Crown Health Enterprise

Report on Opinion - Case 97HDC3419

Complaint

The complainant complained to the Commissioner about the care her son ("the consumer") received in hospital as follows:

- *In early November 1996, the consumer was admitted to hospital for the removal of a dermoid cyst, during which time he contracted post operative meningitis.*
- *The complainant received conflicting information regarding her son's condition.*
- *A lumbar puncture was performed on the consumer without consent.*
- *The consumer's wound was sutured seven times, in conditions which appeared to be un-sterile.*
- *There was a lack of co-operation, and agreement, on the management of the consumer's care, in particular, the insertion of a central line.*
- *When the complainant took her complaint concerning her son's treatment to the hospital, she was made to feel as if she had no right to complain.*

Investigation

The complaint was received by the Commissioner on 9 January 1997 and an investigation was undertaken. Information was obtained from:

The Complainant (the consumer's mother)
The Acting Chief Executive, Crown Health Enterprise
A Neurosurgical Registrar
A Consultant Surgeon
A Social Worker

The consumer's medical notes were obtained and viewed.

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Outcome of Investigation

The consumer, aged 5 years, was admitted to hospital in early November 1996 for the removal of two dermoid cysts. The Acting Chief Executive of the Crown Health Enterprise concerned, in his letter to the Commissioner's office dated 22 May 1997, stated that informed consent was obtained for the procedure from the complainant prior to her son's operation. This followed a detailed discussion of the procedure involved and its inherent risks including the risk of meningitis. This is disputed by the complainant who said that had the risk of meningitis been stated she would not have consented to the operation going ahead. She would have requested more information about the nature and effects of meningitis seeing that it was a potentially fatal condition. On the form titled "Agreement To Treatment" the medical procedure is described and the risk of blood transfusion is specifically mentioned. The complainant made diary notes whilst she was at the hospital with the consumer. She noted in her diary that when the subject was brought up in a subsequent meeting with the Neurosurgical Registrar, the latter said something like *"when will we have time to do surgery if we discussed each detail"*.

The consumer's surgery was completed the day after admission without incident but on the fourth post operative day cerebrospinal fluid (CSF) started leaking from the wound. CSF leaks happened on days 4, 9 and 11 after surgery. The first two leaks were sutured under local anaesthetic and on the third occasion the wound was re-sutured under general anaesthetic.

As a result of these leaks there was a greater risk of meningitis and permission was sought to insert an IV lure for the administration of antibiotics. This was refused by the complainant.

Subsequently, the consumer developed meningitis and investigations were carried out to obtain a better picture of the consumer's condition. Lumbar punctures were carried out on days 8, 20 and 23 after surgery. The complainant states that prior to the first lumbar puncture on day 8 a member of the medical team visited the complainant and told her that there was a possibility that they would need to perform a lumbar puncture on her son.

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Outcome of Investigation, ***continued***

There was no explanation about the procedure and why it was necessary. Similarly on day 16 after surgery the consumer's father was informed that a second lumbar puncture was to be performed on day 20. Again, there was no explanation provided.

The complainant has made mention of the scarcity of information that was made available to her and her husband about their son's condition and his treatment. Entries in the consumer's medical notes on days 12 and 18 after surgery confirm that meetings were requested with medical staff to explain matters to the child's parents. On day 12 the social worker noted the following :
"Mother... is very concerned and upset that she has not been given an explanation as to why [the child's] wound is leaking all the time...."
On day 18 the entry in the nursing notes states :
"Father present, wife raised concerns to him re: second opinion. Could you please ensure a.m staff that [the Neurosurgical Registrar] could talk to father at some stage re: what is happening with [the child] ?"

On day 22 after surgery, the consumer was taken down to theatre to have a central venous catheter inserted. However the anaesthetist did not agree with the type of line that was proposed for the consumer. There was a delay of about three-quarters of an hour as the house surgeon tried to locate the Neurosurgical Registrar to resolve this difference in opinion. The complainant states that the whole affair was very distressing for her and her child, as they did not understand what was going on around them. The entry in the nursing notes on that day states :

".....went down for a central line which was delayed due to anaesthetist and medical team not agreed on which type of line patient is to have. Procedure will probably (no time confirmed) take place tomorrow....Mum is very stressed about all the delays and indecision. Expressed she will not consent to anything further unless she is given a thorough explanation of the procedure decided on."

The procedure was performed the following day with the assistance of a different anaesthetist. The complainant stated that she was visited by the Neurosurgical Registrar, who told her that the previous day's incident was due to a personality clash and should never have happened.

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Outcome of Investigation, *continued*

Despite inquiry, the Commissioner was unable to discover the name of the anaesthetist on duty on the day this incident occurred.

On day 8 after surgery the consumer became feverish with clinical signs of meningism. Initial medical opinion was that leakage of CSF fluid had irritated the meninges hence causing chemical meningitis. Subsequent analysis of CSF obtained from the lumbar puncture confirmed that the consumer had contracted bacterial meningitis. The consumer's discharge summary notes state that he had contracted both chemical and bacterial meningitis. The consumer was commenced on Cefotaxime and Gentamicin to combat the bacterial infection. The complainant was concerned that she *"was getting conflicting information about her son's condition"*. In particular she had difficulty understanding whether he was suffering from chemical or bacterial meningitis, given that some members of the medical team referred to chemical meningitis and others, bacterial meningitis.

The complainant also pointed out that she felt her complaint was not taken seriously when she approached medical staff about her concerns. In his response the Acting Chief Executive said:

"I regret that [the complainant] felt she was made to feel as though she had no right to complain. [The Crown Health Enterprise] has a formal complaints process in place and it is unfortunate that this service appears not to have been offered to [the complainant] at the time."

Code of Health and Disability Services Consumers' Rights

RIGHT 4
Right to Services of an Appropriate Standard

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

RIGHT 5
Right to Effective Communication

1) *Every consumer has the right to effective communication in a form, language, and manner that enables the consumer to understand the information provided. Where necessary and reasonably practicable, this includes the right to a competent interpreter.*

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Code of Health and Disability Services Consumers' Rights, *continued*

RIGHT 6
Right to be Fully Informed

1) *Every consumer has the right to the information that a reasonable consumer, in that consumer's circumstances, would expect to receive, including -*
   a) *An explanation of his or her condition; and*
   b) *An explanation of the options available, including an assessment of the expected risks, side effects, benefits, and costs of each option; and*

RIGHT 7
Right to Make an Informed Choice and Give Informed Consent

1) *Services may be provided to a consumer only if that consumer makes an informed choice and gives informed consent, except where any enactment, or the common law, or any other provision of this Code provides otherwise.*

RIGHT 10
Right to Complain

6) *Every provider, unless an employee of a provider, must have a complaints procedure that ensures that -*

   b) *The consumer is informed of any relevant internal and external complaints procedures…*

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Opinion: Breach

In my opinion, the Crown Health Enterprise breached Rights 4(5), 5(1), 6(1), 7(1) and 10(6)(b) of the Code of Health and Disability Services Consumers' Rights.

Right 4(5)
In my opinion, the Crown Health Enterprise breached Right 4(5) of the Code of Rights in that its medical staff failed to co-operate in the care of the consumer. It is evident from the medical records that the anaesthetist and the medical team had a difference of opinion about which type of line to use as a central catheter, which was not resolved despite the consumer being prepared for theatre. The ensuing delay was quite stressful for mother and child and resulted in the complainant requesting another meeting with the team to ease her anxiety about her child's care.

Right 5(1)
In my opinion the Crown Health Enterprise breached Right 5(1) of the Code of Rights in that its staff did not effectively communicate to the complainant what was wrong with her son. The complainant was uncertain whether her son had chemical or bacterial meningitis. Medical staff did not appreciate the need to distinguish between the two, given that they administered antibiotics to alleviate both forms of meningitis. The imprecise nature of information that was made available to the complainant made the whole situation difficult to manage, at a time when she was also having to cope with the seriousness of her son's illness.

Also, in my opinion the disagreement between the anaesthetist and the medical team over which type of line to use as a catheter and the ensuing delay was clumsily handled by the medical team. Very little was communicated to the complainant in the way of explanation and once again she was left in the position of requesting another meeting to get the matter clarified for her.

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Opinion, ***continued***

Right 6(1)
In my opinion the Crown Health Enterprise breached Right 6(1) of the Code of Rights in that its staff did not fully inform the complainant about the nature of the two lumbar punctures performed post operatively. In particular no explanation was given as to why this mode of investigation was deemed necessary. It appears that the complainant and some members of the team did not have a good rapport. The consultant surgeon commented that "*mother was difficult and obstructive*". This was unfortunate but it did not excuse medical staff from their obligation to inform the complainant of the nature of her son's condition, the treatment options and an assessment of these risks and/or benefits.

Right 7(1)
In my opinion the Crown Health Enterprise breached Right 7(1) of the Code of Rights in that its medical staff did not provide the opportunity for the complainant to make an informed choice and give informed consent prior to her son's operation in early November 1996. There is a difference of opinion as to whether the risk of meningitis was mentioned by the Neurosurgical Registrar to the complainant at the meeting on the day of the operation. I accept the complainant's statement that had the risk of meningitis been discussed she would not have given her consent. The risk of meningitis is not stated on the form titled "Agreement To Treatment".

Right 10(6)(b)
In my opinion the Crown Health Enterprise breached Right 10(6)(b) as its staff failed to inform the complainant of the internal complaints procedures that the Crown Health Enterprise currently has in place. However, when a patient's family has immediate concerns and requires information, it is critical this occurs immediately. In such cases this is a matter of effective implementation of Right 6 rather than entering a potentially long process of complaint.

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Actions

I recommend that the Crown Health Enterprise:

1. Apologises in writing to the consumer's family for its breaches of the Code. This apology should be sent to the Commissioner's office and will be forwarded to the complainant. A copy will be kept on file.
2. Reminds its staff of their obligations under the Code of Rights to fully inform and communicate in an effective manner with patients and their families.
3. Ensures that a specific health professional is named as having prime responsibility for the care of every patient. Co-ordinating and communicating with the family will be that health professional's responsibility as well as the co-ordination of the team providing service.
4. Draws to the attention of its medical staff the following excerpt from the Medical Council's 1995 statement for the profession on information and consent:

   "*The Medical Council affirms that if it can be shown that a doctor has failed to provide adequate information and thereby has failed to ensure that the patient comprehends, so far as is possible, the factors required to make decisions about medical procedures, such failure could be considered as medical misconduct and could be the subject of disciplinary proceedings.*"

5. Ensures it maintains appropriate records of staff rostered so that the persons accountable are known and recorded.
6. Notes that the initial response from the Crown Health Enterprise was incorrect in its stated facts and the Crown Health Enterprise should review the collection of this information as to how this occurred.
7. Reviews the appropriateness and consistency of the standard of medical note keeping and reminds staff of its obligations to patient care and safety in this regard. In this investigation the standard by the social worker was clear, concise and many lessons could be learnt from this.

A copy of this opinion will be sent to the Health Funding Authority and the Neurosurgical Registrar. A copy of this opinion, with all identifying features removed, will be sent to all Hospital and Health Services.