



Failure to diagnose an aortic dissection breaches the Code

22HDC01091

In a report published today, Deputy Commissioner Carolyn Cooper has found a senior doctor at Health New Zealand | Te Whatu Ora breached the Code of Health and Disability Services Consumers' Rights (the Code) for care provided to a woman at a public hospital Emergency Department.

The woman, who had chest pain and shortness of breath, was admitted to hospital after an ambulance was called to her home. She was discharged later the same day with a prescription for indigestion medication. She was then admitted a second time the following day and, sadly, died the next day in the Intensive Care Unit (ICU). The Coroner determined that the cause of death was an aortic dissection, a serious condition in which a tear occurs in the inner layer of the body's main artery (the aorta).

Ms Cooper found the senior doctor breached the Code in failing to provide services of an appropriate standard | Tautikanga. The breach covered several issues with the care provided.

The senior doctor ruled out the diagnosis of aortic dissection, despite the woman's presentation and concerning symptoms.

"Although this is a rare diagnosis, it is one with severe consequences and I'm not satisfied that appropriate steps were taken to allow the senior doctor to exclude this confidently," Ms Cooper said.

In addition, the senior doctor did not utilise appropriate tools for discounting other relevant diagnoses, and did not utilise the supervision available to him or seek cardiology advice before discharging the woman following her first ED presentation.

"I consider that had the appropriate review of the woman's history been undertaken, along with the advice from her family about the significant family history, it would have been appropriate for the senior doctor to have obtained cardiology advice prior to the woman's discharge," Ms Cooper said.

She also found the senior doctor breached the Code for failing to document the woman's presentation in a way that included: vital observations, discounted diagnoses, interpretation of the chest X-ray and clear instructions regarding the circumstances under which to re-present to ED.

Ms Cooper found the breaches in care related to the individual actions of the senior doctor whose responsibility it was, "to ensure the woman was assessed

appropriately and not discharged until presenting symptoms had been reviewed adequately.”

However, Ms Cooper made an adverse comment about Health NZ in relation to pain relief and vital sign monitoring and the Serious Adverse Event Review.

Ms Cooper expressed her condolences to the family for their loss in such traumatic circumstances.

Changes made since this event, by both the senior doctor and Health NZ, along with further recommendations from Ms Cooper, are outlined in detail in the report.

16 September 2024

Editor’s notes

Please only use the photo provided with this media release. For any questions about the photo, please contact the communications team.

The full report of this case can be viewed on HDC’s website - see HDC's '[Latest Decisions](#)'.

Names have been removed from the report to protect privacy of the individuals involved in this case.

The Commissioner will usually name group providers and public hospitals found in breach of the Code unless it would not be in the public interest or would unfairly compromise the privacy interests of an individual provider or a consumer. More information for the media, including HDC’s naming policy and why we don't comment on complaints, can be found on our website [here](#).

HDC promotes and protects the rights of people using health and disability services as set out in the [Code of Health and Disability Services Consumers' Rights](#) (the Code).

In 2022/23 HDC made 592 quality improvement recommendations to individual complaints and we have a high compliance rate of around 96%.

Health and disability service users can now access an [animated video](#) to help them understand their health and disability service rights under the Code.

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