Dr C

Medical Centre

A Report by the

Deputy Health and Disability Commissioner

(Case 17HDC00490)

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

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Executive summary

1. This report relates to the care provided to Ms A by Dr C[1] in 2016. One morning, Ms A telephoned her medical centre and left a telephone message requesting a doctor's appointment. Registered nurse (RN) RN E telephoned Ms A back and recollected that she had a weak voice and sounded unwell. RN E told HDC that Ms A reported "[three] days [of] sickness, difficulty breathing and difficulty sleeping".

2. At approximately midday, Ms A presented to the medical centre and was seen by Dr C. Dr C's notes state that Ms A reported that she had been short of breath and coughing for three days but did not have any pain or fever. Dr C documented that Ms A had a rapid heartbeat. Dr C took Ms A's pulse and oxygen levels with a finger oximeter,[2] and noted that Ms A's fingers were cold. Ms A's pulse[3] was 168 beats per minute (bpm) and regular, her oxygen saturation was 94%, and her blood pressure[4] was 90/80mmHg. Dr C did not take Ms A's temperature.

3. In light of the observations, Dr C asked RN E to carry out an electrocardiogram (ECG)[5] on Ms A. The ECG showed a sinus tachycardia around 158bpm. Dr C concluded that Ms A's shortness of breath and low blood pressure were probably a result of the sinus tachycardia. In Dr C's opinion, the most likely cause of the sinus tachycardia was alcohol abuse and anxiety.

4. Dr C planned to slow down the heart rate to improve the effectiveness of the heart contractions, using bisoprolol[6] 2.5mg. Dr C advised Ms A to contact the medical centre or the GP on call if she experienced any deterioration at any time, or if she did not feel any significant improvement within two days.

5. At the end of the clinical day (some time after 3pm), RN E looked back on the notes to see what had happened to Ms A. RN E told HDC that she was "very surprised" by Dr C's note and course of action. RN E said that as soon as she arrived at work the following day, she discussed her concerns with the Clinical Nurse Leader, RN F. RN F recommended that RN E telephone Ms A to follow up on how she was feeling. At 4pm, the medical centre received a call from paramedics, who were at Ms A's house. Ms A had been found deceased.

Findings

6. Dr C breached Right 4(1)[7] of the Code of Health and Disability Services Consumers' Rights (the Code) by failing to take Ms A's temperature and to recognise the seriousness of her symptoms, and to take appropriate action in response.

[1] Dr C was employed by the medical centre as a salaried doctor.
[2] An instrument used for continuous measurement of the degree of oxygen saturation of the circulating blood.
[3] A normal resting heart rate is between 60 and 100 beats per minute.
[4] Normal adult blood pressure is more than 90/60mmHg and less than 120/80mmHg.
[5] The process of recording the electrical activity of the heart over a period of time using electrodes placed on the skin.
[6] Bisoprolol belongs to a group of drugs called beta-blockers, and is used to treat hypertension (high blood pressure).
[7] Right 4(1) states: "Every consumer has the right to have services provided with reasonable care and skill."

7. The medical centre was not found in breach of the Code.

Recommendations

8. It is recommended that Dr C provide a formal written apology to Ms A's family for her breach of the Code.

9. In the event that Dr C does reapply for an annual practising certificate, it is recommended that the Medical Council of New Zealand consider carrying out a review of her competence.

Complaint and investigation

10. The Commissioner received a complaint from Ms B about the services provided to her late daughter, Ms A, by Dr C at the medical centre. The following issues were identified for investigation:

- *Whether Dr C provided Ms A with an appropriate standard of care in 2016.*
- *Whether the medical centre provided Ms A with an appropriate standard of care in 2016.*

11. This report is the opinion of Kevin Allan, Deputy Commissioner, and is made in accordance with the power delegated to him by the Commissioner.

12. The parties directly involved in the investigation were:

Ms A (dec)	Consumer
Ms B	Complainant/mother
Dr C	Provider/general registrant[8]
Medical centre	Provider/medical practice

13. Information was reviewed from:

Dr D	Provider/general registrant
RN E	Provider/registered nurse
RN F	Provider/Clinical Nurse Leader
Medical Council of New Zealand	

14. In-house clinical advice was obtained from Dr David Maplesden[9] **(Appendix A)**.

Information gathered during investigation

Background

15. Ms A, aged 42 years at the time of these events, enrolled at the medical centre in 2014. She had a history of alcohol dependency, anxiety with depression, and recurrent breast

[8] This term denotes a doctor who is practising in general practice but is not vocationally registered in this field.
[9] An experienced, vocationally registered general practitioner.

abscesses. This report relates to the care provided to Ms A by Dr C on the day prior to her death.

Consultation with Dr C

16. In the morning, Ms A telephoned the medical centre and left a telephone message requesting a doctor's appointment. RN E telephoned Ms A back and recollected that she had a weak voice and sounded unwell. RN E told HDC that Ms A reported "[three] days [of] sickness, difficulty breathing and difficulty sleeping". RN E booked Ms A for the next available appointment with Dr C.

17. At approximately midday, Ms A presented to the medical centre and was seen by Dr C. Dr C's notes state that Ms A reported that she had been short of breath and coughing for three days but did not have any pain or fever. Dr C also documented that Ms A was not coughing up any phlegm or mucous, and did not have a blocked nose or sore throat.

18. Dr C told HDC that, on examination, she found that Ms A could talk in normal sentences without wheezing or shortness of breath. Ms A's respiration rate was about 18 breaths per minute, and Dr C did not observe any fever, throat infection or swelling of the lymph nodes. When Dr C listened to Ms A's lungs, she heard normal breath sounds without wheeze or signs of fluid in any part of the lungs. Dr C said that inspiration and expiration were not prolonged or abnormal.

19. Dr C documented that Ms A had a rapid heartbeat. Dr C took Ms A's pulse and oxygen levels with a finger oximeter, and noted that Ms A's fingers were cold. Ms A's pulse was 168 beats per minute (bpm) and regular, her oxygen saturation was 94%, and her blood pressure[10] was 90/80mmHg. Dr C did not take Ms A's temperature.

20. Dr C told HDC that her differential diagnoses included:

- Tachycardia[11] causing low blood pressure secondary to myocardial infarction.
- Chest infection. Dr C thought this to be unlikely because Ms A had no blocked nose, sore throat or fever, and normal findings on examination of her lungs.
- Pulmonary embolism. Dr C also thought this to be very unlikely because there was no sudden onset of shortness of breath and no history of localised chest pain.

21. In light of the observations, Dr C asked RN E to carry out an electrocardiogram (ECG) on Ms A. RN E stated that "[Dr C] said [Ms A] was fine but had a rapid pulse". RN E entered the emergency room and found Ms A sitting on the bed. RN E advised Ms A that she was going to carry out an ECG, and asked Ms A to take off her top and bra and lie on the bed. Dr C left the room after RN E placed the ECG leads on Ms A. RN E told HDC:

> "I asked [Ms A] if she had any pain in her chest and she said that she had had pain 'everywhere'. I asked her how long this had been going on for and she said for [three] days she had been aching and sweating at night. [Ms A] looked tired and sweaty and was breathing shallow and rapid with a cough that sounded moist on her chest."

[10] Normal adult blood pressure is more than 90/60mmHg and less than 120/80mmHg.
[11] Also known as sinus tachycardia and refers to an abnormally rapid heartbeat.

22. RN E added that Dr C then returned to the room. Dr C confirmed that she does not believe that she was present when Ms A reported the pain and possible fever symptoms to RN E. Dr C recalled Ms A having only a "brief dry coughing spell on lying down", and that it disappeared after a while. RN E recalled Dr C asking Ms A whether the coughing was worse when she was lying down, and Ms A agreeing that it was.

23. The ECG showed a sinus tachycardia around 158bpm. Dr C documented that other than the sinus tachycardia, the ECG did not show any abnormalities. She thought it very unlikely that Ms A had had a myocardial infarction, because after three days of symptoms the ECG was normal in this regard. Dr C concluded that Ms A's shortness of breath and low blood pressure were probably a result of the sinus tachycardia. In Dr C's opinion, the most likely cause of the sinus tachycardia was alcohol abuse and anxiety. She planned to slow down the heart rate to improve the effectiveness of the heart contractions, with bisoprolol 2.5mg.

24. Dr C told HDC that she discussed Ms A's case with her colleague, Dr D. Dr D told HDC that Dr C's provisional diagnosis was of sinus tachycardia, and her plan was to advise Ms A to try bisoprolol and see what effect this had on her symptoms. Dr D recalled that he "did not disagree with the plan".

25. Dr C returned to Ms A and explained the proposed treatment and told Ms A that her symptoms should improve within two days. Dr C advised Ms A to contact the medical centre or the GP on call if she experienced any deterioration at any time, or if she did not feel any significant improvement within two days.

26. Dr C completed a prescription for 30 tablets of bisoprolol fumarate 2.5mg (one tablet, once daily). She told HDC that sending Ms A for review at a hospital in a main centre would not have been straightforward. Dr C knew it to be likely that Ms A would have found travelling home logistically difficult, and therefore would have resisted a referral. Dr C reasoned that this was a factor in her decision to monitor Ms A in her home town to see whether the symptoms resolved.

27. Dr C documented the following about the consultation:

> "Smoking status discussed. Advice given on smoking cessation. Return to nurse when ready for smoking cessation services.
>
> [S]hort of breath since 3 days. [C]oughs.
>
> O[bservations] pulse 168
>
> BP 90/60
>
> O2 level 94%
>
> Lungs; normal breathing
>
> E[xamination] Tachycardia
>
> P[lan]/ECG: sinus tachycardia
>
> Start bisoprolol
>
> [C]ome back if not improved in 2 days."

Subsequent events

28. At the end of the clinical day (some time after 3pm), RN E looked back on the notes to see what had happened to Ms A. RN E told HDC that she was "very surprised" by Dr C's note and course of action. RN E stated:

> "I was surprised no bloods had been [taken] or antibiotics or even that the patient hadn't gone to hospital as I felt that she was so unwell. I was surprised that the GP note said 'breathing ok' as I didn't agree with that observation and also noted there was no temperature. I contemplated phoning the patient then but I didn't."

29. RN E told HDC that she was unable to notify any of the other staff at the medical centre about her concerns. She explained that the Clinical Nurse Leader, RN F, had already left for the day. RN E also stated that in between seeing 10 patients and completing non-patient nursing tasks, she checked the availability of the other GPs, but no appointments were left that day. RN E considered that, although Ms A was unwell, she could wait to be seen in the morning.

30. RN E said that as soon as she arrived at work the following day, she discussed her concerns with RN F. RN F recommended that RN E telephone Ms A to follow up on how she was feeling. RN E was unable to get hold of Ms A. RN E also attempted to contact community health services and an RN at the service but was unable to speak to anyone. A message was left on the RN's cell phone.

31. At 4pm, the medical centre received a telephone call from paramedics, who were at Ms A's house. Ms A had been found deceased.

Dr C — further information

32. Dr C told HDC that she is very sorry for the outcome of this case. She still feels terrible about Ms A's death and has reflected on the events leading to it on numerous occasions.

33. Dr C is now retired. The status of her practising certificate is recorded as "non-practising". She told HDC that she does not intend to return to practise medicine, and does not foresee this changing.

The medical centre — further information

34. The practice stated that it was very sorry to hear of Ms A's death, and passes on its condolences to her family.

35. The practice reported that upon employment in 2013, initially Dr C was supervised by two highly experienced GPs. Dr C was successfully signed off from clinical supervision following the required assessment period. The practice told HDC that it did not receive any adverse comment or concerns from any of Dr C's clinical supervisors regarding note-keeping or clinical judgement.

36. The practice added that Dr C completed an induction and orientation under supervision. Dr C completed regular continuing medical education (CME) and met all the requirements of her practising certificate during her employment.

37. The practice advised HDC that it is unaware of any specific cases that would have given it cause for concern about Dr C's clinical judgement prior to Ms A's case.

38. The practice told HDC that concerns about Ms A's case were raised by the medical centre to the Medical Council of New Zealand (MCNZ), and Dr C did not return to work until advice had been received from MCNZ that Dr C had signed a voluntary undertaking. This required that Dr C not participate in the on-call roster or assess acute medical cases, and that she have all her clinical notes assessed by nominated clinical supervisors. Dr C worked under these conditions until she retired three months later.

39. The practice advised HDC that Ms A's case has been discussed and reviewed with all clinical team members. It stated that there is "a strong culture of openness where immediate verbal or written feedback is encouraged", and that "the GPs have an open-door policy and nurses are encouraged to verbalise any concerns about patient care". The practice added that this culture is now supported by daily "protected huddle time", where all team members gather and have an opportunity to discuss cases, clinical care, and clinical governance issues.

Responses to provisional opinion

Ms A's family

40. Ms A's family were given an opportunity to comment on the "information gathered" section of the provisional opinion.

Dr C

41. Dr C was given an opportunity to comment on the provisional opinion. Dr C accepts that it would have been appropriate to have taken Ms A's temperature and refer her to hospital. She deeply regrets the outcome following Ms A's presentation.

The medical centre

42. The practice was given an opportunity to comment on the provisional opinion. It confirmed that it had no comment to make in relation to the opinion.

Opinion: Dr C — breach

43. This report relates to the care provided to Ms A by Dr C. As outlined above, Ms A presented to Dr C having been unwell for three days with symptoms of a cough and shortness of breath. Ms A had tachycardia and low blood pressure. My in-house clinical advisor, Dr David Maplesden, is mildly to moderately critical that Dr C did not take Ms A's temperature. He advised:

> "[Ms A] had a very cool periphery which, in the context of the other clinical findings, might have represented a degree of peripheral shutdown secondary to shock. Given the possibility of sepsis as a cause of shock, [Ms A's] temperature should have been taken."

44. Dr Maplesden advised me that Dr C's assessment findings alone suggested that Ms A was "significantly unwell". He stated that "tachycardia was a symptom rather than a diagnosis and the cause required careful assessment to determine whether symptoms were an

appropriate physiological response to an underlying illness". Dr Maplesden considered that it was neither a safe nor reasonable action to attribute the findings observed to "anxiety and alcohol" and to treat the tachycardia with a beta-blocker without further investigating the cause.

45. Dr Maplesden advised:

> "[A] majority of my colleagues, when faced with a clammy patient with cold periphery, new onset sinus tachycardia of >150/min and hypotension, would recognise such symptoms as a cause for significant clinical concern and would consider rapid hospital admission for stabilisation and further investigation whatever underlying pathology was suspected."

46. Dr Maplesden concluded that Dr C's management of Ms A would be met with "severe disapproval" by his peers.

47. I accept Dr Maplesden's advice. I consider that by failing to take Ms A's temperature and to recognise the seriousness of her symptoms, and to take appropriate action in response to her symptoms, Dr C breached Right 4(1) of the Code.

Opinion: Medical centre — no breach

48. As a healthcare provider, the medical centre is responsible for providing services in accordance with the Code. In this case, I consider that the concerns arising from this investigation do not indicate broader systemic or organisational issues at the medical centre. Therefore, I consider that the medical centre did not breach the Code directly.

49. At the time of these events, Dr C was an employee of the medical centre. Accordingly, the medical centre is an employing authority for the purposes of the Act. As set out above, I have found that Dr C breached Right 4(1) of the Code.

50. In addition to any direct liability for a breach of the Code, under section 72(2) of the Health and Disability Commissioner Act 1994 (the Act), an employing authority is vicariously liable for any actions or omissions of its employee. A defence is available to the employing authority under section 72(5) if it can prove that it took such steps as were reasonably practicable to prevent the acts or omissions of its employee.

51. The practice told HDC that upon employment with the medical centre, initially Dr C was supervised by two highly experienced GPs, and was successfully signed off from clinical supervision following the required assessment period. The practice added that Dr C completed an induction and orientation under supervision, and completed regular continuing education, meeting all of the requirements of her practising certificate. The practice advised HDC that prior to Ms A's case it was unaware of any specific cases that would have given it cause for concern about Dr C's clinical judgement.

52. Dr Maplesden advised that the medical centre's response indicates that there was appropriate structured orientation and supervision of Dr C when she joined the medical

centre. Dr Maplesden does not believe that prior to Ms A's case there was an indication for collegial referral of Dr C to MCNZ.

53. I note the information provided by the parties involved and the advice I have received from Dr Maplesden. I am satisfied that the medical centre took such steps as were reasonably practicable to prevent Dr C's actions and, accordingly, I do not find the medical centre vicariously liable for Dr C's breach of the Code.

Other comment

54. While it was Dr C's responsibility to assess Ms A's symptoms, I am thoughtful about RN E's role in Ms A's care. In my view, RN E's concerns about Ms A appeared sufficiently serious to warrant consulting another GP at the medical centre, even if this occurred between appointments. I do, however, acknowledge that RN E did notify the Clinical Nurse Leader of her concerns as soon as she arrived at work the following day, and took steps to contact Ms A, the community health service, and the RN at the service.

55. I note that the medical centre's response indicates that Ms A's case has been reviewed and discussed with all clinical team members. The practice has advised HDC that there is a strong culture of openness at the medical centre, and this is now supported by daily "protected huddle time" where team members meet and have the opportunity to discuss concerns, clinical care, and clinical governance.

Recommendations

56. I recommend that Dr C provide a formal written apology to Ms A's family for her breach of the Code. The apology is to be sent to HDC within three weeks of the date of this report, for forwarding to Ms A's family.

57. In the event that Dr C does reapply for an annual practising certificate, I recommend that the Medical Council of New Zealand consider carrying out a review of her competence.

Follow-up actions

58. Dr C will be referred to the Director of Proceedings in accordance with section 45(2)(f) of the Health and Disability Commissioner Act 1994, for the purpose of deciding whether any proceedings should be taken.

59. A copy of this report with details identifying the parties removed, except the expert who advised on this case, will be sent to the Coroner, and the Coroner will be advised of Dr C's name.

60. A copy of this report with details identifying the parties removed, except the expert who advised on this case, will be sent to the district health board and the Medical Council of New Zealand, and they will be advised of Dr C's name.

61. A copy of this report with details identifying the parties removed, except the expert who advised on this case, will be placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

Addendum

62. The Director decided not to issue proceedings.

Appendix A: In-house clinical advice to the Commissioner

The following in-house clinical advice was obtained from Dr David Maplesden on 12 September 2017:

"1. Thank you for the request that I provide clinical advice in relation to notification from the Medical Council of New Zealand (MCNZ) about the care provided to the late [Ms A] by [Dr C] of [the medical centre]. In preparing the advice on this case to the best of my knowledge I have no personal or professional conflict of interest. I agree to follow the Commissioner's Guidelines for Independent Advisors. I have reviewed the information on file: MCNZ documentation including e-mails from [the medical centre's Clinical Director at the time], [Dr D] and statement from practice nurse [RN E]; response from [Dr C] to the Coroner; response to MCNZ from [Dr C's] legal representative; [the medical centre's clinical notes]. I am not aware of the cause of [Ms A's] death (Coronial autopsy report yet to be received).

2. [Ms A] was a 42-year old lady who had enrolled at [the medical centre] [in 2014]. She had a past history of alcohol dependency (ongoing — under care of DHB Alcohol & Drug Service), anxiety with depression and recurrent breast abscesses. She was a current smoker. In her response to the Coroner, [Dr C] describes consultations with [Ms A] at [the medical centre] (by providers other than herself) as follows: [date] 2015 — stress related, prescribed sedative; [date] 2015 — review of stress/depression, breast abscess, prescribed low dose nortriptyline and antibiotic; [date] 2015 — psychosocial issues including ongoing alcohol abuse/dependency, hallucinations. Recently prescribed amitriptyline by another provider and this was stopped. Bloods showed elevated GGT and CRP; [date] 2015 — assessed as depressed and commenced on citalopram for two week trial. No follow-up regarding this.

3. On [date] 2015 [Dr C] states she met [Ms A] for the first time with a flare of her recurrent breast infections. [Ms A] had already been referred to Breast Clinic. [Dr C] photographed [Ms A's] breasts and sent another referral to Breast Clinic. She prescribed a topical antibiotic.

   Comment: Clinical notes have not been provided for the consultations noted above and I am unable to comment further on the GP management on these occasions. However, the consultations do not appear directly related to [Ms A's] presentation [in] 2016, that presentation being the main subject of this advice.

4. [Ms A] presented to [Dr C] next [in] 2016. Consultation notes are:

   Smoking status discussed. Advice given on smoking cessation. Return to nurse when ready for smoking cessation services.

   short of breath since 3 days. coughs

   0/ pulse 168

   BP 90/60

02 level 94%

lungs; normal breathing

E/ Tachycardia

P/ECG: sinus tachycardia

start bisoprolol

come back if not improved in 2 days

ECG confirmed a sinus tachycardia of 158/min. A prescription was provided for bisoprolol 2.5mg tabs, one daily x 30.

5. In her response to the Coroner [Dr C] elaborates on the consultation:

(i) [Ms A] walked into the consultation room and described a three day history of shortness of breath and non-productive cough. She denied pain or fever and did not have a sore throat or blocked nose.

(ii) [Ms A] was speaking in full sentences with no obvious respiratory distress or wheeze. [Dr C] states *I did not find any fever* and in a clinical note made [a few days after] [Ms A's] death [Dr C] recorded *she felt cool, although I did not take the temperature … She had cold fingers and that often shows a lower 02 saturation level than real* [explaining why [Ms A's] oxygen saturations might have been reduced].

(iii) [Dr C] states there was no abnormality on examination of [Ms A's] neck glands, throat or on auscultation of the lung fields. Tachycardia of 168/min was noted together with reduced oxygen saturation on room air of 94%. [Dr C] notes again: *since her hands were very cold I felt the measurements with the finger pulse oximeter were less reliable due to the diminished flow … her blood pressure was low at 90/60mm Hg.*

(iv) [Dr C] describes her differential diagnosis as:

- *Tachycardia causing low BP secondary to myocardial infarction*
- *Chest infection. I thought this unlikely because she had no blocked nose, sore throat nor fever and there were normal findings on examining her lungs*
- *Pulmonary embolism. I thought this very unlikely because there was no sudden shortness of breath and no history of (localized) chest pain*

(v) [Dr C] asked her nurse to perform an ECG on [Ms A]. [Ms A] had a brief coughing spell when she lay down but then recovered. The ECG showed sinus tachycardia but no ischaemic changes. *My conclusion was that [Ms A] was probably short of breath and had a low blood pressure as a result of the sinus tachycardia. The most likely cause of the later was in my opinion her alcohol abuse and anxiety.* [Dr C] reasoned that by slowing down [Ms A's] pulse with a beta-blocker (bisoprolol) the shortness of breath would improve. She states she discussed the case with [her colleague Dr D] who concurred with her plan.

(vi) [Dr C] explained to [Ms A] the reason for the medication and that she *should improve within 2 days.* She was asked to re-present should her symptoms deteriorate or not have improved by two days.

6. In an e-mail to MCNZ dated [a few days after Ms A's death] [Dr D] notes that [RN E] came to see her clinical leader to express concern at [Dr C's] management of [Ms A] the previous day. *This nurse expresses that the patient was unable to lie flat due to difficulty with breathing, her resps sounded moist and her skin was clammy. When she went to see what the outcome was for the patient the patient had been sent home.* The clinical leader advised [RN E] to contact the patient to determine her wellbeing. [Ms A] did not answer her phone and a message was left for a health support worker to visit. [Ms A] was found deceased at home later that day with death likely to have occurred that morning. [Dr C's] legal representative notes there was no contemporaneous documentation by the nurse expressing concern at [Ms A's] wellbeing nor did she notify [Dr C] of her concerns.

7. An unsigned report confirmed as being provided by [RN E (following notification of Ms A's death)] records the nurse's impression of [Ms A's] wellbeing at the time of the consultation in question.

(i) [Ms A] had rung that morning reporting three days of unwellness with difficulty breathing and difficulty sleeping. The call was triaged by [RN E] who felt [Ms A] sounded unwell and booked her the next available GP appointment.

(ii) [RN E] next saw [Ms A] in the emergency room after being asked to perform an ECG on her. [Dr C] attended briefly while the ECG electrodes were attached. [RN E] asked [Ms A] if she had any chest pain and [Ms A] responded *that she had pain 'everywhere' ... going on ... for 3 days and she had been aching and sweating at night. She looked tired and sweaty and was breathing shallow and rapid with a cough that sounded moist on her chest.*

(iii) [Dr C] came back into the room and heard [Ms A] coughing, asking her if it was worse when she lay flat. *The patient said yes.* The ECG was completed and handed to [Dr C] and [Ms A] was asked to dress herself and return to [Dr C's] office. [RN E] observed [Dr C] coming out of [Dr D's] room with the ECG but she did not see [Ms A] again.

(iv) [RN E] states that [later that day] she checked [Ms A's] notes to see what her management had been. She was surprised to see that [Ms A's] breathing had been described as 'OK' and that [Ms A] had not been admitted to hospital or had blood tests taken. She noted [Ms A] had not had her temperature taken and that there had been no prescription for antibiotics. She contemplated ringing [Ms A] at the time but elected to report her concerns to her clinical leader the next morning, which she did. On the clinical leader's advice she attempted to contact [Ms A] and then a health visitor. She found out later in the day that [Ms A] was deceased.

8. Comments

(i) On the basis of [Dr C's] documentation and response it appears [Ms A] had been unwell for three days with symptoms of cough and shortness of breath. She had a very significant tachycardia and was hypotensive. Her oxygen saturations were somewhat reduced but smoking related lung disease may have contributed to this finding. There is a difference in opinion between [Dr C] and [RN E] regarding presence of increased work of breathing. [Ms A] had a very cool periphery which, in the context of the other clinical findings, might have represented a degree of peripheral shutdown secondary to shock. Given the possibility of sepsis as a cause of shock, [Ms A's] temperature should have been taken. Although it would not necessarily have altered management, it might have led to identification of systemic inflammatory response syndrome (SIRS) if significantly elevated or reduced.

I am mildly to moderately critical that [Ms A's] temperature was not recorded given the clinical scenario presented. Basic physical assessment was otherwise adequate although specific comment on mentation and hydration status might have been helpful.

(ii) Even without [RN E's] comments, the assessment findings suggest [Ms A] was significantly unwell. I am unable to dispute the finding of clear lungfields and absence of tachypnoea. However, it appears the tachycardia and hypotension were new findings and were associated with general unwellness, cough and at least subjective shortness of breath. In this context, the tachycardia was a symptom rather than a diagnosis and the cause required careful assessment to determine whether the symptoms were an appropriate physiological response to an underlying illness. The differential diagnosis for causes of new onset tachycardia is extensive and I do not think it was a safe or reasonable action to attribute the findings observed to 'anxiety and alcohol' and to treat the symptom (tachycardia) with a beta-blocker without further investigating the cause. I think a majority of my colleagues, when faced with a clammy patient with cold periphery, new onset sinus tachycardia of >150/min and hypotension, would recognise such symptoms as a cause for significant clinical concern and would consider rapid hospital admission for stabilisation and further investigation whatever underlying pathology was suspected. Such actions would not necessarily have prevented [Ms A's] death but would certainly have been more appropriate than the decisions that were made. I think [Dr C's] management decisions on this occasion would be met with severe disapproval by my peers. I note MCNZ is already involved in reviewing [Dr C's] performance and [Dr C] may already have relinquished her practicing certificate."

Further in-house clinical advice was obtained from Dr Maplesden on 18 September 2017:

"1. Thank you for requesting my comment on further information received on this case. My initial advice was provided on 12 September 2016. I have corrected the spelling of [RN E's] surname in that advice. I have reviewed the following documents: further response from [Dr C] per her solicitors; statement from [Dr

C's] [colleague Dr D], recalling the brief consultation he had with [Dr C] [that day] regarding [Ms A's] presentation; response from [the medical centre], regarding oversight and support provided to [Dr C] during the time of her employment by the medical centre.

2. [Dr C's] response clarifies that she was not present when [Ms A] apparently informed [RN E] of symptoms of pain and fever. This does not alter my original advice — that [Dr C's] management of [Ms A] would be met with severe disapproval by my peers. There was no additional new information provided that would impact on this advice.

3. [Dr D] recalls the information provided to him regarding [Dr C's] assessment of [Ms A] and her management plan with which he concurred. With the benefit of hindsight, this was a missed opportunity to accurately determine the severity of [Ms A's] unwellness and to institute a more suitable management plan. However, given the circumstances (informal seeking of brief advice rather than formal supervisory setting and request for review and second opinion) I think it was not unreasonable for [Dr D] to assume the competency of [Dr C's] assessment of the patient and diagnostic formulation based on the information provided to him, and for him to concur with her plan.

4. The [practice's] response I think indicates there was appropriate structured orientation and supervision of [Dr C] both when she first joined [the medical centre] and when concerns were raised at the standard of her clinical documentation. I feel the management of the incident in question was also handled by [the medical centre] in a professional fashion. The [two] complaints about [Dr C] received by [the medical centre] might have raised some concerns about [Dr C's] clinical competency (based on the limited information provided) but I do not think there was an indication for collegial referral of [Dr C] to the Medical Council on the basis of the complaints, and as far as I am aware the complaints were resolved at the medical centre level, including discussion with [Dr C], and were not escalated by the complainants to HDC.

5. It may be appropriate to seek expert nursing advice regarding [RN E's] role in [Ms A's] management. I wonder if [RN E] might have been more proactive in raising her concerns at [Ms A's] unwellness with [Dr C] or another clinician at [the medical centre], or by undertaking additional observations at the time of ECG recording including temperature and respiratory rate."