General Practitioner, Dr B

A Public Hospital

A Report by the

Health and Disability Commissioner

(Case 03HDC11072)

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

Parties involved

Mr A (dec)	Consumer
Mr A's son	Complainant
Dr B	General practitioner / Provider
A Public Hospital	Provider

Complaint

On 25 July 2003 the Commissioner received a complaint from Mr A's son about the medical care his father, Mr A, received from Dr B at a public hospital. The following issues were identified for investigation:

- *The circumstances/adequacy of the treatment Mr A (dec) received at the hospital on 30 and 31 March 2003 up until his discharge*
- *The appropriateness of Mr A's discharge on 31 March 2003*
- *The adequacy of the hospital's systems in relation to Mr A's care.*

An investigation was commenced on 19 September 2003.

Information reviewed

- Information provided by Mr A's son
- Information provided by Dr B
- Information provided by the public hospital
- Information provided by the Coroner
- Information provided by the medical service
- Information provided by ACC

Independent expert advice was obtained from Dr Tony Birch, general practitioner.

Names have been removed to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

Information gathered during investigation

Background

Mr A was a 78-year-old gentleman with a history of tinnitus, cellulitis, chronic obstructive airways disease, angina and alcoholism.

Mr A had been at a hotel on 30 March 2003 from approximately 11.00am to 8.00pm and, according to the publican, he had had about nine 7oz drinks during that day. Mr A was found on the ground outside the hotel at around 8.20pm. It is thought he may have been there for about 15 minutes before he was found by other patrons entering the hotel. Mr A appeared to have been unconscious for some of that time and had bruising and grazing to the left-hand side of his face, a black left eye, and bruising on his left elbow.

An ambulance was called and Mr A was taken to the hospital, where he was admitted at 10.30pm. The ambulance officers noted in their report that on arrival Mr A was:

> "… conscious, uncooperative, contusions + laceration L eye + eyebrow. Nil pain. PM HX Cardiac ?COAD. Current medications: Nitrolingual 400 MCG, Captopril, Glytrin Spray, Digoxine."

At the hospital Mr A was seen by Dr B, general practitioner, who was on call for the hospital. Dr B spoke to the ambulance officers and read their report. Dr B stated that he formed an open list of likely diagnoses that may have explained why Mr A had fallen, and what injuries he may have sustained as a result. Dr B considered that as Mr A was very inebriated (reported by the ambulance officers), he could have tripped or had a seizure. The ambulance officers reported that Mr A was taking digoxin and NTG, and Dr B thought that might suggest Mr A had had a Stokes-Adams attack. Mr A also had a contusion on his face, which may have indicated concussion and/or subdural haemorrhage.

Dr B stated that with these diagnoses in mind, he examined Mr A as carefully as possible, although this was not easy as Mr A appeared very inebriated, smelt strongly of alcohol, and was uncooperative. He would not answer questions about headaches, dizziness, chest pain or shortness of breath, and kept saying he wanted to leave. Dr B found no lacerations or haematomas on Mr A's scalp. Bruising was noted around Mr A's left eye, as were abrasions on his face. Dr B attempted to look in Mr A's mouth to check whether he had bitten his tongue. Mr A's neck movement was observed. His neck veins were checked for jugular venous pressure, and his arteries for bruits. Both were normal. Dr B palpated Mr A's chest for pain, and checked for any bruising or swelling. A neurological examination showed that pupil size, equality and reactivity were all normal. Cranial nerves, motor and sensory reflexes, and coordination were also assessed. Dr B stated:

> "The Lung fields were auscultated for air entry bilaterally and for additional sounds – rhonchi being heard bilaterally. The heart sounds were auscultated for rate and rhythm and extra sounds or murmurs."

Dr B's principal diagnosis was recorded as periorbital contusion. Additional recorded diagnoses were alcoholism and unsteady gait. Bruising on Mr A's left shoulder and forearm

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was also recorded. Altered memory tracking was noted in the records, as well as vomiting and incontinence.

Mr A was kept in hospital overnight to rule out concussion. Dr B said that Mr A did not want to stay overnight, but Dr B told him he had to remain for observation, and Mr A went along with this. Flixotide, digoxin, captopril and NTG were ordered for his existing conditions.

Dr B instructed hospital staff to record neurological observations overnight every hour for the first four hours, then every four hours thereafter. Only one observation is recorded in the medical notes for 30 March 2003. The statement given by the registered comprehensive nurse to ACC stated: "He refused further examination or recordings."

Dr B examined Mr A on the morning of 31 March 2003. Dr B stated that "[Mr A's] head was clear – meaning he was oriented to time, person and place and conversing coherently". There was no evidence of significant head injury, even though Mr A had a left periorbital contusion. Mr A's co-ordination was not good, but he said this was normal for him. Dr B considered that this was probably due to cerebellar effects from Mr A's long-term alcoholism. Mr A was moderately short of breath, but told Dr B that it was his lungs, and that he would be fine. Dr B observed that Mr A's blood pressure had dropped from the previous evening, but noted that readings taken after rest are often lower.

Dr B said that Mr A insisted on going home. Dr B advised him that he needed medical follow-up, and also arranged for the social worker and the alcohol counsellor to see him before he was discharged. The social worker, who had assessed Mr A previously at his home, noted that he was anxious to return home. She planned to arrange a further home visit. After talking with Mr A, the alcohol counsellor was of the view that Mr A had no desire to change his lifestyle.

Dr B stated that Mr A "was treated with respect for his self and respect for his wishes".

Mr A was discharged into the care of two friends, and advised to follow up with his general practitioner. His friends used a wheelchair to take him to the car, as Mr A was having difficulty walking. After they had driven away Mr A vomited in the back seat, slumped over, and had a cardiac arrest at approximately 10.15am. Mr A's friends returned with him to the hospital.

Hospital staff attempted to resuscitate Mr A, but were unsuccessful. He died at 10.55am on. […].

Post-mortem examination
The post-mortem examination found 8mg of alcohol per 100ml of blood and 24mg of alcohol per 100ml of urine. Amitriptyline was the only medicinal drug detected, and the level found was consistent with therapeutic use. Marked interstitial fibrosis and scarring, consistent with ischaemic heart disease, was noted. The liver also showed acute vascular congestion, consistent with right ventricular failure.

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Coroner's inquest
A Coroner's inquest was held into Mr A's death, and found that the cause of death was acute cardiac failure due to ischaemic heart disease. The Coroner noted that the Police were called after Mr A's death: "[They] noted that [the] deceased had recent bruising and grazes to the left side of his face and a black left eye. There was also bruising on his left elbow. These injuries appeared consistent with a fall as described."

ACC finding
Mr A's son submitted a claim in respect of his father's death to the Medical Misadventure Unit of ACC in respect of the services provided by Dr B at the hospital. ACC obtained advice from an independent expert, [Dr C], a consultant in emergency medicine. Copies of [Dr C]'s advice and the ACC decision are attached as Appendix 1 and Appendix 2 respectively.

On 9 March 2004 ACC advised Mr A's son that his claim had been declined.

Independent advice to Commissioner

Initial advice
The following expert advice was obtained from Dr Tony Birch, medical practitioner:

"**Report**

1. *In your opinion, what was the likely cause of [Mr A's] collapse at the hotel on the evening of 30 March 2003?*

   I can do no more than agree with the opinion expressed in the papers forwarded to me: that he was under the influence of alcohol, tripped on his way to his car (leaving a 'Jandle' some way behind him) and lay there stunned and unconscious (probably from a combination of the fall, his general debility and the effect of alcohol). A puzzling fact, unaccounted for in any of the papers is that [Mr A] had the drug Amitriptyline in his blood at post-mortem. There is no evidence anywhere of this being prescribed. If he had taken this inadvertently, this would almost certainly be a factor in the events of that night and the following morning.

2. *Was [Mr A's] examination by [Dr B] on the evening of 30 March appropriate and complete?*

   I have no concerns about the way in which [Dr B] dealt with [Mr A] on the night of 30th March. I would have done the same things under these circumstances, waiting until the morning when, presumably, the patient would be sober to complete my assessment.

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3. *Should [Dr B] have obtained an ECG, given [Mr A's] medical history?*

   From what I have available to me, there is nothing in [Mr A's] medical history that would make one specifically think to record an ECG. His previous history is of alcoholism, chronic obstructive respiratory disease and hypertension. The fact that he is prescribed a Glyceryl trinitrate spray alludes to a diagnosis of angina but he was prescribed no preventive medication, and the specialist physician makes no mention of heart disease. In fact he wonders, in his letter of June 2001, why he is on heart medication at all. It is only in retrospect that one feels the lack of an ECG.

4. *Was the treatment provided to [Mr A] by [Dr B] appropriate?*

   It seems appropriate to me that [Dr B] persuaded [Mr A] to stay in hospital overnight for observation and made no changes in the medications he was currently taking.

5. *Please comment specifically on [Dr B's] instructions regarding the neurological observations overnight?*

   This would be a routine order. The purpose of this is not only to have an early warning of any neurological change, but also to be sure that a close eye is kept on the patient.

6. *Were the neurological observations carried out by hospital staff adequate under the circumstances?*

   It seems that [Mr A] was restless and up and about through the night. It appears that he only slept for ten minutes from about 05:30AM. I cannot find in the notes, however, any charting of the observations that were requested. This might be something that the hospital might look into.

7. *Was [Dr B's] examination of [Mr A], prior to his discharge, appropriate and complete?*

   It appears that [Dr B] saw [Mr A] on the next morning and had a look at his injuries. He appears to have been happy with progress. In his notes at the time he makes no mention of a thorough examination. In view of the fact that [Mr A] had been inebriated on the previous examination, I would have expected more detail. The fact that he asked for a social worker to see him supports [Dr B's] contention that [Mr A] was very keen to go home, this may have had a bearing on the detail of the examination.

8. *Was it appropriate to discharge [Mr A] the next morning?*

   With the benefit of hindsight, it was obviously NOT appropriate for [Mr A] to be discharged that next morning. What concerned me reading the notes was the finding of a marked drop in [Mr A's] blood pressure and in his O_2 saturation that morning. He also appears to have been unable to walk to the car with his friends. Under these

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circumstances I would have expected a rethink of the decision. Health practitioners are more aware these days of patients' rights and their ability to make decisions for themselves. A hospital is not a prison, and [Mr A] had every right to leave. However, given the adverse finding at 06:30 that morning, I would have expected some attempt to dissuade him from his desired course of action: or at least some mention in the notes that this had been done and that he had left despite advice against this course of action.

Reading between the lines, it appears that [Dr B] felt somewhat powerless in the face of [Mr A's] obvious intention to continue to live in the unhealthy way in which he was living. This, of course, is his choice but it would probably have influenced decision-making.

9. *Were there any indicators that [Mr A] was at risk of a myocardial infarction either on the evening prior to his death, or on the morning of his discharge? If so, should these have been recognised by [Dr B]?*

From my reading of the pathologist's report, there is little evidence that [Mr A] suffered a myocardial infarction prior to his death. (There are, however, sections of this report not on file.) The coroner's findings are 'acute cardiac failure due to ischaemic heart disease'. This could well have been a consequence of the inhalation of vomitus and the subsequent stress on an already diseased heart with low output from a low blood pressure and inadequate oxygenation (an O_2 saturation of only 85% while on oxygen – down from 92% about 7 hours previously).

With the benefit of hindsight it seems clear that [Mr A] should have been prevailed upon to stay for another 24 hours observation while the cause of the deteriorating observations was investigated. I suspect that [Mr A's] desire to leave probably influenced [Dr B's] decision. It would have been easier to make a judgment on this had there been anything in [Dr B's] note of 31st March to this effect. All one can say on the evidence presented is that it appears that [Dr B] made an error of judgement on that morning.

10. *Are there any other matters relating to professional standards which you believe to be relevant to this complaint?*

The only thing that occurs to me is that a more thorough and in-depth WRITTEN assessment would have made things so much easier to judge. I believe that standards in this area are improving, but we as a profession need to continue to improve."

Further advice

Dr Birch provided the following further information in response to issues raised in his advice:

"The presence of Amitriptyline would have reacted with the alcohol enhancing the sedating qualities of both. In high dosage or overdosage, Amitriptyline has a toxic effect

on the heart. There is nothing anywhere to indicate that this drug was prescribed, but it was found at post-mortem in the blood.

The error of judgment I refer to is in discharging [Mr A] – even allowing him to go out – in the light of a falling blood pressure and a low oxygen concentration. I believe that [Dr B] himself would concede this in hindsight. Whether this would have made any difference to the outcome for [Mr A] is impossible to say. This error of judgement is one which many doctors, including myself, will have made in a lifetime. I do not believe that it means that [Dr B] is not a good doctor; he is just human, like us all."

Code of Health and Disability Services Consumers' Rights

The following Rights in the Code of Health and Disability Services Consumers' Rights are applicable to this complaint:

RIGHT 4
Right to Services of an Appropriate Standard

(1) Every consumer has the right to have services provided with reasonable care and skill.

(2) Every consumer has the right to have services provided that comply with legal, professional, ethical, and other relevant standards.

…

(4) Every consumer has the right to have services provided in a manner that minimises the potential harm to, and optimises the quality of life of, that consumer.

Opinion: No breach – Dr B

Assessment of illness/diagnosis
Under Right 4(1) of the Code of Health and Disability Services Consumers' Rights (the Code) patients are entitled to services provided with reasonable care and skill. An important part of forming a diagnosis is an examination that is properly and carefully carried out in accordance with relevant guidelines and policies.

Mr A's son has complained that Dr B treated his father for intoxication, rather than possible concussion. He is also concerned that further tests such as an ECG were not done. He believes his father should not have been discharged as he was obviously still not well, with his blood pressure and oxygen levels dropping.

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After his fall outside the hotel, Mr A was taken by ambulance to the hospital, where he was admitted at 10.30pm. The ambulance report recorded that Mr A was uncooperative and reported no pain. They noted his current medications were Nitrolingual 400 MCG, captopril (an ACE inhibitor used in the treatment of hypertension and heart failure), digoxin (used in the treatment of atrial fibrillation) and glyceryl trinitrate spray (used to treat angina).

Dr B stated that a thorough examination was undertaken, even though Mr A was uncooperative and did not respond to questions about his condition. Mr A did not describe any chest pain, headache, dizziness or shortness of breath. Mr A was reluctant to stay in hospital, but Dr B told him he had to stay overnight for observation.

My expert, Dr Tony Birch, advised that he had no concerns with Dr B's treatment of Mr A on the evening of 30 March 2003.

Dr Birch stated that there was nothing in Mr A's medical history that indicated that an ECG should have been taken. It was only in hindsight that an ECG would have been useful.

The medical advisor to ACC, [Dr C], was of the same opinion. He commented that given Mr A's presentation and no complaint of chest pain, it was not unreasonable that no ECG was taken.

Both advisors agree that there is no evidence that Mr A suffered from a myocardial infarction.

Dr Birch said that it was appropriate for Dr B to persuade Mr A to stay in hospital overnight for observation and to make no changes to the medications he was currently taking.

Dr Birch noted that the observations that Dr B ordered to be taken overnight were routine. They were to ensure an early warning of any neurological change, and that a close eye was being kept on Mr A. Dr Birch noted that he could not find any charting of the requested observations. However, the statement by the registered comprehensive nurse to ACC makes it clear that Mr A refused further recordings.

The advisor to ACC also considered that Dr B's examination of Mr A on 30 March was of an acceptable standard. He stated that the decision to advise Mr A to stay overnight was correct. [Dr C] said:

> "In the absence of brain CT a period of 4 hours neurological observations is generally recommended following head injury with return of normal consciousness. This is complicated by the presence of alcohol and overnight observation is generally regarded as the appropriate level of care when minor head injury co-exists with alcohol intoxication."

The ACC advisor noted that there was no evidence that Mr A had suffered from a seizure. On admission to the hospital Mr A had a Glasgow Coma Score of 14, which in [Dr C]'s

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opinion indicated mild neurological impairment. He commented that Mr A's incontinence can be attributed to a combination of this impairment and intoxication.

Dr Birch noted that Dr B's record of his examination of Mr A on 31 March 2003 is brief, but he appeared happy with Mr A's progress. Dr Birch stated that, as Mr A was inebriated the previous evening, he would have expected more detail about the review in the morning. My advisor noted, however, that the social worker supports Dr B's contention that Mr A was anxious to go home, and this may have impacted on the detail of the examination.

Dr Birch noted that, with the benefit of hindsight, it was not appropriate to discharge Mr A. The marked drop in Mr A's blood pressure and oxygen saturation that morning, combined with the fact that Mr A could not walk to his friend's car, should have prompted reconsideration of the decision to discharge him, and further investigations should have been made into Mr A's reduced blood pressure and oxygen levels. However, Mr A's keenness to leave the hospital probably influenced Dr B's decision to discharge him and recommend follow-up with his general practitioner.

Dr Birch also stated:

> "Health practitioners are more aware these days of patients' rights and their ability to make decisions for themselves. A hospital is not a prison, and [Mr A] had every right to leave. However, given the adverse finding at 0630 that morning, I would have expected some attempt to dissuade him from his desired course of action: or at least some mention in the notes that this had been done and that he had left despite advice against this course of action.
>
> Reading between the lines, it appears that [Dr B] felt somewhat powerless in the face of [Mr A's] obvious intention to continue to live in the unhealthy ways in which he was living. This, of course, is his choice but it would probably have influenced decision-making."

I am satisfied that Dr B provided Mr A with an appropriate standard of care on 30 March when he assessed him and admitted him for observation.

It is clear from the information available that Mr A did not wish to remain in hospital and told Dr B so. He explained to Dr B that his shortness of breath was usual, as was his unsteady gait. Dr B arranged follow-up care with a social worker and a visit from an alcohol and drug counsellor before Mr A was discharged. He advised Mr A to see his own doctor in his hometown. Dr B was aware that Mr A's blood pressure had dropped from the previous evening but was not unduly concerned as it was a resting recording. I accept the advice of my expert that in hindsight, Mr A's drop in blood pressure and low oxygen concentration were signals that should have led Dr B to advise Mr A to remain in hospital on 31 March. I draw these comments to Dr B's attention. However, in all the circumstances (including Mr A's clearly stated desire to go home and lack of willingness to co-operate with those caring for him) Dr B's medical care on 31 March was reasonable. Accordingly, Dr B did not breach Right 4(1) of the Code.

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Opinion: No breach – The Public Hospital

Vicarious liability
Employers are responsible under section 72(2) of the Health and Disability Commissioner Act 1994 for ensuring that employees comply with the Code of Health and Disability Services Consumers' Rights. Under section 72(5) it is a defence for an employing authority to prove that it took such steps as were reasonably practicable to prevent the employee from breaching the Code.

As Dr B has not been found in breach of the Code, the issue of vicarious liability on the part of the hospital does not arise.

Other comments

Observations
Dr B's instructions were for observations to be undertaken by nursing staff at one hourly intervals for the first four hours, and then at four-hourly intervals if Mr A's condition was stable.

However, only one observation appears to have been taken during the night by a registered nurse. It appears, therefore, that Dr B's instructions were not followed in this instance. My advisor noted that the hospital may wish to look into this. I note, however, from the statement the registered comprehensive nurse gave to ACC, that Mr A refused further recordings. This refusal should have been recorded in Mr A's clinical records.

Amitriptyline
My advisor also noted that amitriptyline was found in Mr A's blood during post-mortem. Dr Birch stated that this drug would have reacted with the alcohol, enhancing the sedating qualities of both. He also noted that in high doses or in overdosage, amitriptyline has a toxic effect on the heart. However, there is nothing in the records to indicate that this drug was prescribed for Mr A. My advisor stated that if Mr A had taken amitriptyline inadvertently, it would have been a factor in the events on 30 and 31 March.

I note that in this case, the level of amitriptyline found at post-mortem was at a level consistent with therapeutic use. The ambulance officers did not record amitriptyline in Mr A's current medications, nor is it recorded anywhere in the hospital records. It is clear that the hospital staff were unaware that Mr A had taken amitriptyline, and did not have any reason to suspect that he was taking any other medication than those listed in the records.

Clinical records
My advisor comments on the standard of Dr B's note-taking, noting that he should have made a more thorough and in-depth written assessment, particularly his assessment of Mr A on 31 March. I accept this advice. Doctors have a duty to keep good records, and record-keeping is an integral part of providing health care. The relevant professional standards are

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contained in the 'New Zealand Standard for Health Records' (NZS 8153:2002), which states: "People have the right to expect their health records to be a complete, thorough and accurate record of past and current consultations." The New Zealand Medical Association 'Code of Ethics' (2002) states in Recommendation 5: "Doctors should ensure that information is recorded accurately and is securely maintained."

I draw these standards and my expert's comments to Dr B's attention.

Recommendation

I recommend that Dr B review his practice to ensure that his record-keeping is accurate and comprehensive, including all relevant information.

Follow-up actions

- A copy of this report will be sent to the Medical Council of New Zealand and the Royal New Zealand College of General Practitioners.
- A copy of this report, with details identifying the parties removed, will be placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

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Appendix 1 – [Dr C]'s advice to ACC

"REQUEST FOR INDEPENDENT ADVICE ON A MEDICAL MISADVENTURE CLAIM

[Mr A]

Date of birth: 29.6.24

Date of injury: 31.3.03

Medical speciality: Emergency

Claim number: […]

Declaration

I am [Dr C] MB ChB, FRCS, FFAEM, FACEM.

I am a fully registered specialist in Emergency Medicine (MCNZ …).

I am the Clinical Director of Emergency Medicine at [a public hospital].

This report provided to ACC is based on my interpretation of the clinical notes and reports made available to me (including the post mortem report).

Summary of care:

[Mr A] (DOB 29/6/1924) attended the Emergency Department at the hospital, […] on the evening of 30/3/03. He was seen and examined by [Dr B]. [Mr A] was detained for observation overnight. On the morning of 31/3/03 [Mr A] was once again seen by [Dr B] and discharged home after an assessment by a social worker and alcohol counsellor. Follow up was advised at the […] surgery. [Mr A] was escorted to his car but collapsed and was returned to the […] Emergency Department. Resuscitation was commenced but was unsuccessful. He was pronounced dead at 10.50 on […]. A coroner's autopsy was performed by [a pathologist] on 1st April 2003. The cause of death was given as Acute cardiac failure due to Ischaemic heart disease.

1. Has a physical injury occurred as a result of medical treatment?

- No.
- Death occurred […] after medical treatment but did not occur as a result of that treatment.
- The body of [Mr A] has been subjected to post mortem examination by [the pathologist], MB ChB, F F Path, MIAC. The cause of death has been documented as being due to: Acute cardiac failure due to Ischaemic heart disease.
- The contemporaneous clinical records indicate that [Mr A] previously suffered from chronic obstructive airways disease, cardiomegally, bullous emphysema and

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was taking Captopril (an ACE inhibitor used in the treatment of hypertension and heart failure) Digoxin (used in the treatment of atrial fibrillation) Glyceryl trinitrate (used to treat angina) and Flixotide (a bronchodilator).
- The pre-existing Ischaemic heart disease was confirmed at post mortem by 'The aorta and major blood vessels showed moderate atheroma complicated by calcification, haemorrhage and thrombosis'.

2. Was a registered health professional involved in the provision of treatment?

- Yes, [Dr B], MD was directing treatment.
- [Dr B] had seen and examined [Mr A] when he attended [the public hospital] Emergency Department on 30/3/03.
- [Dr B] subsequently saw and discharged [Mr A] on the morning of 31/3/03.
- Nursing staff in [the hospital] were also involved in the provision of treatment (statements from [the registered comprehensive nurse and two registered nurses])
- None of the health professionals (above mentioned) failed to provide treatment of an appropriate manner to [Mr A].

3. If so, was the injury caused by medical error on the part of a registered health professional?

- No
- I can find no evidence of medical error on the part of any of the registered health professionals involved in the care of [Mr A].
- The treatment of [Mr A] on 30th and 31st March 2003 was appropriate to his condition.
- The treatment appears to have been correctly provided.
- The doctor and nurses involved provided care to a standard appropriate to the presenting complaint, clinical findings, past medical history and subsequent observation of the patient.
- There was no failure by any registered health professional to observe a standard of care and skill reasonably to be expected in the circumstances.

4. If the injury was not caused by an individual health professional, was the injury caused by medical error on the part of an organisation?

- No

5. If there is no evidence of medical error, does the claim meet the criteria for medical mishap?

- No
- The personal injury (death) did not result from treatment properly given, by or at the direction of a registered health professional.

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6. **Are there any issues of competency which ACC needs to refer to the relevant professional body and the Health and Disability Commissioner for investigation?**

   - No
   - The contemporaneous clinical records and subsequent reports indicate that [Mr A] was treated appropriately following his presentation to [the hospital's] A&E on 31/3/03. [Dr B] has taken an appropriate history and examined the patient according to an acceptable standard. Advice to be detained overnight for neurological observation was correct (despite reluctance of the patient) on account of the lack of clear competence of the patient to take his own discharge. There is clinical evidence that [Mr A] was under the influence of alcohol and post mortem examination of his blood identified residual amounts of alcohol (8mg per 100 ml). In the absence of brain CT a period of 4 hours neurological observations is generally recommended following head injury with return of normal consciousness. This is complicated by the presence of alcohol and overnight observation is generally regarded as the appropriate level of care when minor head injury co-exists with alcohol intoxication. The neurological observations remained stable overnight as reported in the nursing record.
   - Note has been made by the complainant that no ECG was taken on arrival. In the light of the presentation and lack of complaint of chest pain this was not unreasonable. There is no documented evidence of seizure and in the light of his subsequent neurological recovery following a period of unconsciousness on the evening of 31/3/03 (and lack of brain injury on post mortem) it can be assumed that [Mr A] suffered a period of concussion following a fall complicated by alcohol intake. His incontinence of urine can be attributed to his altered neurological state and intoxication. On presentation he was noted to have a GCS of 14 indicating mild neurological impairment. By 22.50hrs his pulse was 92 and his oxygen saturation was 92%. He declined further recordings. The following morning, although short of breath he was able to eat breakfast. There is no evidence that [Mr A] collapsed or died from Myocardial Infarction.

7. **If the claim meets the criteria for medical misadventure, does it raise any issues that in the public interest ACC should report to the appropriate authority?**

   - No."

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Appendix 2 – ACC decision

"**Medical Misadventure Report to Claimant**

Claimant full name: Est [Mr A]
Date of birth: 29/06/1924
Claim number: […]
Date of incident: 31/03/2003
Medical speciality: Medical

This report summarises ACC's findings in relation to the above medical misadventure claim.

Physical injury caused by medical treatment
For ACC to accept cover for a medical misadventure claim, the following must apply:

- There must have been a personal injury, which was caused when the claimant was seeking or receiving medical treatment from, or at the direction of, a registered health professional; and
- The injury must have been caused by medical error, or medical mishap.

In this case based on the information available there was a presentation at the Emergency Department, the hospital on 30/03/2003. The clinical record records that there had been a fall resulting in skin wounds to the face and head, and concussion was a possibility. There is no evidence of an acute chest complaint, but pre-existing medical history was acknowledged and considered within the treatment plan; there were known heart and lung conditions.

An additional complication was evidence of alcohol intoxication. The autopsy report shows residual alcohol in the blood and urine.

The treatment plan was to admit overnight under observation and see what would reveal itself. The clinical record accounts for these observations which show no relative cause for concern. The subjective notations do not show any relative cause for concern.

Discharge was organised on 31/03/2003 and was appropriate given the clinical picture, the follow-up after discharge and at the direction of the Est claimant.

Shortly after discharge, there was a collapse in the vicinity of the hospital car park, which required resuscitation. The resuscitation was not successful and death was pronounced at about 1055 hours.

Cause of death
The autopsy report by [the pathologist] records the cause of death as:

> '*Acute cardiac failure due to ischaemic heart disease.*'

This cause of death is not a physical injury caused as a result of medical treatment.

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[Dr C] in his independent advice writes:

> *'The pre-existing Ischaemic heart disease was confirmed at post mortem by the aorta and major blood vessels showed moderate artheroma complicated by calcification, haemorrhage and thrombosis,' and*
>
> *'There is no evidence that [Mr A] collapsed or died from Myocardial Infarction.'*

The Injury Prevention, Rehabilitation and Compensation Act 2001, Section 26 (2) states:

> *'Personal injury does not include a cardio-vascular or cerebro-vascular episode unless it is a personal injury of a kind prescribed in section 20(2) (i) or (j).'*

The cause of death was not caused by a registered health professional, therefore, a medical misadventure did not occur.

In the absence of a personal injury caused by medical misadventure, medical error and mishap can not occur. However, ACC will still make comment on error.

Medical error

Medical error occurs where a registered health professional or organisation fails to observe a standard of care and skill reasonably to be expected in the circumstances. Medical error can arise in giving treatment; deciding whether or not to give treatment; deciding what treatment to provide; obtaining consent to treatment; or diagnosis.

In this case based on the information available there was an issue of no ECG taken on arrival. This is reasonable in the circumstances given the salient reason for presentation and no presence of any cardiac symptoms. The level of observation as part of the plan is appropriate.

[Dr C] in his independent advice writes:

> *'In the light of the presentation and lack of complaint of chest pain this was not unreasonable,' and*
>
> *'In the absence of brain CT a period of 4 hours neurological observations is generally recommended following head injury with return to normal consciousness.'*

In this case based on the information available there is no medical error. [Dr C] in his independent advice writes:

> *'None of the health professionals failed to provide treatment of an appropriate manner to [Mr A],' and*
>
> *'There was no failure by any registered health professional to observe a standard of care and skill reasonably to be expected in the circumstances.'*

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Summary
The claim is declined because a personal injury can not be demonstrated as causally linked to the treatment given or at the direction of the health professional. [Mr A] died as a result of a pre-existing health problem. When a personal injury is not caused by medical misadventure a medical error or medical mishap can not be considered.

The issue of pertinence of the use of ECG and CT scan has been raised. Whist there is no medical misadventure in this claim, it is worth consulting [the] Medical Director to assess if any pertinent points outside of this medical misadventure claim need some form of consideration by the hospital or in general.

If new evidence is provided that demonstrates a personal injury caused by medical misadventure then ACC may reconsider the claim.

Information considered
ACC used the following information in assessing this claim:

1 Treatment details sheet
2 Clinical records from [the public hospital]
3 Medical report from [Dr B], Medical Doctor
4 Medical report from [the registered comprehensive nurse]
5 Medical report from [the] registered nurse
6 Medical report from [the] registered nurse
7 Medical report from [a] General Practitioner
8 Autopsy report from [the] pathologist
9 Independent advice from [Dr C], Consultant in Emergency Medicine."

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