Ambulance Officer / Regional Ambulance Service
Doctor / Nurse / Crown Health Enterprise

Report on Opinion - Case 97HDC5922

Complaint

The Commissioner received a complaint on behalf of the complainant's niece and his wife. The complaint was that:

- *An ambulance officer attempted to lift the complainant's niece out of a car following an accident in mid-January 1997, despite being told that she was seriously hurt. When his niece was lifted by the ambulance officer, the niece screamed, which caused the ambulance officer to drop her back on to the seat. Prior to being moved by the ambulance officer, the complainant's niece was able to move her hands and feet. After being moved, she could not.*
- *Following the accident, the complainant's niece was not transferred by air ambulance to a hospital.*
- *Upon arrival at the hospital, the complainant's niece was left unattended in the ambulance for 15 minutes.*
- *Staff at the hospital did not arrange for a head x-ray for the complainant's wife, who had sustained head injuries in the car accident.*
- *The examination of the complainant's wife failed to establish that there was a laceration to her right ear which required sutures.*

Investigation

The complaint was received by the Commissioner on 14 May 1997 and an investigation was undertaken. Information was obtained from:

The Complainant
The First Consumer (Complainant's wife)
The Second Consumer (Complainant's niece)
Passenger in car (Complainant's and his wife's daughter)
Driver of car (Complainant's and his wife's daughter)
A Witness
Two Voluntary Ambulance Officers, The Order of St John
A Senior Fire Service Officer
A Fire Service Officer
The Chief Executive Officer of the Regional Ambulance Service
An Operations Manager, Clinical Services
The Director of Emergency Medicine
A Doctor, Department of Emergency Medicine
A Nurse, Department of Emergency Medicine
The Family's GP

Continued on next page

Ambulance Officer / Regional Ambulance Service
Doctor / Nurse / Crown Health Enterprise

Report on Opinion - Case 97HDC5922, continued

Investigation ***continued***

A copy of the affidavit sworn by a witness at the scene of the car accident was supplied to this office. Other information obtained and considered were:

- Both of the consumers' relevant medical records from the hospital;
- The ambulance reports;
- The ambulance service's internal investigation records, including a report of interviews with the two ambulance officers, the senior fire service officer and the witness;
- A report and other information from the Crown Health Enterprise.

The Commissioner sought advice from an independent expert.

Outcome of Investigation

On a date in mid-January 1997 the complainant's daughter was driving a car on State Highway 3. The other occupants in the car were the complainant's wife, their niece, their other daughter and her son. The daughter driving the car swerved to avoid a collision with a truck and lost control of the car. The car went down off the road, rolled twice and hit a bank. After the accident, the daughter driving the car said she asked the complainant's niece twice to get off the other daughter's son but the niece said she could not move. The other daughter (a passenger) advised the Commissioner that the complainant's niece was slumped forward in the back seat, with her head resting on the back of the front seat. The daughter unclipped the car seat and removed it with her son still in it. She advised that when she returned to the car, the niece was lying on the back seat. The niece said that she had a sore neck.

The witness and some other people arrived at the scene. The complainant's daughter (passenger) and the witness assisted her mother, who had hit her head in the accident, to get out of the car. The witness returned to the car and saw the niece lying on the back seat of the car. In his affidavit, the witness stated that the niece could move at the time he saw her. He states:

> *"18. ...[I] asked her whether she was able to move her fingers? She said she could and I observed the movement of the fingers to the point where she was able to scratch her other arm.*
>
> *19. I THEN asked her whether she was able to move her feet? She said yes, she was okay, she was then able to move her leg on top of the other leg and was attempting to kick off her shoes.*
>
> *20. ...In all I observed her limbs being legs, arms and fingers were all in working order."*

Continued on next page

Ambulance Officer / Regional Ambulance Service
Doctor / Nurse / Crown Health Enterprise

Report on Opinion - Case 97HDC5922, continued

Outcome of Investigation ***continued***

The fire service was the first of the emergency services to arrive on the scene. A senior fire service officer and one of the firemen who attended, said he sat in the driver's seat and comforted the niece, who was lying on her right side across the back seat. The witness, who had been comforting the niece, had already moved away and was by this time attending to the complainant's wife on the side of the road. He did not observe what the firemen were doing.

Two volunteer ambulance officers (one female, one male) arrived at 6.48pm. The female ambulance officer, whose level of standing was the proficiency (basic) level and who had 15 years' experience with the ambulance service, was the senior of the two ambulance officers. The complainant's daughter (passenger) spoke to the male ambulance officer. The witness was adamant there was only one ambulance officer. In his affidavit, the witness said:

> *"25. THERE was only 1 officer that came out of the ambulance and that was a female."*

The witness said he told the female officer about the injuries of each of the injured passengers in the car. In his affidavit he said:

> *"26. WHEN I indicated the injuries to the young woman at the back of the car, being that of very little movement and extreme pain, the officer replied "she's only in shock."*

In particular, he said that the niece did not want to be moved. The female officer said she did not remember speaking to or noticing any bystander in particular at the crash site. She also said she did not recall the witness at all. The female officer attended to the complainant's wife and the daughter that was driving the car while the male officer attended the niece.

The male officer assessed the niece while she was still in the car and was standing outside the car by the niece's head. The senior fire service officer said that a fire service officer was asked to help with the assessment of the niece. He said that the fire service officer leaned from the other side of the car and touched the niece's feet to see whether she could feel them. The fire service officer was unable to recall details of the assessment but confirmed he had been involved in an assessment of the niece's condition. The senior fire service officer said that the assessment ascertained that the patient "*could not move or feel her legs*". It was noted in the ambulance report that the niece had *"sore shoulders, neck, head, no feeling from lower back down".* The niece also said that she had difficulty breathing and was given oxygen by the male officer.

Continued on next page

Ambulance Officer / Regional Ambulance Service
Doctor / Nurse / Crown Health Enterprise

Report on Opinion - Case 97HDC5922, continued

Outcome of Investigation ***continued***

The female officer approached the car and the male officer advised her of the findings that he had made. The female officer said the niece was lying on her side along the rear seat with her head near the door of the car. Standing by the vehicle, she also quickly assessed the niece and agreed with the male officer. The female officer said that at no time was she in the vehicle and this was confirmed by the fireman in the front seat. He also said the female officer did not sit the niece up or move her and at no time did the niece scream.

The witness in his affidavit recalled:

> *"29. IMMEDIATELY after my brief the ambulance officer* [female] *went to the young woman and picked her up from the position she was in. The young woman screamed! Immediately the officer put the girl down."*

The witness also said there were two other witnesses to this event. Although attempts have been made by the Commissioner to locate them, the Commissioner has been unable to do so.

The passenger and her mother could not remember the niece screaming at all. The driver recalls the niece groaning and calling out to the family members for support but no screaming.

The fire service deputy was dispatched to get a long spinal board from the ambulance station. The two ambulance officers went to the ambulance. The male officer got a stiff neck cervical collar and returned to the car. The female officer said she advised the Regional Operations Centre ("the ROC") of the accident. She said she told them that she had two moderate patients and one minor patient, and that one of the patients had spinal injuries. The Commissioner was unable to verify details of this conversation. The ROC advised that while all incoming and outgoing calls are recorded, the tapes are stored for one month and then reused after that time. Information is downloaded only if there are compelling reasons or specific requests made within that month for information to be stored. Written transcripts are not kept.

Continued on next page

Ambulance Officer / Regional Ambulance Service
Doctor / Nurse / Crown Health Enterprise

Report on Opinion - Case 97HDC5922, continued

Outcome of Investigation *continued*

The female officer loaded and treated the driver of the car and her mother. The mother kept getting out of the ambulance and walking toward her family while the female officer attended to her head wound.

When the female officer returned to the car she and the other officer fitted the cervical collar to the niece while she was lying down. The witness had left the accident scene before the stiff-neck collar was placed on the niece. The ambulance officers and the fire service officers then extracted the niece from the car. She was taken out on a long spinal board and then transferred to a stretcher by a "log roll". The fire service officer advised the Commissioner that the fire service officers in attendance disagreed with the ambulance officers' request that the niece be transferred from the spinal board to a stretcher but complied with the request. The female officer said the niece's head was kept in alignment by the fire service officers. The female officer says that the niece was loaded into the ambulance and checked again for movement of limbs. It was said that the female officer commented to the other passengers in the ambulance that "*the injury* [the niece's] *is not serious, it is only serious if the legs are cold*". The female officer said she does not recall making such a statement. There were more checks for movement of limbs carried out by the male officer while the niece was in the ambulance. The male officer said the niece was treated as having a potential spinal injury from the outset.

The female officer said the use of the air ambulance for transport was discussed with the fire service. However, she did not suggest to the ROC that an air ambulance should be sent. She said she understood that the decision to airlift was to be left to the ROC.

The Chief Executive Officer ("CEO") of the ambulance service, in his letter to the complainant dated mid-May 1997, summarised the ambulance service's policy at the time:

> *"Our service policy clearly states: for suspected spinal injury patients, where the road travel time is greater than 30 minutes to hospital, evacuation by air ambulance should be considered. Unfortunately, in this particular case the responding crew using an old criteria believed the Regional Operations Centre would decide if air transport should be used, when in fact it is the 'on scene' officers who must decide. Although air evacuation was discussed at the scene no request was made."*

Continued on next page

Ambulance Officer / Regional Ambulance Service Doctor / Nurse / Crown Health Enterprise

Report on Opinion - Case 97HDC5922, continued

Outcome of Investigation *continued*

The CEO admits that the niece fitted the criteria to be airlifted to the hospital. However, the CEO also indicated that the outcome of this case was unlikely to have been any different had an air ambulance been used.

The female officer radioed the hospital before the ambulance departed the scene, advising that the emergency status was a "2", meaning that the patient status was classified as *"moderate"*. The number of passengers and the estimated time of arrival at the hospital were also transmitted. A letter reporting on an investigation conducted by the director of emergency medicine of the Crown Health Enterprise dated late August 1997 stated that all the patients were deemed to be stable with no evidence of life or limb threatening signs which would have necessitated a trauma call (status 3).

The ambulance left the accident scene at 7.35pm and took all the occupants of the car to the Hospital. The female officer drove while the male officer was in the back of the ambulance with the passengers. On the way to the hospital the ambulance stopped as the niece said she wanted to vomit. The niece was taken outside the ambulance on the stretcher to vomit. The male officer said the niece was partially log-rolled whilst at the same time "*leaning the stretcher over so that her neck was straight*".

The ambulance arrived at the hospital at 8.25pm, a journey of 50 minutes. The daughter driving the car was in shock and placed in a wheelchair. Her nephew was placed on her lap and her sister pushed them into the hospital. The ambulance officers brought the complainant's wife into the hospital on the stretcher bed and handed her over to hospital staff. The complainant's wife and her daughter were taken to a cubicle and their injuries were treated. During this time, the niece remained in the ambulance. The female officer said she and the other officer went straight back to the ambulance for the niece. She said it would have taken approximately three minutes to get back to the ambulance. Hospital records show that the niece was triaged at 8.40pm. The director of emergency medicine's report stated:

> "*A neurological examination revealed a deficit with some reduction in power to her arms, flaccid legs with no reflexes, sensory loss from below her xiphisternum and no anal tone on rectal examination…* [the niece] *sustained a C6/C7 dislocation with 75% displacement… She was noted to be completely tetraplegic from the time she was seen by the ambulance officers at the scene*".

Continued on next page

Ambulance Officer / Regional Ambulance Service
Doctor / Nurse / Crown Health Enterprise

Report on Opinion - Case 97HDC5922, continued

Outcome of Investigation *continued*

About twenty minutes after leaving the ambulance, the complainant's daughter (passenger) asked where the niece was. An orderly went to find out. Another ten minutes or so passed so she asked again and found out that the niece was being x-rayed.

It appears that at the time of the accident the niece was not wearing her seat belt. The Crown Health Enterprise's report said that it is likely that her head hit the roof of the car which caused a hyper-flexion injury to the neck area known as the cervical spine, dislocating it. The most likely scenario is that the "bi-lateral facet joint dislocation", the most serious hyper-flexion injury, sustained at the time of the accident resulted in "immediate neurological deficit". The director of emergency medicine said:

> "*Once spinal injury has occurred with neurological deficit, there is very little one can do acutely to treat it or cause any resolution of the deficit*".

She also said that there is a high risk of this type of injury occurring when a passenger is unrestrained in the back of a car that rolls.

Attempts have been made by the Commissioner to speak to the niece about this matter. The niece indicated that she has been unable to remember anything about what happened at the scene of the accident. She does, however, remember being left in the ambulance at the hospital. She does not know how long she was left there. She said it seemed like she was on her own for "ages" and she felt scared. The niece has been attending a spinal unit in the area. She is unable to walk and is permanently paralysed.

The complainant's wife underwent triage assessment at 8.30pm. Under the heading "condition of patient" on the emergency department assessment sheet, the following is recorded by a nurse:

> "*Patient conscious and co-op. GCS 15* [Glasgow Coma Score – used to ascertain the consciousness of the patient]. *Head wrapped in bandages. Pt states no other injury sites. Not K'oed*".

Continued on next page

Ambulance Officer / Regional Ambulance Service Doctor / Nurse / Crown Health Enterprise

Report on Opinion - Case 97HDC5922, continued

Outcome of Investigation *continued*

The complainant's wife said that her head was shaved and that half of her head was covered by a sheet to isolate the areas where the cuts were. While in the cubicle, she was told that she was going to receive some injections and that these would numb the pain so that the "cuts" could be "stitched up".

She was later shifted to another cubicle. A doctor arrived to conduct an examination. The nurse was also present at this time. The consumer's clinical notes record that she had been wearing a seatbelt in the crash, remembered the entire event and was able to walk around after the accident. The report of the examination stated:

> "*O/E – speaking. Tml, chest clear, warm, well perfused, pulse, BP. Abdo[men] soft, not tender, no masses. Full range spontaneous neck movement. Neuro[logical exam] – GCS 15 [/15], eyes…, ears…; limbs 2 x large laceration to scalp.*"

The director of emergency medicine stated these findings:

> *"Revealed a fully conscious and conversive patient, who was warm and well perfused with normal vital signs…On neurological examination, she had a GCS of 15/15, pupils were normal and reactive to light, and there was a full range of eye movements…There were two large lacerations to her scalp. These were explored and no evidence seen of fracture".*

The wounds were anaesthetised, cleaned and sutured. The doctor's recorded plan was to administer prophylactic antibiotics, arrange for review by a GP in two days and removal of the sutures in five days.

Continued on next page

Ambulance Officer / Regional Ambulance Service
Doctor / Nurse / Crown Health Enterprise

Report on Opinion - Case 97HDC5922, continued

Outcome of Investigation *continued*

As the lacerations on the consumer's head were being sutured, her husband arrived and witnessed the events that followed. Having completed the suturing of the consumer's head, the doctor made a comment to the effect that he had completed her treatment. As he walked out of the cubicle, the consumer commented on the injury to her ear. The nurse described the injury as difficult to detect:

> "*The injury to* [the consumer's] *ear was not immediately obvious. Her head lacerations were oozing and there was a large amount of dry and fresh blood covering her face and ears. The wounds on her scalp were large and required extensive suturing and hair cutting.* [The doctor] *did this under difficult conditions, i.e. this was the period when the emergency department* [was being refurbished]*... I held a lamp during the suturing to ensure that the best possible light was available.*
>
> *After* [the doctor] *finished suturing the scalp, I was about to commence cleaning* [the consumer's] *head. Before I could do this,* [the consumer] *pointed out that she thought that she had a wound on her ear that would need suturing. As stated, this had not initially been noticed because of the amount of old and new blood covering her head. It would certainly have been observed following further cleaning of* [the consumer's] *head."*

The consumer had a laceration to the pinna of her right ear. After a discussion with the plastics registrar, the consumer's ear was cleaned and sutured. The doctor signed a statement dated late May 1997 that stated:

> "*There was no evidence of bony injury or neurological defect*".

The consumer was discharged in the early hours of the morning. The journey to her home took approximately three and a half hours. There is no record that she was asked by any of the hospital staff where she was going to go or how far her journey was to get home that night. The hospital had her address on the file as just the town she lived in.

The consumer saw her GP some days later. Her GP arranged for an x-ray of her head. The x-ray showed that the consumer had a fractured skull. The GP said that if the fracture had been discovered earlier, the consumer's treatment would have been different. He said the consumer would have been kept in hospital for observation. However, he also commented that as he had not been at the hospital he could not make a proper assessment of the situation.

Continued on next page

Ambulance Officer / Regional Ambulance Service Doctor / Nurse / Crown Health Enterprise

Report on Opinion - Case 97HDC5922, continued

Outcome of Investigation *continued*

The doctor from the hospital, in a letter dated late February 1998, stated:

> *"The policy in* [the hospital] *is that in head injury cases, if there is sufficient neurological deficit a CT scan is indicated. If there is no significant neurological deficit and local exploration does not indicate a fracture an x-ray is not indicated."*

The Crown Health Enterprise also advised us that the ideal tool for investigations of a head injury is a CT scan and that skull x-rays are no longer part of routine investigations for head injury.

This accords with the expert advice received by the Commissioner:

> "*A CT scan is a study of choice for a patient with suspect neurologic injury… Indications for CT include seizures, abnormal mental status, abnormal neurological examination or signs of depressed skull fracture.*
>
> *Brief loss of consciousness alone or mild amnesia in an awake, alert patient is a low yield indication and does not require CT scan but rather a period of observation or hospital admission for observation.*
>
> *Indications for skull x-rays are few with the availability of CT scanning. A skull x-ray is indicated if physical examination suggests bony depression of the skull, if there is evidence by history or examination of a penetrating trauma or if there is evidence of subgaleal (below the fascia of the skull) haematoma. Skull radiographs may show a fracture in patients without significant intracranial injuries. Conversely, they are often normal in patients with significant injuries. Hence they have little place in the investigation of the head injured patient and certainly should not be used as a "screening test" to determine which patients should proceed to CT. A negative skull radiograph does not exclude significant intracranial injury. The presence of a skull fracture in an otherwise asymptomatic patient with a normal Glasgow Coma Scale is not in itself indicative of an increased risk of significant intracranial injury."*

Continued on next page

Ambulance Officer / Regional Ambulance Service Doctor / Nurse / Crown Health Enterprise

Report on Opinion - Case 97HDC5922, continued

Outcome of Investigation *continued*

In a letter dated late March 1998 the operations manager of clinical services of the Crown Health Enterprise advised the Commissioner:

> *"Accepted clinical practice based on literature is that a CT scan is definitive investigation for assessment of intracranial injury and that skull x-rays are of little benefit."*

The Crown Health Enterprise set out its accepted practice in respect of indications for a CT brain scan. In summary, if a patient with a head injury has a GCS of 8 or less it is accepted practice for a CT brain scan to be obtained, for patients with a GCS of 9 to 12 a CT scan is invariably obtained, and for patients with a GCS of 13-15:

> *"The indications for a CT scan would include patients who are symptomatic with vomiting and or severe headache after 4 hours, or have a penetrating head injury/depressed skull fracture, a suspected child abuse injury, or display focal neurological signs (seizure activity, focal neurological deficit). It is not routine practice to scan or x-ray patients with a normal level of consciousness simply because they had an injury to the head. All decisions are based on clinical judgement and accepted best practice and hence there are no fixed protocols for CT scanning of the brain."*

The director of emergency medicine advised that scalp lacerations on their own do not constitute criteria for a brain scan. In her report she stated:

> "*There was no history of any loss of consciousness, she* [the consumer] *was not amnesic regarding the accident, and apart from the scalp lacerations, there was no other evidence to suggest a more serious head injury… The appropriate management of scalp lacerations is to clean and suture, which occurred. She was also placed on antibiotics as prophylaxis. Had the skull fracture been diagnosed at the time, there would have been no other change in management.*"

Continued on next page

Ambulance Officer / Regional Ambulance Service
Doctor / Nurse / Crown Health Enterprise

Report on Opinion - Case 97HDC5922, continued

Outcome of Investigation *continued*

The opinion was confirmed by the advice the Commissioner received from the independent expert:

> "*As* [the consumer] *was fully conscious, had no loss of consciousness, remembered the events, was mobile after the event, had normal GCS scores and, on examination, had no other indications for CT, no other imaging examination is indicated. The treatment prescribed was the appropriate treatment… Everything that was indicated was undertaken by* [the doctor] *and the ED team at* [the hospital]*."*

The independent expert also advised that it is highly unlikely, given the nature of the consumer's injury, her immediate post injury course and the lack of physical signs or other complications or indications, that any particular consequences would arise if a head injury like hers had been left untreated. The expert also advised that it was appropriate, given the circumstances of the injury, that follow up care was carried out by the patient's GP. The expert emphasised that:

> *"A skull fracture that is not depressed, in itself, is not of major importance and rarely if ever leads to a deterioration in a patient's condition."*

Ambulance Officer / Regional Ambulance Service
Doctor / Nurse / Crown Health Enterprise

Report on Opinion - Case 97HDC5922, continued

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

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

(3) Every consumer has the right to have services provided in a manner consistent with his or her needs.

(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.

Clause Three – Provider Compliance

(1) A provider is not in breach of this Code if the provider has taken reasonable actions in the circumstances to give effect to the rights, and comply with the duties, in this Code.

(2) The onus is on the provider to prove that it took reasonable actions.

Opinion: Breach – Ambulance Officer and Ambulance Service

Complaint: Following the accident, the complainant's niece was not transferred by air ambulance to the hospital.

The female ambulance officer

In my opinion, the ambulance officer breached Rights 4(2), 4(3) and 4(4) of the Code of Health and Disability Services Consumers' Rights. She failed to properly consider the option of airlifting the niece to the hospital.

While the ambulance officer advised that she was following what she understood to be policy in the area at that time, in my opinion, as the on-scene officer she should have considered evacuating the consumer by air. If an air ambulance had been used, the journey to the hospital would have been faster. The travel time by road was 50 minutes. The chief executive of the ambulance service stated that the niece did fit the criteria to be airlifted to the hospital. The chief executive estimates that, had an air ambulance been dispatched, the overall saving in time would have been around 30 minutes. He states that the outcome of this case is unlikely to have been any different if an air ambulance was used. It is not my role to speculate on the outcome but rather to form an opinion based on the facts. In my opinion, transfer by air ambulance was consistent with the niece's needs and would have minimised the potential harm to, and optimised the quality of life of, the consumer.

Continued on next page

Ambulance Officer / Regional Ambulance Service Doctor / Nurse / Crown Health Enterprise

Report on Opinion - Case 97HDC5922, continued

Opinion: Breach - Ambulance Officer and Ambulance Service, *continued*

The ambulance service

In my opinion, the ambulance service breached Rights 4(2), 4(3) and 4(4) of the Code of Health and Disability Services Consumers' Rights by failing to ensure the ambulance officer was informed of, and complied with, current policy. The ambulance service is the employing authority of the officer and is liable for her actions or omissions under section 72 of the Health and Disability Commissioner Act 1994, unless the ambulance service provides evidence that it took such steps as were reasonably practicable to prevent the breach of the Code of Rights. As I have not received sufficient evidence of such steps, in my opinion the ambulance service has not taken reasonably practicable steps to ensure its ambulance officers were aware of, and complied with, current ambulance service policy.

Opinion : No Breach - Ambulance Officer

Complaint: Upon arrival the complainant's niece was left unattended in the ambulance for 15 minutes

In my opinion, there has not been a breach of the Code of Health and Disability Services Consumers' Rights.

The ambulance arrived at the hospital at 8.25p.m. and the complainant's niece was the last person to leave the ambulance. The niece was assessed (triaged) at 8.40 p.m. The ambulance service explained that the ambulance arrival time is automatically recorded when the "at destination" button on the ambulance radio is depressed and this is done as the ambulance is approaching the hospital because of radio reception problems within the hospital complex. When time is allowed for the ambulance to drive into the hospital grounds, reverse into the ambulance bay, unload the other injured passengers and transport the consumer through the hospital corridors to the emergency department, which had temporarily relocated due to alterations, then, in my opinion, the niece would not have been alone in the ambulance for longer than four minutes. The niece was the most seriously injured consumer in the ambulance, had just gone through a terrifying accident and could not move her legs. The consumer does not remember anything at the scene of the accident but she remembers being terrified at being left alone in the ambulance. The ambulance service advised me that there is no written policy with respect to this issue, but indicated the requirement that ambulance officers remain with patients is implicit.

Continued on next page

Ambulance Officer / Regional Ambulance Service
Doctor / Nurse / Crown Health Enterprise

Report on Opinion - Case 97HDC5922, continued

Opinion: No Breach – Ambulance Officer, *continued*

I accept the female ambulance officer's explanation that the male officer was unable to escort the other injured passengers into the emergency department because, due to its temporary relocation, he was uncertain where it was. Further, I accept the female officer's decision to move the complainant's first as the officer had assessed the niece as being in a stable condition but that the wife's condition was not stable. The ambulance officer was also concerned that the wife would not remain in the ambulance and would wander into the hospital on her own if the niece was transferred to the emergency department first. The ambulance officer therefore made the decision to transport the three other injured passengers to the emergency department before the niece. Both of the ambulance officers transported the wife on a stretcher and her daughter was in a wheelchair with her other daughter pushing her. Considering all the various factors, in my opinion the officer's actions were reasonable in the circumstances.

Opinion: No Breach - Ambulance Officer

Complaint: The ambulance officer attempted to lift the complainant's niece out of the car, despite being told that she was seriously hurt. The consumer screamed and the ambulance officer dropped her back on to the seat

In my opinion, the ambulance officer did not breach Right 4(2) of the Code of Rights in the way that the complainant's niece was handled.

The witness supplied information about the treatment of the niece at the scene of the accident which is not consistent with the information from the internal investigation conducted by the ambulance service and information from those members of the family who were at the accident scene.

While the witness saw only one female ambulance officer, information from all the sources named above clearly indicate that there were two ambulance officers. Similarly, the witness was the only person to hear the niece scream. Information from the family, the ambulance officers and the fire officer in the car said that the niece did not scream over this period.

Ambulance Officer / Regional Ambulance Service Doctor / Nurse / Crown Health Enterprise

Report on Opinion - Case 97HDC5922, continued

Opinion: No Breach - Doctor and Crown Health Enterprise

Complaint: Failure to x-ray the complainant's wife

In my opinion, the doctor did not breach the Code of Health and Disability Services Consumers' Rights by not arranging for the complainant's wife to receive an x-ray. It is clear from the emergency department assessment sheet and the consumer's own statement that she was conscious after the accident, mobile and aware of her surroundings. An x-ray is no longer considered the appropriate tool for investigation and the medical examination of the wife by the doctor gave no indication for a CT scan. In the Commissioner's opinion, the treatment prescribed was the appropriate treatment in the circumstances.

My advisor informs me that the consumer's post injury recovery would not have been any different had the fracture been identified while she was at the hospital.

In my opinion, the Crown Health Enterprise's policy of using a CT scan rather than a skull x-ray in investigating a concern about a head injury is in accordance with reasonable medical practice. The actions of the doctor were in accordance with the Crown Health Enterprise's policy and were reasonable in the circumstances.

Opinion: No Breach - Doctor and Nurse

Complaint: Failure to identify laceration to the consumer's ear

In my opinion, the failure to identify the laceration to the consumer's ear was not a breach of the Code of Health and Disability Services Consumers' Rights. The complainant's wife advised the doctor about the laceration to her ear. In triage, the consumer did not tell the nurse there were any other injury sites. The nurse stated that she was about to clean the consumer's head. Undoubtedly she would have found the injury in this process and ensured it was dealt with in an appropriate manner. In my opinion, the actions of the nurse and the doctor were appropriate.

Ambulance Officer / Regional Ambulance Service Doctor / Nurse / Crown Health Enterprise

Report on Opinion - Case 97HDC5922, continued

Future Actions

Ambulance officer

I recommend that the ambulance officer take the following action:

- Apologises in writing to the complainant's niece for breaching the Code of Rights. This apology is to be sent to the Commissioner and will be forwarded to the niece.
- Reads the Code of Health and Disability Services Consumers' Rights.
- Provides an undertaking to the Commissioner that she keeps herself up-to-date with the policies of the Order of St John and provide assurances that she will follow these policies.

The Ambulance Service

I recommend that the ambulance service take the following action:

- Apologises in writing to the family involved acknowledging that the ambulance service did not comply with the Code of Rights. This apology is to be sent to the Commissioner and will be forwarded to the family.
- Formulates a nation-wide written policy with respect to officers' obligations to remain with consumers who are being transported by ambulance. Once completed, a copy of this written policy is to be forwarded to the Commissioner.
- Provides evidence to the Commissioner that all reasonable actions have been taken to ensure that of the ambulance service's staff are updated with current policies on a regular basis and appropriately trained. Such actions must include voluntary officers.
- Ensures appropriate hand-over procedures are in place with all hospitals throughout New Zealand to ensure the smooth transferral of consumers from ambulance officers to hospital staff, including the effective transferral of information, both verbal and written, from ambulance officers to hospital staff.

Continued on next page

Ambulance Officer / Regional Ambulance Service
Doctor / Nurse / Crown Health Enterprise

Report on Opinion - Case 97HDC5922, continued

Future Actions, *continued*

Crown Health Enterprise

I recommend that the Crown Health Enterprise takes the following action:

- Reviews its procedures with ambulance services to ensure the smooth transferral of consumers from ambulance officers to emergency department staff and to ensure the effective transferral of information, both verbal and written, from ambulance officers to emergency department staff.
- Ensures that consumers are not discharged in the middle of the night with a long journey ahead of them. The Crown Health Enterprise should establish procedures to ensure consumers are asked how they are going to get home, the length of the journey time and whether they have appropriate support staff for both the journey and at their homes.

A copy of this opinion will be sent to the parties and the Health Funding Authority.