General Practitioner, Dr B

An Accident and Medical Clinic

A Report by the

Health and Disability Commissioner

(Case 03HDC06973)

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

Parties involved

Master A	Consumer
Ms A	Complainant / Consumer's mother
Mr A	Consumer's father
Dr B	General Practitioner / Provider
Ms C	Nurse
Dr D	Paediatrician / Advisor to ACC
Dr E	Paediatric Intensivist
An Accident and Medical Clinic	Medical Centre / Provider

Complaint

On 15 May 2003 the Commissioner received a complaint from Ms A about the service her son, Master A, received from Dr B at an accident and medical clinic (the Clinic) on 21 February 2003. The complaint was summarised as follows:

On 21 February 2003, Dr B did not provide services of an appropriate standard to Master A. In particular, Dr B did not:

- *undertake adequate investigation into Master A's condition*
- *diagnose Master A with meningococcal disease*
- *refer to secondary medical services for follow-up*
- *advise Ms A what symptoms would indicate meningococcal disease and to be alert for in the immediate period after leaving the clinic.*

An investigation was commenced on 3 June 2003.

Information reviewed

- Information provided by:
  - Ms A
  - Dr B
  - The Clinic
  - Nurse Ms C
  - ACC
  - A Public Hospital

Independent expert advice was obtained from Dr Ian St George, a general practitioner.

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Information gathered during investigation

Background
This complaint concerns Dr B, whom Ms A consulted when she took her two-and-a-half-year-old son, Master A, to the Clinic on 21 February 2003. Master A had woken at about 10.30am that morning, vomited three times within half an hour, did not like the light or being picked up, and was drowsy.

Ms A took Master A to the nearest medical centre, which was the Clinic. Master A was seen initially by registered nurse Ms C at 11.35am. Ms C noted that Master A was "listless, feverish, shaky, vomiting x 3 past 30 mins, light sensitive" and had a temperature of 38.9º.

Ms C said that she was concerned that Master A had a high temperature, looked unwell and had not had any medication. She then went to speak to Dr B about Master A. Dr B examined Master A immediately.

Ms A said that she asked Dr B whether Master A might have meningitis. She stated that "[Dr B] … examined [Master A], made him look left and right and simply said no it is a virus. I informed him that [Master A] seemed sore, so he prescribed painkillers and sent me on my way."

Master A was examined by Dr B at 11.35am. Dr B's notes record:

> "Noticed fever, grizzly, wt 14kg, runny nose, occ. cough, vomited x 3 today, no diarrhea, (reduced) drinking/(reduced) eating, mild to moderately distressed, febrile, chest/throat/ears clear, (no) lymph (nodes enlarged), (no) neck stiffness, (no) skin rash, abdo unremarkable. (Diagnosis) Viral illness likely – ? early URTI +/- gastroenteritis."

Dr B stated that he examined Master A to exclude meningococcal disease. The medical notes record that no rash was present, and he had no palpable cervical lymphadenopathy (disease of the lymph nodes). "His neck was examined carefully by asking him to perform neck movements from side to side and looking up and down which he was able to do without problems. There was no evidence of neck stiffness indicating meningeal irritation."

Dr B stated that from his examination of Master A he formed the opinion that Master A had a virus, with probable upper respiratory tract infection and gastroenteritis. Dr B prescribed paracetamol to control Master A's temperature. Ms C gave Master A a Pamol suppository according to verbal instructions from Dr B at 11.40am, and this was recorded in the notes.

Dr B explained that "it is very difficult to detect meningococcal disease at the early stage because the signs and symptoms are very much like those of common viral illnesses. When I examined [Master A] there was no evidence of meningococcal disease, with no neck stiffness or skin rash."

Dr B recalled that he advised Ms A to observe Master A carefully, and give him small amounts of fluid regularly to keep him hydrated. Dr B also told Ms A to watch for a rash, and to seek urgent medical attention if she found one, or if Master A did not get better. Ms

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A does not recall Dr B giving this advice, but says she already knew the symptoms to look for as her friend's child had been sick with meningitis. Ms C said she heard Dr B talking to Ms A about Master A's condition and ongoing care, but cannot recall exactly what he said.

Ms C was aware that Ms A was very concerned about Master A, and offered to look after him while Ms A filled the prescription at the pharmacy across the road. Ms C said of Ms A that "she looked tired and was on her own with [Master A] and I thought it might be easier for her to obtain the prescription without the concerns of coping with a sick child in the pharmacy". While Ms A was in the pharmacy, Master A drifted in and out of sleep but did not vomit, was not shaking and had no signs of a rash. Ms C stated that "as an experienced senior nurse I did not assess his condition to be serious at that time, although he did look an unwell, feverish looking toddler". Ms A returned from the pharmacy and took Master A home.

Ms A stated that Master A went to sleep when they returned home, but she had to check him regularly as he was vomiting in his sleep. She noticed a rash on Master A at approximately 3.30pm and that he was still vomiting, was feverish and drowsy, did not like to be picked up, and would not open his eyes unless it was dark. Ms A decided to take Master A to hospital. Master A was admitted to a public hospital at 7.43pm with signs of shock and was diagnosed with meningococcaemia. Master A was transferred to a children's hospital at 10pm that evening.

Master A was in a drug-induced coma for two weeks, and remained in hospital for two and a half months. He suffered renal failure, had his right foot amputated, and lost his thumb, index and middle fingers on his right hand. He also has extensive permanent scarring to both legs, right hand and arm, left hand, bottom, face, groin, and neck because of septicaemia.

Ms A has complained that Dr B was blasé and casual, and did not share her concern about the seriousness of Master A's condition, or that he might have meningitis. She has also questioned why Dr B did not send Master A to hospital for further tests.

Expert advice

I requested independent expert advice from Dr Ian St George, a general practitioner. The advice is quoted in full below. Dr St George advised that the service provided by Dr B fell within accepted standard practice. However, Dr St George did note that Dr B had not made himself available to the family to discuss what had happened.

Advocacy

As a result of Dr St George's advice, I considered that Ms A should have the opportunity to discuss her complaint with Dr B. To this end the matter was referred to an advocate, and a copy of Dr St George's advice was sent to both parties to assist them. Unfortunately, the advocacy process was not successful and no meeting took place. Ms A wrote to me further clarifying her concerns about the care provided by Dr B.

I sought further advice from Dr St George regarding these concerns. His further advice is quoted below.

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ACC
Ms A submitted a claim on Master A's behalf to the Medical Misadventure Unit of ACC about the services provided by Dr B. ACC obtained the advice of an independent expert, Dr D, a paediatrician. Copies of Dr D's advice and the ACC decision are attached as Appendix 1 and Appendix 2 respectively.

On 2 March 2004 ACC advised Ms A that her claim had been accepted as medical error.

A copy of the ACC decision and Dr D's advice was forwarded to Dr St George for his opinion. Dr St George's further advice is quoted below.

Response to provisional opinion
Ms A and Mr A responded to the Commissioner's provisional opinion on 14 June 2004.

Independent advice to Commissioner

Initial advice
The following expert advice was obtained from Dr Ian St George, an independent general practitioner:

> "1. My full name is Ian Michael St George. I am an Otago Medical School graduate and have MD, FRACP, FRNZCGP. I work as a general practitioner in Wellington, am Medical Advisor to the Medical Council of NZ, and Medical Director of Healthline. I have held various academic appointments at Senior Lecturer level, and was Postgraduate Dean at the Wellington School of Medicine, and recently Chief Censor for the Royal NZ College of General Practitioners. I am an advisor for the Health and Disability Commissioner and the ACC.
>
> I respond to your letter of 28 July 2003 seeking advice in relation to [Ms A's] complaints against [Dr B]. I am asked to advise the Commissioner whether [Dr B] provided services to [Master A] that complied with appropriate standards. [Ms A] complains that on 21 February [Dr B] failed to diagnose meningitis with dire consequences for [Master A], that (in her words) '[Dr B] was careless and we were let down by his medical examination and diagnosis'. She asks for a letter of apology, compensation, and a personal meeting with [Dr B].
>
> 2. You ask me to advise on whether [Dr B] provided services with reasonable care and skill, and in accordance with proper professional standards, and on
> - whether [Dr B's] examination of [Master A] was reasonable, given [Master A's] symptoms and [Ms A's] concerns, when [Master A] presented to the clinic on 21 February 2003;
> - whether the conclusions that [Dr B] drew from his examination of [Master A] and diagnosis were reasonable in the circumstances;

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- what information I would expect a GP practising in similar circumstances to give to a parent about meningococcal disease;
- whether [Dr B's] actions were reasonable in respect of treatment; whether he should have referred [Master A] on to secondary services.
- What other follow-up would have been reasonable after [Master A] left the surgery;
- What the relevant standards are, relating to this complaint, and whether [Dr B] complied with those; if there was a departure from those standards, what its degree was;
- Other professional standards matters.

3. I have read your paper detailing the background, summarising the complaint, listing the supporting information, and detailing the advice you seek; I will not retype that information here.

4. I have assessed whether the doctor's actions were reasonable in the circumstances by the standards of the profession, as far as they have been stated or previously judged, at the time of the incidents. I state here I have no personal, financial or professional connection with any party that could bias my assessment.

5. I make the following points.

- A proportion of the population carry the meningococcus bacteria without symptoms; that is, there is a balance between the person's ability to defend against invasion of their body by the bacteria, and the invasive quality of the bacteria themselves. These people are *asymptomatic meningococcus carriers*.
- Sometimes these people develop invasive disease – either *meningitis* where the membranes covering the brain and spinal cord become infected; or *septicaemia* where the bacterium multiplies in the blood. These are the two forms of *meningococcal disease*.
- The question is, what upsets that balance and triggers the normally quiescent bacteria to become invasive?
- Some theorists suggest a mutation, rendering a clone of bacteria more invasive;
- Others suggest all such bacteria have the potential to invade, and that the actual invasion is the result of altered resistance in the carrier.
- That resistance may be altered by severe viral upper respiratory infection.
- It is important to understand the sequence; a healthy meningococcus carrier gets a severe viral infection, attends a doctor who rightly diagnoses viral infection, and later develops invasive disease.
- In that case, at the stage early in their illness when many of the people who develop meningococcal disease present to primary care doctors, they probably do not even have meningococcal disease.
- Indeed, the statistics in New Zealand appear to support that interpretation of events – most cases of invasive disease admitted to hospitals have been seen earlier by a doctor and the diagnosis 'missed'.
- [Master A] did not have meningitis; he had meningococcal septicaemia. Thus he would not have been expected to have headache or neck stiffness, and indeed he did not when he was admitted to hospital.

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6. I note further

- [Dr B] was faced with a sick child whose mother expressed concerns about meningococcal disease, and who [Ms C], the clinic nurse, had noted was 'listless, feverish, shaky, vomiting x 3 past 30 mins, light sensitive' and had a temperature of 38.9 deg C. There was past asthma, no allergies, but a dislike for Pamol.
- He wrote (contemporaneous clinical record), 'Noticed fever, grizzly, runny nose, occ. coughing, vomited x 3 today, no diarrhoea, (reduced) drinking/(reduced) eating. On examination mild to moderately distressed, febrile, chest/throat/ears clear, (no) lymph (nodes enlarged), (no) neck stiffness, (no) skin rash; abdo unremarkable. (Diagnosis) viral illness likely - ? early URTI +/- gastroenteritis.'
- He recorded he gave Pamol, advised on cooling measures, and suggested small amounts of fluids frequently.
- [Ms C] wrote, 'As an experienced senior nurse I did not assess his condition to be serious at that time, although he did look an unwell, feverish looking toddler.'

7. In my opinion

- [Dr B's] letter and contemporaneous records are supported by [Ms C]' statements.
- He did provide services with reasonable care and skill, in accordance with proper professional standards.
- His examination was reasonable; he looked for rash and neck stiffness and did not find them. He did not note, or later comment on the photophobia (light sensitivity), but although this is a recognised symptom of meningitis, it is common in other severe viral illnesses, and [Master A] did not have meningitis.
- [Ms A] wrote that her 'family doctor was shocked that [Dr B] sent [Master A] away with no blood or urine tests'. I am not shocked by [Dr B's] failure to investigate, and doubt if any general practitioner would have ordered investigations, knowing the results would be unlikely to be helpful.
- [Dr B's] conclusions were reasonable, are supported by [Ms C's] observation, and were in all likelihood accurate, as I suggest above: [Master A] was probably not suffering meningococcal disease when [Dr B] saw him.
- [Dr B's] records show he advised fluids and cooling measures; he states in his letter, 'I advised [Ms A] to observe him carefully and to give him small amounts of fluid frequently to maintain hydration. I also advised her to watch out for any skin rash. I advised her to seek urgent medical attention … if a rash occurred or he did not get better.'
- On the other hand, in the notes taken after a phone call between [investigation staff] and herself, [Ms A] is reported as saying 'the doctor was very blasé and casual and did not share [Ms A's] concern about [Master A] …'. She did not remember parts of [Dr B's] examination that are clearly recorded in the contemporaneous clinical record, nor 'what symptoms to look for if it was meningitis' – though she knew these anyway.
- [Dr B's] treatment was appropriate; there was no indication to refer [Master A] when he saw him. Resource constraints quite simply do not allow referral of all such children for second opinions, and in any case the second opinion would be likely to be the same: [Master A] appeared to have a viral illness, and probably did.

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- [Dr B's] advice about watching out for signs of invasive meningococcal disease was appropriate; no other follow-up appeared necessary at that time.
- The standards of care that apply here are those of a competent practitioner dealing with a similar presentation. I do not believe [Dr B's] management of [Master A] departed from that standard.
- I am concerned that [Dr B] has not been available to speak with [Ms A]: the evidence on complaints is clear: they arise from poor communication more often than from medical errors.

8. [Master A] has suffered a terrible illness, and he and his family will suffer the consequences all his life. Naturally they are angry. That anger has been inappropriately directed at [Dr B's] medical management, and with no opportunity for communication with him, has persisted."

Additional advice

Dr St George provided the following further advice in response to additional questions and Ms A's letter of 2 December 2003:

"I respond to your letter of 29 January 2004 seeking further advice in relation to complaints against [Dr B].

You ask:

- what symptoms should be looked for when there is a possibility of meningococcal disease, and
- what examinations are appropriate, and in particular
- whether a central nervous system examination should have been done.

Symptoms: I note the following from the Health Ministry website:

'At first it can be hard to tell meningococcal disease from other similar illnesses such as influenza. The illness may quickly get worse – sometimes in just a few hours – and this is why it is important to keep your eye on people who rapidly become ill.

Parents or caregivers are warned a baby or child may be seriously ill if they:

- Have a fever
- Refuse drinks or feeds
- Are sleepy or floppy
- Are hard to rouse
- Vomit
- Are crying or unsettled
- Have a rash/spots
- Have a headache
- Dislike bright lights'

I agree. Nearly all of those symptoms are not only those of meningococcal disease but are also those of any severe viral illness. It is not until the child is hard to rouse or the

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rash appears that the diagnosis is clear, and by then a good deal of damage has already been done. That, sadly, is the nature of what we are all trying to deal with.

Examinations: a full examination of the skin for rash is critically important, but most children are presented before the rash appears, as [Master A] was.

What is important here is to try to separate the child with early meningococcal disease from the many children with severe viral infections – to send them all to hospital would overwhelm already stretched services. There is no single examination, or set of examinations that will do this: most often there will be a feeling, an undefinable sense that something is different about this child, that this child is really ill and different from the others: something called clinical nouse.

Having said that, I reiterate my point in my earlier opinion: many children who later develop invasive meningococcal disease do have only a viral illness when they are first presented. [Dr E's] conclusions (that there was 'early misappreciation of the diagnosis' and 'failure of recognition of the condition prior to hospital arrival'), if they were meant to apply to [Dr B], are unwarranted.

Central nervous system examination: there is no indication for a CNS examination other than to exclude meningitis (neck stiffness and kernigism). Neither [Dr B] nor the admitting officer at [the children's hospital] found neck stiffness. Furthermore a CNS examination was not recorded by the admitting officer at [the children's hospital], and I can find no mention of neurological abnormality on admission anywhere in the files you sent me.

Additional comments: While it is quite possible that earlier treatment would have been associated with a better outcome, there is nothing to suggest earlier diagnosis was possible at the time [Dr B] saw the child.

If indeed [Dr B] is known for his 'casual laugh a lot attitude' he may wish to take steps to alter that perception. What is at issue here, however, is whether he made a thorough clinical assessment of [Master A] when he saw him, or whether he should have done more to make a diagnosis of meningococcal disease.

I see no evidence to lead me to alter my opinion of 30 July:

[Dr B's] treatment was appropriate; there was no indication to refer [Master A] when he saw him. Resource constraints quite simply do not allow referral of all such children for second opinions, and in any case the second opinion would be likely to be the same: [Master A] appeared to have a viral illness, and probably did.

[Dr B's] advice about watching out for signs of invasive meningococcal disease was appropriate; no other follow-up appeared necessary at that time.

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> The standards of care that apply here are those of a competent practitioner dealing with a similar presentation. I do not believe [Dr B's] management of [Master A] departed from that standard."

Further additional advice

Dr St George provided further advice in response to the ACC decision and expert advice as follows:

> "I respond to your letter of 6 April 2004 seeking advice further to my reports of 30 July 2003 and 4 February 2004 in relation to complaints against [Dr B]. You ask me to comment on
> 1. the apparent brevity of [Dr B's] consultation;
> 2. the significance of not recording the respiratory or heart rate, and assessment of [Master A's] level of hydration;
> 3. the absence of any comment by [Dr B] on the observations of shakiness or light sensitivity recorded by nurse [Ms C];
> 4. the absence of any recorded management plan.
>
> I have read the papers in the file you sent, including duplicates of earlier papers, as well as
> 1. [Master A's] parents' letter dated 2 December 2003 seeking a second opinion to mine.
> 2. The ACC papers, including a report from the ACC Panel, and the letter from [Dr D].
>
> I will address your specific questions
> 1. Most general practitioners book four to six patients per hour, allowing 20 minutes to half an hour or longer for complex cases with multiple chronic illnesses, and shorter periods for acute illnesses. Five minutes was an adequate period to conduct this consultation; in that time it is easy to establish the severity of a patient's illness, and at the time of the consultation there were no signs of meningococcal disease. As I have stated earlier, [Master A] may not at the time of the consultation, have been suffering more than a severe viral illness, only later developing meningococcal invasion. [Dr D] wrote, 'We know (from retrospect) that [Master A] was in the early stages of meningococcal septicaemia when he was seen by [Dr B] …' I suggest, with respect, we do not know that. The contemporaneous (ie not retrospective) evidence from [Dr B] and [Ms C] is that the child had a viral illness at the time they saw him.
> 2. I cannot recall when I last recorded the respiratory rate or heart rate in a child who appeared to have an acute viral infection, unless there was evidence of lower respiratory tract involvement; in every case of fever the heart rate is raised, so these measures add no useful information. Dehydration is a common effect of diarrhoea, but is rare from fever alone; I usually note the state of hydration in a child presenting with diarrhoea, but can see no advantage in doing so otherwise – I am aware when noting the state of hydration that it is clinically a very difficult state to assess.

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3. As I noted on 30 July, 'He did not note, or later comment on the photophobia (light sensitivity), but although this is a recognised symptom of meningitis, it is common in other severe viral illnesses, and [Master A] did not have meningitis.' I would say the same for the shakiness: shivering is common in high fever from viral illness, as [Dr D] noted: it does not necessarily signify a rigor from bacterial infection.
4. There is a recorded management plan – 'Pamol 125mg pr, prn-qid, cooling measures, Brufen prn-tds. Review GP follow-up prn'. That is as much as most general practitioners would record, and supports [Dr B's] contentions on what he advised. I place no importance on [Dr D's] suggestion that the difference between Pamol and paracetamol implies a 'lack of attention to detail', and I find his arguments in his (5) speculative and circular.

I cannot comment on [Dr B's] communication skills (eg the parents' contention that [Dr B] is jocular and blasé), but reiterate what I wrote on 30 July, 'I am concerned that [Dr B] has not been available to speak with [Ms A]: the evidence on complaints is clear: they arise from poor communication more often than from medical errors."

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.

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) And explanation of the options available, including an assessment of the expected risks, side effects, benefits, and costs of each option;…

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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.

Ms A has complained that Dr B did not diagnose her two-and-a-half-year-old son, Master A, with meningococcal septicaemia. Ms A is concerned that Dr B was too casual in his examination and diagnosis, and did not exercise caution and send Master A to hospital for further tests. She alleges that the delay in diagnosing Master A with meningococcal septicaemia was unreasonable.

There is no dispute that Master A has suffered from meningococcal septicaemia, and continues to suffer from the effects of the disease. It is alleged that Dr B should have diagnosed meningococcal disease when he saw Master A, or used caution and sent him to hospital for further tests. I do not accept that for the reasons set out below.

Master A was first seen at an Accident and Medical Clinic by Ms C, registered nurse, at approximately 11.25am. Ms C said she assessed Master A and recorded in the medical notes that he was listless, feverish, shaky, had vomited three times within half an hour and was light sensitive. Master A also had a temperature of 38.9°C. Ms C stated in her response that she observed that Master A was a pale, listless, sick-looking toddler, but did not think he was seriously ill.

Ms A was very concerned about Master A's condition and asked Dr B if he had meningitis. In response, Dr B asked Master A to look left and right, and then told her that Master A had a virus, and not meningitis.

Dr B recorded that Master A presented with fever, vomiting and agitation. In addition, Dr B said Master A was grizzly, had a runny nose and occasional cough. Dr B also noted that Master A had had reduced food and fluid intake, but no diarrhoea. On examination, Dr B recorded that Master A was mild to moderately distressed, but his chest was clear, throat and ears were normal, and his abdomen was soft and non-tender.

Dr B stated that he examined Master A carefully in order to exclude meningococcal disease. He said he thoroughly examined Master A's skin and observed that no rash was present. Dr B also stated that Master A did not have any palpable cervical lymphadenopathy. He examined Master A's neck by asking him to perform neck movements from side to side and to look up and down, and there was no evidence of neck stiffness that would indicate meningeal irritation.

I note that Ms A did not notice a rash on Master A until approximately 3.30pm that afternoon, four hours after Dr B's examination.

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My advisor stated that a proportion of the population carry the meningococcus bacteria without symptoms. Sometimes carriers develop invasive disease. The sequence is that a healthy meningococcus carrier develops a severe viral infection, and later develops invasive meningococcal disease. Dr St George noted that some theorists believe that resistance to the disease may be reduced or changed by severe viral upper respiratory infection. In addition, he commented:

> "… [A]t the stage early in their illness when many of the people who develop meningococcal disease present to primary care doctors, they probably do not even have meningococcal disease … the statistics in New Zealand support that interpretation … most cases of invasive disease admitted to hospitals have been seen earlier by a doctor and the diagnosis 'missed'.
>
> [Master A] did not have meningitis; he had meningococcal septicaemia. Thus he would not have been expected to have headache or neck stiffness, and indeed he did not when he was admitted to hospital."

Ms A stated that "[her] … family doctor was shocked that [Dr B] sent [Master A] away with no blood or urine tests". My advisor commented that he was not surprised that Dr B did not investigate further by requesting such tests, and doubted if any other general practitioner would either, as it was unlikely that the results would have been helpful.

My advisor commented that there is no examination that will distinguish a child with a serious viral infection from one with early meningococcal disease; rather, it is a sense that a child is different from other very ill children, something he describes as "clinical nouse". Dr St George stated that many children who later develop meningococcal disease do initially only have a viral illness when they first present.

My advisor also commented:

> "… [Dr B's] examination was reasonable; he looked for rash and neck stiffness and did not find them. He did not note, or later comment on the photophobia (light sensitivity), but although this is a recognised symptom of meningitis, it is common in other severe viral illnesses, and [Master A] did not have meningitis."

ACC obtained advice from Dr D, a paediatrician. He advised that Dr B's examination appeared cursory given Master A's condition, and that the entire consultation seemed to take only five minutes. Dr D raised the issue that Dr B did not comment on Ms C's recordings of light sensitivity and shakiness.

Dr D stated that the heart rate may have been useful to indicate the severity of Master A's illness. Dr D also noted that the amount of Pamol written by him in the notes differed from what the nurse recorded as given to Master A, although he noted it was still a reasonable dose. He also noted that Pamol was recorded in the notes instead of Panadol, and said that this indicated a lack of attention to detail.

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Dr D further commented: "We know (from retrospect) that [Master A] was in the early stages of meningococcal septicaemia when he was seen by [Dr B] and that he got worse throughout the day with a rash appearing at 1530 hours." I note that Dr D also stated that Master A had "quite a high temperature, he had probably had rigors, he did not like the light and he had been vomiting. While these signs are not being diagnostic of meningococcal disease this boy sounds quite sick to me and I personally would not have been comfortable to send him home under those circumstances."

My advisor, Dr St George, responded to the advice from Dr D. In contrast to Dr D, my advisor stated that five minutes is an adequate timeframe for a general practitioner to conduct a consultation, and establish the severity of a patient's illness.

Dr St George said that where there is a fever the heart rate will naturally be raised, so it adds no useful information to record a patient's heart rate. He could not recall the last time he recorded the heart or respiratory rates in a child who appeared to have a viral infection for this reason. Dr St George also noted that the level of hydration is clinically very difficult to measure, and is usually noted only where a child presents with diarrhoea as well as fever. This is because dehydration is common with diarrhoea, whereas it is rare with fever alone. I note that Master A did not have diarrhoea.

In addition, Dr St George advised that while light sensitivity is a recognised symptom of meningococcal disease, it is also a common symptom in other severe viral illnesses. Shivering is also common where there is a high fever associated with viral illness. It does not necessarily follow that a patient has rigors. Dr St George noted Dr D's comment that a high temperature, rigors, light sensitivity and vomiting are not diagnostic of meningococcal disease. In any event, Dr D stated that "[Master A] could not have had meningococcal disease definitively diagnosed at that early stage …".

Dr St George advised that he placed no importance on Dr D's observations about the interchange of the terms Pamol and Panadol. He also disagreed with Dr D's assertion that we now know that Master A was in the early stages of meningococcal disease when Dr B saw him. Dr St George stated that the evidence from Dr B and Ms C from records made at the time of the consultation, is that Master A appeared to have a viral infection.

Dr St George advised that Dr B provided services in accordance with proper professional standards, and with reasonable care and skill.

As Dr B is a general practitioner, it is appropriate that I obtain independent advice from a peer general practitioner in forming my own opinion of the appropriate standard of care. This is because a peer can fairly comment on the situation with an appreciation of the circumstances the provider faced at the time.

It is clear from the information provided that meningococcal disease is very difficult to diagnose until the more invasive symptoms, such as a rash, appear. It is a disease that may develop rapidly over a few hours with devastating and even fatal results. Unfortunately, there are no definitive tests that will establish that a patient has meningococcal disease in its early stages.

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I accept my advisor's view that if Dr B carried out the consultation described in his response to my investigation, it was appropriate and in accordance with professional standards. I agree that Master A may have had only a viral illness when Dr B saw him that morning, and that it progressed rapidly in the afternoon, and it was not until 3.30pm that meningococcal disease was evidenced by a rash. Alternatively, Master A may have been in the early stages of the disease when he was at the clinic, but was not exhibiting sufficient signs of the disease in order for a diagnosis of meningococcal disease to be made at that point.

After considering the information and advice I have received, it appears that it is not possible to state whether Master A had meningococcal septicaemia when he was examined by Dr B. It is clear, however, that Master A appeared to have a virus. While earlier medical intervention may have prevented the complications that Master A has suffered, there is no evidence that Master A had meningococcal disease at the time Dr B saw him, and therefore no indication that further medical intervention was necessary at that time. As my advisor noted, Dr B's treatment was appropriate.

Accordingly, after considering all the evidence gathered, including my advisor's comments, the ACC decision and expert advice, I am satisfied that the care provided by Dr B to Master A was reasonable, and that Dr B did not breach Right 4(1) of the Code.

Information
Under Right 6 of the Code, patients are entitled to information that is reasonable in the circumstances. This includes an explanation of their condition, the options available, the expected risks, and any side effects, benefits and costs of treatment.

Ms A stated that she did not recall Dr B advising her about the symptoms of meningitis or what to do if she thought Master A developed any of the signs. Ms A commented that she already knew of the symptoms that indicate meningitis, as a friend's child had developed it. When she questioned whether Master A had meningitis, Dr B told her that Master A had a virus.

Dr B stated that he advised Ms A to watch for any skin rash, and to seek urgent medical attention if one appeared, or if Master A did not improve.

Dr D noted that Dr B's records do not indicate that Ms A was advised how to recognise a meningococcal rash, or how urgently she should seek medical assistance if one appeared. My advisor stated that Dr B's notes were as much as most general practitioners would record, and supports what Dr B stated he advised Ms A to do if a rash appeared.

My advisor stated that Dr B's advice regarding looking for symptoms of invasive meningococcal disease was appropriate under the circumstances.

In my opinion, it is unclear precisely what information Dr B gave to Ms A regarding meningococcal disease. It does appear, however, that Dr B gave Ms A advice regarding a rash.

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Follow-up / referral to secondary medical services
Ms A is concerned that Dr B did not take a cautious approach and refer Master A to hospital for further investigation.

Dr D stated that "[Master A] could not have had meningococcal septicaemia definitively diagnosed at that early stage, but to me he sounded sick enough, if not to be referred immediately to ED then at least to have a specific plan made to reassess him unless he rapidly improved".

My advisor stated:

> "… [T]here was no indication to refer [Master A] when he saw him. Resource constraints quite simply do not allow referral of all such children for second opinions, and in any case the second opinion would be likely to be the same: [Master A] appeared to have a viral infection, and probably did."

My advisor said that Dr B's advice to Ms A to watch for a skin rash was appropriate, and that no further follow-up appeared necessary.

I accept that it is not possible for all ill patients to be referred for a second opinion. Given that Ms A was concerned that Master A might have meningitis, but there was no evidence that he had meningococcal disease at the time of the consultation, it was appropriate for Dr B to advise her to seek urgent medical attention if a rash appeared, or Master A's condition did not improve.

Accordingly, my opinion is that Dr B did not breach the Code in relation to this matter.

Further comment
My advisor stated that he was concerned that Dr B had not been available to speak with Ms A since the incident. I share this concern. The consequences of Master A's illness have had a severe impact on Master A and his family. Dr B should have contacted the family and made himself available to discuss any issues they had. Complaints to my Office are often the result of a lack of communication and understanding between the parties, and taking the initiative to address the issues promptly can save a lot of time and unnecessary ill feeling.

Dr St George also commented that if Dr B is known for his "casual, laugh a lot attitude" as described by Ms A, then he may wish to consider taking steps to change this image. I draw these comments to Dr B's attention.

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Opinion: No breach – Accident and Medical Clinic

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.

The Accident and Medical Clinic provided a copy of the meningitis policy and drug protocol for the clinic, as well as meningitis cards and pamphlets, which were available at the clinic. However, as Dr B did not breach the Code, the question of vicarious liability does not arise.

Actions

I recommend that Dr B take the following actions:

- In light of the comments made above, make himself available to Master A and his family to discuss what happened to Master A.
- In future make himself available to patients and their families after serious illnesses to discuss any issues they may have.
- Re-familiarise himself with the presenting symptoms for meningococcal disease and the relevant guidelines issued by the Ministry of Health to general practitioners, and review his practice accordingly.
- Review the information that he gives to patients and their families in light of Right 6 of the Code, and in particular on meningococcal disease.

Further 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 sent to the New Zealand Accident and Medical Practitioners Association and placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

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Appendix 1 – Dr D's Report to ACC

"16 February 2004

…
Medical Misadventure
ACC National Claims Unit
P.O. Box 1426
WELLINGTON

Fax …

Dear […]

Re: [Master A] b 8/5/2000
[…]

Thank you for asking me to review this file and comment on this case. It is alleged that a delay in making the diagnosis of meningococcal septicaemia was unreasonable and that this delay was responsible for the poor outcome in [Master A's] case.

[Master A] was logged at [the Clinic] in […] at 1125 hours on 21 February 2003 at an age of 2 years 9 months. He was subsequently seen by a nurse ([Ms C]) who recorded the following: *Listless, Feverish, shakey, Vomiting X* 3, *Light sensitive.*

The temperature was taken (38.9°C) but no other observations such as pulse rate or respiratory rate were recorded. Past history of Asthma was also noted as were '*ventolin, flixotide*' as medications. Under Allergies: '*nil known meds. Dislikes Pamol*' was recorded. These recordings were timed at 1135 hours.

He was then seen by [Dr B].

His notes are as follows:

Under History & Examination:

Noticed fever, grizzly, wt 14kg, Runny nose, occ. coughing, vomited X 3 today, No diarrhoea, ↓ drinking/↓ eating.

O/E Mild to moderately distressed.
Febrile
Chest/Throat/ears → clear

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°lymph/° neck stiff/° skin rash
Abd → unremarkable

=> *viral illness likely -? early URTI +/- gastroenteritis*

Under Diagnosis, Management, Discharge Plan, Treatment (R_x)

=> *pamol 125mg PR, PRN – qid*
cooling measures Brufen PRN – tds

Keep up with fluid – small amount frequently Review/GP f/u PRN
Signed [Dr B]

Pamol 250mg PR signed as given 11:40am by R [Ms C]

There are a number of comments about this consultation and the written notes that I would like to make.

1) It appears that [Dr B] took the history, performed the examination and completed his notes and prescription in no more than 5 minutes.

2) He suggested 'pamol' 125mg PR in his notes but this was changed to '250mg pamol PR' in the drug administration section and was signed as having been given by Nurse [Ms C]

3) 'Pamol' is a trade name for paracetamol and to my knowledge is available in this brand only as suspension and drops but not as a suppository. Paracetamol is available under the 'Panadol' brand as 125mg as 250mg suppositories. Mixing up trade names with generic names is unfortunately done frequently but when written down suggests a lack of attention to detail. I cannot but guess that the actual dose given was 250mg – a reasonable dose but it should have been clear exactly what he was given.

4) [Dr B] did not comment on all the nurse's recordings – in particular 'shakey' and 'light sensitive'. I interpret the fact that he was noted to be shaky earlier was a sign that he had been having rigors and while rigors can occur with some viral illnesses it is more likely to be at least a severe viral illness or a bacterial infection. It is also possible (but not likely) that he had had a febrile convulsion. [Dr B] did comment that he was '*mild to moderately distressed*'. It is unfortunate that the boy's heart rate was not recorded as this may have given a further clue as to the severity of his illness.

5) '*Review/GP f/u prn*' was mentioned but that alone does not imply that his mother was told how to recognise a meningococcal rash or how urgently her action should be if one appeared. He clearly documented the lack of neck stiffness and rash at the time and stated in his letter that '*it is very difficult to detect meningococcal disease at the early stage because the signs and symptoms are very much like those of*

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> *common viral illnesses*'. This would suggest that in a case like [Master A] that [Dr B] knew that he could still have meningococcal disease and that it would be a paediatric emergency once the diagnosis was made.

[Master A] was logged in at [the] Emergency Department (ED) at [the public hospital] at 1945 hours and required major resuscitation prior to being transferred directly from there to the Paediatric Intensive Care Unit (PICU) at [the children's hospital] at 2159 hours. I have perused the notes from [the] ED and feel that [Master A's] diagnosis was recognised promptly, together with the fact that he was shocked and severely unwell and that his management there was entirely appropriate.

It was also appropriate that he was transferred to [the children's hospital] PICU and I believe that the care provided there saved his life but was not able to prevent the severe compromise to his peripheral limb perfusion necessitating the amputation of his right foot and fingers of his right hand together with his problems with anuric renal failure.

The main question here is: Would another course of action have changed the outcome and if so is this a case of error or mishap.

In [Dr E's] letter of 9 September 2003 she states '*It is our clinical impression, however, that those who progress into anuric renal failure tend to be those in whom delayed resuscitation occurs, either by failure of recognition of the condition prior to arrival, as in this case, or slow initiation of fluid therapy after hospital admission.*' She clearly feels that there was a '*failure of recognition of the condition*'. We know (from retrospect) that [Master A] was in the early stages of meningococcal septicaemia when he was seen by [Dr B] and that he got worse throughout the day with a rash appearing at 1530 hours. There was a further 4 hours 15 minutes from the time the rash appeared at home until he was seen at [the] ED.

I do not believe that this further delay would have occurred if [Master A's] mother had really understood the urgency of the situation. I also cannot believe that it is possible to take a history, perform an examination, write the notes and treatment **as well as**: '*advise [Ms A] to observe him carefully and to give him small amounts of fluid frequently to maintain hydration. I also advised her to watch out for any skin rash I advised to seek urgent medical attention (either come back to the clinic or to her own GP, or to go to [the ED] in [the public hospital]) if a rash occurred or he did not get better.*' – **all in no more than 5 minutes**. Such an explanation alone should take at least 5 minutes not the whole consultation and explanation.

[Dr B] may have been under pressure of work to assess and diagnose [Master A] rapidly. Even although the history and examination appear cursory under the circumstances of quite a sick little boy, the prudent option would have been to refer him to [the ED] at that time for review. He had quite a high temperature, he had probably had rigors, he did not like the light and he had been vomiting. While these signs are not being diagnostic of meningococcal disease this boy sounds quite sick to me and I personally would not have been comfortable to send him home under those circumstances. He did not appear to be assessed for dehydration or shock (eg pulse rate

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was not measured and there were no comments about capillary return or skin turgor) and yet, in a vomiting child, he was prescribed small, frequent amounts of oral fluids, given one dose or other of rectal paracetamol and sent home.

There are many young children seen by GPs with temperatures, and non-specific signs and symptoms of various infections. [Master A] could not have had meningococcal septicaemia definitively diagnosed at that early stage, but to me he sounded sick enough, if not to be referred immediately to ED then at least to have a specific plan made to reassess him unless he rapidly improved. I believe that [Ms A] was reassured by her visit with [Dr B] – and she certainly did not seek urgent attention when his rash appeared at 1530 hours. She should have known that calling for an ambulance at that point would have been an appropriate response.

My overall assessment here is therefore that [Dr B] did fail to observe a standard of care and skill to be reasonably expected under the circumstances. While I believe that this failure was in itself one that occurs frequently in medical and allied health practice generally, in this case it had severe consequences for [Master A]. While I cannot prove that [Master A] would not have had his severe complications if the correct treatment had been started earlier it is, on the balance of probabilities, a fair assumption that the outcome would have been substantially better, with every likelihood that his limbs would have been preserved.

To answer the specific questions:

Physical Injury
Has the claimant suffered physical injury as a result of medical treatment?

Answer: Yes. I believe that he has. The injury has occurred because of a delay in the recognition and treatment for meningococcal septicaemia.

Causal Link
On the balance of probabilities, can the alleged injury be attributed to the treatment the claimant received?

Answer: Yes. I believe it can.

Medical Error
Is there an issue of medical error as defined by the Act?

Answer: Yes, I believe that [Dr B] did on this occasion fail to observe the standard of care and skill to be reasonably expected under the circumstances.

Medical Mishap
If this is not a case of error, then does this fit the medical mishap criteria?

Answer: Not applicable

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I therefore believe, from the evidence before me, that this claim should be accepted as error.

Please let me know if there are points that need further clarification or if any further information is required.

With kind regards

Yours sincerely

[Dr D]
MBChB, FRACP, FRCPCH
Paediatrician"

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Appendix 2 – ACC decision

"MEETING OF THE MEDICAL MISADVENTURE PANEL AT […] ON MONDAY 1 MARCH 2004

Panel

Barrister:	**[…]**
Lay Member:	**[…]**
General Practitioner of […] and Independent Advisor to ACC:	**[Dr …]**
Senior Clinical Advisor:	**[…]**

[Master A]: […]:

Issue:
Alleged negligent failure to diagnose meningococcal septicaemia.

History:
[Master A] was seen at [the Clinic] in […] on the morning of 21 February 2003. The triage time logged in by the Nurse, [Ms C], is given as 11:35am.

The clinical notes from [the Clinic] record the nurse's triage notes. She has recorded under 'Nurses Notes & Comments' concerning [Master A] the following:

listless, feverish, shakey, vomiting x 3, *light sensitive.*

[Ms C] has recorded his temperature as being 38.9°C. He had a history of asthma for which he was taking Ventolin and Flixotide. He had no known allergies to medications but she noted that he disliked Pamol.

It is not clear from the clinical notes when [Master A] was seen by [Dr B], the General Practitioner on duty. [Dr B] has taken a history which is recorded as follows:

> '*Noticed fever, grizzly, wt 14kg, runny nose, occ. coughing, vomited x3 today, no diarrhoea, ↓ drinking/↓ eating.*
> *O/E mild to moderately distressed. Febrile chest/throat/ears→. °lymph/no neck stiff/no skin rash.*
> *= => Abd →unremarkable.*
> *= => viral illness -?early urti +/- gastroenteritis.*'

In the section entitled diagnosis management and discharge plan and medications, [Dr B] has recorded:

> '*-=> Pamol 125mgPR, PRN-qid.*
> *Cooling measures. Brufen PRN-tds.*

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Keep up with fluid – small amount frequently. Review/GP f/u PRN.'

In the medication section it is noted that [Master A] was administered Pamol 250mg PR signed at 11:40am R [Ms C].

The Panel has before it a letter dated 10 May 2003 from [Master A's] mother, [Ms A].

She stated in her letter that [Master A] was vomiting and very lifeless and her concern was that he had the meningitis virus. She said she asked [Dr B] if he thought it was, that he examined [Master A], made him look left then right and told her it was not meningitis but a virus. She stated that she told [Dr B] that [Master A] seemed sore, whereupon he prescribed painkillers when the consultation was ended. She said the nurse sat with [Master A] as he was so sick while she went to get the prescription.

[Ms A] stated that following the consultation with [Dr B], she noticed a rash around 3:30pm in the afternoon but by the time she rushed [Master A] to hospital it was nearly too late.

On file are the notes from the Emergency Department at the Public Hospital. [Master A] was first seen in the Emergency Department at [the public hospital] at 1945 hours on the evening of 21 February 2003. His history was documented as being unwell for one day with a fever, cough, wheeze, vomiting x 10 and some loose stool. He had become more lethargic over the evening and had developed a generalised petechial rash over an hour. It was clear that [Master A] was very unwell with clinical signs consistent with meningococcal septicaemia and septic shock. He had a rash consistent with this disease which spread rapidly while in the Emergency Department and he required resuscitation. After treatment in the Emergency Department in [the public hospital], [Master A] was subsequently transferred from the Emergency Department at [the public hospital] to the Paediatric Intensive Care Unit at [the children's hospital].

There is also on file a letter of 9 September 2003 from [Dr E], Paediatric Intensivist at [the children's hospital]. In her letter, [Dr E] has set out [Master A's] extremely stormy course following his admission with what is described as fulminant meningococcal septicaemia late in the evening of 21 February 2003. Despite full maximal therapy and early resuscitation at presentation, [Master A] progressed to anuric renal failure. His full meningococcal septicaemia necessitated the amputation of [Master A's] right foot and ankle and also the loss of thumb, middle and index fingers of his right hand.

In his letter of 18 June 2003 to the Health and Disability Commissioner, [Dr B] stated that he had made the diagnosis of a viral illness with probable early upper respiratory tract infection and gastroenteritis. He stated that he advised the child's mother to observe [Master A] carefully and to give him small amounts of fluid frequently to maintain hydration. He stated he also advised her to watch out for any skin rash, and to seek urgent medical attention (either return to the Clinic or her own G.P. or go to [the ED] at [the public hospital]) if a rash occurred or he did not get better.

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Physical injury:
The Panel has considered whether there has been a physical injury in this claim. The Panel refers to the letter of 16 February 2004, from [Dr D], Paediatrician and independent advisor to the Medical Misadventure Unit. [Dr D], as a specialist Paediatrician, is of the view that [Master A] has sustained a physical injury because of the delay in recognition and treatment for meningococcal septicaemia. It is his view that on the balance of probabilities that had [Master A] received the correct treatment earlier than it was given, the outcome would have been substantially better with every likelihood that his limbs would have been preserved.

The Panel is satisfied on the evidence before it that [Master A] has sustained a physical injury as a result of the delay in diagnosis of meningococcal septicaemia.

Medical error:
Delay in making the diagnosis of a particular illness does not of itself necessarily amount to medical error. What the panel must consider is whether in the particular circumstances of this claim, there was anything done or not done by a registered health professional which fell below a reasonable standard of care and skill which led to delay in making the diagnosis, which delay gave rise to the physical injury.

In his report, [Dr D] is of the view that there has been medical error regarding this claim. On page 2 of his report, [Dr D] has made a number of comments about the consultation. It is in five respects that he considers the consultation to be unsatisfactory. He observed:

1) [Dr B] appeared to have taken a history, performed a clinical examination, completed his notes and written a prescription in no more than five minutes.

2) [Dr B] had written 'Pamol' 125mg PR in his notes as the medication but this was changed to 250mg Pamol PR in the drug administration section.

3) 'Pamol' is the trade name for Paracetamol and 'Pamol' is not available as a suppository. It would have been Paracetamol that was available as a suppository. In [Dr D's] view, mixing up trade names suggests a lack of attention to detail.

4) [Dr B] made no comment at all in his notes on the Nurse's recording and in particular, the symptoms that she recorded [Master A] being *shakey* and *light sensitive.* [Dr D] interpreted the fact that [Master A] had been shaky earlier was a sign of likely rigors and while rigors can occur with some viral illnesses it was more likely to be at least a severe viral illness or a bacterial infection. While [Dr B] recorded that [Master A] was *mild to moderately distressed,* it was unfortunate that [Master A's] heart rate was not recorded as this may have given a further clue as to the severity of his illness.

5) While [Dr B] mentioned *Review/GP f/u prn,* that alone did not imply that [Ms A] was told how to recognise a meningococcal rash or how urgent her actions should be if one appeared. [Dr D] referred to [Dr B's] clear documentation as to lack of

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neck stiffness and rash at the time. He referred also to the statement of [Dr B] in his letter of 18 June 2003 to the Health and Disability Commissioner that '*it is very difficult to detect meningococcal disease at the early stage because the signs and symptoms are very much like those of common viral illness*'. [Dr D] observed this would suggest that in a case like [Master A], [Dr B] knew that [Master A] could still have meningococcal disease and that it would be a paediatric emergency once the diagnosis was made.

** Comment: Every child with a fever can potentially have meningitis so???

In [Dr D's] view, [Dr B] failed to observe a standard of care and skill reasonably to be expected in the circumstances which would constitute medical error.

The Panel has carefully considered all aspects of the consultation [Master A] had with [Dr B] on 21 February 2003. There are three main areas of the consultation which the Panel considers problematic.

1) History. It is clearly recorded in the Nurse's triage notes that [Master A] was a very unwell child at the time of the consultation. He was noted to be listless, feverish, shaky, light sensitive and had vomited on three occasions. It is also recorded that [Master A] had a temperature of 38.9°C.

   The Panel notes that [Master A] had been vomiting without diarrhoea. This is significant in that it suggests another cause for [Master A's] significant unwellness other than gastroenteritis which, in the normal course, is accompanied by diarrhoea.

   The Panel also notes it is recorded that [Master A] was shaky. This symptom is one that is suggestive of rigors and may indicate a systemic effect such as septicaemia. The Panel is of the view that, in and of themselves, [Master A's] history and presenting symptoms were indicative of a more serious illness particularly in a child of two years and nine months. A combination of high fever, and vomiting without diarrhoea, together with a recorded reduction in fluid intake, should have raised significant concerns for [Dr B] and should have alerted him that something more serious was occurring.

   Taking into account [Master A's] history and his presenting symptoms, the nature of these symptoms was sufficiently serious that they should have alerted [Dr B] either to have referred [Master A] on for further specialist assessment or instituted a very specific management plan. [Dr B] did neither.

2) The details of the clinical examination carried out by [Dr B] are recorded in his notes. As already stated, [Master A's] temperature was taken and recorded by Nurse [Ms C]. [Dr B] has recorded his clinical findings, including an absence of any signs of meningitis. However, the Panel notes that [Dr B] made no assessment of either pulse or respiratory rate which, together with temperature, are indicative of systemic illness. The Panel also notes that [Dr B] made no recording of any clinical examination for dehydration. Again, given [Master A's] presenting symptoms of

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high fever, vomiting and reduction of fluid intake, the Panel would have expected [Dr B] to have carried out an assessment of [Master A's] hydration. In the Panel's view, [Dr B] should have undertaken these assessments in order to assess the severity of [Master A's] illness. He did not do so.

3) The Panel notes that [Dr B] diagnosed a viral infection. [Dr B] did not appreciate that even in the absence of specific classic signs of meningococcal disease, the combination of [Master A's] history which had been given and the presenting symptoms were of sufficient significance to have required [Dr B] to have instituted a specific management plan for [Master A]. Any such management plan should have covered the next 2 to 4 hours and included advice for [Master A's] mother to contact the medical centre staff at that time.

   It appears to the Panel that [Master A's] mother was concerned about her son's illness and was conscientious and diligent in her observations of him. In the admission record regarding [Master A] to [the public hospital] it was recorded that he had vomited 10 times at the time of admission. This would suggest that he had vomited on seven occasions subsequent to the consultation with [Dr B]. Such information would have come from [Master A's] mother which further indicates that she was carefully observing her son. The Panel is satisfied also that if [Dr B] had put in place a proper management plan [Master A's] mother would have acted in accordance with it.

Conclusion:
The Panel is satisfied that [Dr B] failed to exercise a standard of care and skill reasonably to be expected in the circumstances and in particular:

(a) Failed to appreciate the extent of [Master A's] unwellness taking into account the history provided by the mother, the observations recorded by the triage nurse and his own examination.

(b) [Dr B] failed to undertake basic assessments such as pulse and respiratory rate and assessment of hydration, all of which should have been undertaken in the circumstances.

(c) [Dr B] failed either to refer [Master A] for further specialist assessment or alternatively put in place a careful management plan for the following 2 to 4 hours at the very least."

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