuanced, dependent on local knowledge and rarely straightforward. There is often a balance between speed of transfer and the ability to start and/or maintain treatment during transfer. It is unknown which transport option would have been best in this case.</p> <p>Flight transfer would likely have been slightly quicker (this would be dependent on the delay to arrival of each mode of transport) and would have the advantage of having personnel who are skilled in the management of emergencies. In her 2022 letter [Dr B] stated that the weather was not such that a helicopter flight could take place but the RN present does not recall that conversation taking place. It is not clear if the doctor had enough prior experience of helicopter transport [in the region] that she would be able to make such a decision without consultation with the service which provides helicopter retrieval.</p> <p>Road ambulance transfer may be very delayed or the accompanying personnel may not have the skills to assist with intravenous or intraosseous access or give fluid during the transfer. All ambulance personnel should be able to give oxygen during transfer.</p> <p>I would only consider family transfer of such a sick child if all other options had been investigated and were not possible, going to be very delayed or had been declined by the family (after an explanation of possible outcomes).</p> <p>A specialist with local knowledge would have likely been able to clarify the situation with regard to helicopter transport and indicate which method of transport would be favoured.</p> <p><u>Whether she should have consulted a paediatrician prior to [Master A's] transfer to Gisborne Hospital.</u> Although [the PHO's] guideline states that a paediatrician should be informed prior to a paediatric</p>
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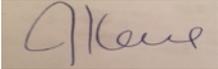
	<p>transfer, calling an Emergency Medicine Specialist would also be considered good practice.</p> <p>It is not clear whether an Emergency Medicine Specialist was consulted (as opposed to an Emergency Department nurse or medical officer).</p> <p><u>Whether any interventions were indicated during her assessment and prior to [Master A's] transfer to Gisborne Hospital.</u></p> <p>In my opinion, several interventions were indicated prior to and/or during transfer to Gisborne Hospital. I would not expect that [Dr B] would have initiated these interventions without appropriate consultation.</p> <p>In her clinical note no management options are mentioned but in the HDC letter of 2022 [Doctor B] states that she considered establishing intravenous access but considered that speed of transfer to Gisborne Hospital should be prioritised.</p> <p>Even if the doctor did not have the skills or experience to treat a very sick child with likely sepsis a discussion with an appropriate specialist in Gisborne should have included possibilities for treatment prior to leaving [the region] and/or during transport.</p> <p>These would include:</p> <ul style="list-style-type: none"><li>— intravenous or intraosseous fluid (which could have been started by a paramedic in a road ambulance or retrieval helicopter)</li><li>— intravenous or intramuscular antibiotics. Intramuscular antibiotics would have been available at [the community health centre] and could have been given there without intravenous access.</li><li>— oxygen (which would have been available at [the community health centre] and during transfer)</li></ul> <p>I believe that these options would have been considered during discussion of such an unwell child with an Emergency Medicine specialist or a Paediatrician.</p>
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	<p><u>Whether the information provided to Gisborne Hospital about [Master A's] transfer was appropriate.</u> In my opinion, [Dr B's] inadequate understanding of how unwell [Master A] was likely led to failure to adequately communicate and seek appropriate help from Gisborne Hospital specialists.</p> <p>I have no objective evidence of the communication between the doctor and Gisborne Hospital.</p> <p>[Dr B's] clinical note states that she told the Emergency Department that [Master A] was coming. Her letter in 2022 states that she had a conversation in detail with the Emergency Medicine Specialist, who agreed with her management. On balance, it seems unlikely that an Emergency Medicine Specialist would have agreed with this management plan if they had been aware of how sick [Master A] was and/or if help or advice had been requested.</p> <p>It is not possible to know whether commencing treatment at this stage would have materially changed the outcome for [Master A]. The [children's hospital] sepsis guideline states: <i>For every hour a child remains in septic shock the mortality risk doubles. Care delivered in the first hour after presentation or sepsis identification is crucial in ensuring the optimum outcome for the patient.</i></p>
<p>What was the standard of care/accepted practice at the time of events? Please refer to relevant standards/material.</p>	<p>Accepted practice is to assess the febrile child for a) high risk features and b) potential sources of infection with a focus on identifying children who are likely to (either or both) be very unwell or have bacterial infections.</p> <p>When caring for a very sick person in a remote environment usual generalist practice is to discuss with an appropriate specialist and ask for advice and help with management and transport.</p> <p><u>Management</u> BPAC (Best Practice Advocacy Centre) "Identifying the risk of serious illness in young children with fever" guideline (2024), which directs users to the NICE (National Institute for Clinical Excellence) "Fever in under 5s: assessment and initial management" guideline (2019, updated 2021) and "Suspected</p>

	<p>sepsis: recognition, diagnosis and early management” (2016, updated 2024).</p> <p><u>Transport</u> [The PHO] policy states that for paediatric patients contact must be made with the on call paediatrician.</p> <p>[The PHO] policy for High complexity patients states that such patients are to be transferred by helicopter/ambulance to [Health NZ Tairāwhiti] in consultation with the appropriate consultant and or medical officer on duty.</p>
<p>Was there a departure from the standard of care or accepted practice?</p> <p>No departure; Mild departure; Moderate departure; or Severe departure.</p>	<p>In my opinion there was a moderate departure from accepted practice.</p> <p>I believe there was a failure to properly assess [Master A] (this assessment based on clinical note rather than 2022 letter to HDC, please see explanation in “Please outline any factors that may limit your assessment of the events” section). This led to:</p> <ul style="list-style-type: none"> <li>— Failure to understand how sick [Master A] was.</li> <li>— Failure to consult appropriately prior to transfer with either an Emergency Specialist or Paediatrician at Gisborne Hospital.</li> <li>— Failure to initiate appropriate treatment prior to transfer.</li> <li>— Failure to consider appropriate transport options.</li> </ul> <p>There are multiple mitigating factors:</p> <p>... [I]t is unknown what training in or experience [Dr B] had of either Emergency Medicine or Paediatrics. Neither vocational registration nor any post-PGY1 experience is a requirement to work as a sole provider for a rural healthcare organisation ...</p> <p>The doctor was in a locum position and had only recently moved to the [region]. She would have had minimal experience of transferring very sick patients out of [the region].</p>

	<p>It is not usually possible for [the ambulance service provider] to tell a remote clinic how long it will take for an ambulance to come. This may lead to a “scoop and run” family transfer scenario because it is not known whether an ambulance will come quickly or there will be a delay of several hours.</p> <p>The doctor was working in a place with significant resource constraints and was clinically and geographically very isolated. If a paramedic-staffed ambulance had been routinely available at short notice or an all-weather helicopter service was readily available different decisions may have been made.</p> <p>Rural healthcare is often very difficult to staff in New Zealand and the doctor was willing to work for a remote rural healthcare provider. It is not clear if the doctor had worked rurally/remotely before this attachment. This entails a degree of clinical courage, which should be acknowledged.</p>
<p>How would the care provided be viewed by your peers? Please reference the views of any peers who were consulted.</p>	<p>I believe that my peers would view the care similarly. In addition to having great sympathy for [Master A’s] whānau they would also feel for a doctor working in clinical and geographical isolation faced with such a sick child.</p>
<p>Please outline any factors that may limit your assessment of the events.</p>	<p>Assessment is confounded by the differences between the clinical note written by the doctor on [Day 5] 2018 and the additional information provided in 2022.</p> <p>The 2022 letter was written four years after the event and after clinical reviews had taken place. The letter refers to the doctor’s examination findings in 2018 (some of which, such as jaundice, she did not note in her clinical notes) and thoughts regarding transport (which she did not note in her clinical note and did not discuss with the RN present, although locum doctors are very dependent on nursing staff for local knowledge). The letter also states that she discussed with the Emergency Medicine consultant in detail and that her management was agreed with. This is not in keeping with her clinical note which says that she “informed ED that they are coming”.</p>

	<p>For these reasons I feel unable to depend on the veracity of the 2022 letter and I have judged the most likely scenario based on:</p> <ul style="list-style-type: none"> <li>— the doctor’s clinical note</li> <li>— the RN note</li> <li>— findings on arrival at Gisborne Hospital</li> <li>— experience of the usual response of hospital specialist when they are asked for advice or help for a very sick child.</li> </ul>
<p>Recommendations for improvement that may help to prevent a similar occurrence in future.</p>	<p>I recommend that doctors who work as Rural Generalists/Rural General Practitioners in New Zealand should be appropriately trained for such work. There is no requirement for a doctor (in either a general or General Practice scope) who is working remotely to have any experience of Emergency Medicine.</p> <p>A doctor who was vocationally registered in Rural Hospital Medicine, or an internationally trained Rural Generalist/Rural General Practitioner has been trained to:</p> <ul style="list-style-type: none"> <li>— Fully assess and recognise a sick child</li> <li>— Initiate resuscitation of a sick child, including using intravenous or intraosseous access to provide fluid resuscitation and antibiotics</li> <li>— Communicate concerns to specialist staff at the local hospital and make complex and nuanced decisions about transport options in discussion with local services.</li> </ul> <p>In the absence of sufficient numbers of such doctors being available for rural/remote placement all other options to support remote clinical staff should be considered. These may include telehealth support (including video consultations with remote specialists), widespread training of doctors working in rural areas in the use of intraosseous access and improved availability of transport options, including both road and flight transport.</p>

Signature: 
Name: Dr Jennifer Keys
Date of Advice: 2 January 2025'