(1) ORDER PROHIBITING PUBLICATION OF NAME OR IDENTIFYING PARTICULARS OF AGGRIEVED PERSON AND HIS MOTHER

(2) ORDER PREVENTING SEARCH OF THE TRIBUNAL FILE WITHOUT LEAVE OF THE CHAIRPERSON OR OF THE TRIBUNAL

IN THE HUMAN RIGHTS REVIEW TRIBUNAL [2020] NZHRRT 8

Reference No. HRRT 050/2019

UNDER	SECTION 50 OF THE HEALTH AND DISABILITY COMMISSIONER ACT 1994
BETWEEN	DIRECTOR OF PROCEEDINGS
	PLAINTIFF
AND	SOUTHERN DISTRICT HEALTH BOARD
	DEFENDANT

AT WELLINGTON

BEFORE:
Ms J Foster, Deputy Chairperson
Dr SJ Hickey MNZM, Member
Dr JAG Fountain, Member

REPRESENTATION:
Ms K Eckersley, Director of Proceedings
Mr G Galloway and Ms M Nicol for defendant

DATE OF DECISION: 6 March 2020

(REDACTED) DECISION OF TRIBUNAL[1]

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[1] These proceedings under s 50 of the Health and Disability Commissioner Act 1994 were filed on 17 December 2019.

[1] [This decision is to be cited as: *Director of Proceedings v Southern District Health Board* [2020] NZHRRT 8]

[2] Prior to the filing of the proceedings the parties resolved all matters in issue and the Tribunal is asked to make a consent declaration. The parties have filed:

[2.1] A Consent Memorandum dated 3 February 2020.

[2.2] An Agreed Summary of Facts, a copy of which is annexed and marked "A".

[3] In the Consent Memorandum the parties request that the Tribunal exercises its jurisdiction and issues:

(a) A declaration pursuant to section 54(1)(a) of the Health and Disability Commissioner Act 1994 ("the Act") that the defendant has breached the Health and Disability Commissioner (Code of Health and Disability Services Consumers' Rights) Regulations 1996 ("the Code") in respect of Right 4(1) by failing to provide services to the aggrieved person with reasonable care and skill, and in respect of Right 4(5) by failing to provide co-operation among providers to ensure quality and continuity of services; and

(b) A final order prohibiting publication of the name and identifying details of the aggrieved person and his mother.

[4] Having perused the Agreed Summary of Facts the Tribunal is satisfied on the balance of probabilities that an action of the defendant breached the Health and Disability Commissioner (Code of Health and Disability Services Consumers' Rights) Regulations 1996 and that a declaration should be made in the terms sought by the parties in paragraph 2(a) of the Consent Memorandum.

[5] The Tribunal is also satisfied that it is desirable to make a final order prohibiting publication of the name and identifying details of the aggrieved person and his mother as sought in paragraph 2(b) of the Consent Memorandum.

DECISION

[6] The decision of the Tribunal is that:

[6.1] A declaration is made pursuant to s 54(1)(a) of the Health and Disability Commissioner Act 1994 that the defendant breached the Health and Disability Commissioner (Code of Health and Disability Services Consumers' Rights) Regulations 1996 in respect of Right 4(1) by failing to provide services to the aggrieved person with reasonable care and skill and Right 4(5) by failing to provide co-operation among providers to ensure quality and continuity of services.

[6.2] A final order is made prohibiting publication of the name and of any other details which might lead to the identification of the aggrieved person and his mother. There is to be no search of the Tribunal file without leave of the Tribunal or of the Chairperson.

.....	.....	.....
Ms J Foster	**Dr SJ Hickey MNZM**	**Dr JAG Fountain**
Deputy Chairperson	**Member**	**Member**

'A'

This is the Agreed Summary of Facts marked with the letter 'A' and referred to in the annexed decision of the Tribunal delivered on 6 March 2020

BEFORE THE HUMAN RIGHTS REVIEW TRIBUNAL

HRRT 050/19

UNDER Section 50 of the Health and Disability Commissioner Act 1994

BETWEEN **THE DIRECTOR OF PROCEEDINGS**, designated under the Health and Disability Commissioner Act 1994

Plaintiff

AND **SOUTHERN DISTRICT HEALTH BOARD**

Defendant

(REDACTED) AGREED SUMMARY OF FACTS

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

Level 11, 86 Victoria Street, Wellington 6011
PO Box 11934, Wellington 6142
Phone: 04 494 7900 Fax: 04 494 7901

Kerrin Eckersley – Director of Proceedings

(REDACTED) AGREED SUMMARY OF FACTS

INTRODUCTION:

1. The plaintiff is the Director of Proceedings exercising statutory functions under sections 15 and 49 of the Health and Disability Commissioner Act 1994 ("the Act").

2. The aggrieved person in these proceedings is "Master A" (deceased).

3. At all material times the defendant, Southern District Health Board, was a healthcare and disability services provider within the meaning of s 3 of the Act, and was providing health services to the aggrieved person within the meaning of s 2 of the Act.

4. In January 2016 the aggrieved person's mother, "Ms A", complained to the Health and Disability Commissioner ("the HDC") about services provided to the aggrieved person by the defendant.

5. In February 2016 the High Court ordered permanent suppression of the names and identifying details of Master A and his mother, Ms A.

6. On 27 March 2019 the HDC (appointed under s 8 of the Act) finalised his opinion that the defendant had breached the aggrieved person's rights under the Health and Disability Commissioner (Code of Health and Disability Services Consumers' Rights) Regulations 1996 ("the Code") and in accordance with s 45(2)(f) of the Act, referred the defendant to the plaintiff.

BACKGROUND

7. In September and October 2015, Master A was 17 months old when his mother took him to Southland Hospital four times due to him not weight-

bearing on his left leg. Eventually, Master A was diagnosed with a spiral tibial fracture.[1]

First presentation

8. On 14 September 2015, Ms A took Master A to Southland Hospital's Emergency Department ("ED"). Previously Master A had been well, but he had not been weight-bearing on his left leg for approximately 36 hours.

9. A Clinical Nurse Specialist ("CNS") examined Master A at 10.23am and presented her findings to a medical officer of specialist scale ("MOSS"),[2] Dr I, and an emergency medicine consultant, Dr J. The CNS told the HDC that in all ED presentations of injury to children she considers the possibility of non-accidental injury. She said that at the time she had no concern regarding non-accidental injury, and therefore no steps were taken in respect of this.

10. A left lower limb X-ray was completed at 12.01pm. Dr I reviewed the X-ray and could not identify a fracture. Dr J then examined Master A and transferred him to the Paediatric Department. There is no record in the clinical notes that non-accidental injury was considered specifically, but it is noted that the cause of injury was unknown.

11. In the Paediatric Department, Master A was reviewed by a consultant paediatrician, Dr C, and a paediatric senior house officer ("SHO") who recorded that Master A was normally fit and well. In terms of his social history, the SHO recorded that Master A lived with a sibling and attended day care full time.

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[1] A spiral tibial fracture, also known as a toddler's fracture, is a spiral fracture of the shaft of the tibia (the shinbone in the leg) with an intact fibula (the calf bone in the leg).

[2] A non-training position for a doctor who has not yet specialised or not yet gained a postgraduate qualification, or an international medical graduate who has a postgraduate qualification from overseas but is not eligible for a consultant role because they do not meet the requirements for a vocational scope of practice.

12. The SHO recorded that on examination, Master A was non-toxic appearing, had "Snuffly breathing", and a non-blanching petechial[3] rash on his upper chest, which his mother noticed the day before after Master A had been caught up in some blankets.

13. Due to the presence of the petechial rash, Dr C took a social history from Ms A and recorded the following:

> "[Ms A explained that] her older [child] lived with her at home. That she had a partner but he did not live at the home and was not alone with [Master A]. [Master A's] father did not have contact with [Master A]. She advised that [Master A's] father was in prison for domestic violence. This had made her very careful about who had access to her children. She confirmed that no one other than Ms A herself, [Master A's sibling] and the day care staff had the care of and contact with [Master A]."

14. Full blood test result were normal. Dr C reviewed the X-ray requested in ED and could not see a fracture. She considered the possibility of a metaphyseal[4] fracture, but saw no sign of this on the X-ray. Dr C also considered whether Master A had a toddler's fracture, or a fracture of the tibia. Dr C concluded that as there was no evidence of a fracture, Master A could be discharged home with regular analgesia. Master A was discharged with Open Access, which meant that the family could call the Paediatric Ward and present straight back to the unit with any concerns. Dr C documented the following plan:

> "1. [Discharge] home
> 2. Return if any deterioration
> 3. Continue regular analgesia at home."

Result of left lower limb X-ray

15. The final X-ray report for Master A's left lower limb was reviewed three days later by ED staff at 11.33am on 17 September 2015. The report found:

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[3] Petechiae are pinpoint, round spots which appear on the skin as a result of bleeding beneath the skin.
[4] The narrow portion of the femur.

> "[A] small osseous[5] fragment adjacent to the posterior[6] aspect of the distal[7] left femoral metaphysis.[8] This does not have the typical appearance of a non-accidental injury although it is not a typical normal variant either. A small fracture cannot be completely excluded. Further imaging such as an MRI may also be valuable."

16. No further action was taken by ED staff in respect of this report. An MRI was not ordered at this point.

Second presentation

17. Also on 17 September 2015, Master A re-presented to the Paediatric Ward. Master A was reviewed by a paediatric SHO, Dr K, although the time of this review is not documented. Dr K noted Master A's previous presentation, that there was no history of injury or trauma, and that Ms A was concerned that Master A had not improved. Dr K noted that a left lower limb X-ray had been carried out at Master A's previous presentation and that no abnormality had been detected.

18. Dr K discussed Master A's case with a consultant paediatrician, Dr G, who was on call at the time. Dr G told the HDC that he decided to visit Master A "to eliminate the more serious explanations for non-use of a limb". Dr G advised that his "concerns were to exclude bacterial infection of bones/joints, malignancy or fractures, whether inflicted or accidental".

19. Dr G told the HDC that in the context of a busy clinic, he took a concise and focused approach to his assessment of Master A. Dr G stated that he was directed to the left foot as being the source of discomfort rather than any other part of Master A's leg. The clinical notes record that the left foot had "no obvious deformity/swelling/bruising/redness". Dr G told the HDC that although he did not conduct a focused examination on Master

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[5] Osseous is a term used to refer to something consisting of, or resembling, bone. In this context it is referring to a bone fragment.
[6] Further back in position.
[7] Situated away from the centre of the body or from the point of attachment.
[8] The narrow portion of the femur.

A's tibia and fibula, he did hold the distal aspect when evaluating Master A's ankle and foot.

20. An X-ray was requested for Master A's left foot but not his whole leg. Under "Clinical Details" on the examination request form, SHO Dr K documented:

> "Non weight bearing [left] foot 4/7
> No history of injury
> Systemically well
> No bruising/swelling or deformity
> Apparent tenderness mid-forefoot."

21. No abnormality was observed on the left foot X-ray. Dr G told the HDC that Dr K had given him a verbal message that the lower left limb X-ray from the previous presentation was normal, and Dr G had "no awareness" that the X-ray report suggested a possible femoral fracture.

22. Master A's presenting issue was documented as a "likely deep soft tissue injury/strain". Dr G told the HDC that "although inflicted injury was in [his] thinking ... sadly nothing was documented to capture this". He advised he was "satisfied that there was nothing serious accounting for [Master A's] non-weight bearing, based on his reassuring results, and his clinical picture". Master A was discharged home for monitoring and follow-up review in the Paediatric Ward on 21 September 2015 (Monday) if symptoms persisted.

Third presentation

23. Master A and his mother re-presented to the Paediatric Ward at midday on Saturday 19 September 2015. Master A was reviewed by a SHO. The on-call paediatric consultant was Dr H. Although Dr H did not meet Master A, the SHO gave Dr H a history at approximately 1.30pm. Dr H requested that Master A remain in the ward, and that an opinion from the orthopaedic registrar be sought.

24. The SHO documented: "Orthopaedics to arrange MRI and [follow-up]. I will discuss this with the ortho[paedic] reg[istrar]."

25. Later that day, orthopaedic registrar, Dr L, reviewed Master A and noted the results of his left lower limb X-ray of 14 September. Dr L documented:

> "Plan
> — Soft band and crepe bandage for comfort
> — Arrange MRI scan: will be arranged by paediatric department
> — [Review] in orthopaedic clinic with MRI scan."

26. Dr H reported the following to the HDC:

> "I attended the ward at 1630 on Saturday afternoon, to see both [Master A] and another patient under my care … On my arrival to the ward, I was advised [Master A] had gone home. It was not clear why he had gone home and when I enquired, no clear explanation could be provided …
>
> I had attended the ward on Saturday afternoon to see a child who was otherwise well in order to do a Child Protection Assessment. This could have involved obtaining further information from [Master A's] mother regarding any possible mechanisms of injury, further information about [Master A's] living circumstances and a physical examination to look for any other signs of trauma."

Request for MRI

27. On 21 September 2015, orthopaedic registrar, Dr L, completed an MRI request. Under the heading "Clinical Details", he wrote:

> "— non-[weight] bearing on left lower limb for 1 week. Refuse to allow to touch of left knee and foot.
> — no obvious trauma, afebrile.[9]
> …
> — X-ray — left femur lower metaphysis posterior fracture — ? pathological fracture."

Fourth presentation

28. On 1 October 2015, Master A presented to the Orthopaedic Ward to undergo an MRI under general anaesthesia. A pre-anaesthetic checklist

[9] Without fever.

noted that Master A had a broken tooth. No pathology was seen at the distal femoral metaphysis (the site of initial concern on the first X-ray carried out on 14 September). However, abnormality was found on the left tibial shaft, and Master A was admitted to the ward with a working diagnosis of "infection or tumour of left tibial shaft".

29. At approximately 4.30pm, a student nurse, Ms B, completed a Paediatric Nursing Assessment Form. The "Social History" aspect of the form was partially completed. The sections referring to the name of Master A's father and "Any restriction with visitors" were left blank. Ms B told the HDC that when she asked Ms A if she could put something down for the father's name, Ms A said no, and that Ms A did not mention any visitor restrictions. A family violence screen was completed with a negative result.

30. Under the heading "Hygiene/Skin Integrity", Ms B documented faded bruises on Master A's right forehead and cheek, a missing tooth and two black fingernails, and one lost nail on the right hand. Ms B told the HDC that she "did not link a non accidental injury to the presenting complaint", but said that she informed her preceptor, registered nurse ("RN") F, of these observations immediately.

31. RN F advised the house officer on duty of the injuries. RN F advised the HDC that Ms A was questioned about the injuries and gave reasonable explanations (the tooth injury had occurred at kindergarten, and his fingers had been jammed in a door). RN F told the HDC that she did not immediately suspect non-accidental injury as being the cause of the injuries. Although there is no record of any communication with the house officer, at 9.45pm Ms B documented: "Master A here for investigations and a protective environment."

32. On 2 October 2015, Master A and his mother left the hospital in the evening. The Orthopaedic Team recommended that Master A remain in hospital over the weekend (3–4 October) because of the potential risk of a pathological fracture due to the bony abnormality seen. The defendant advised the HDC that Ms A declined this advice and signed an indemnity form, promising to return Master A to the ward after the weekend.

33. Master A and Ms A returned to Southland Hospital on 5 October 2015. A bone scan was planned for Master A, but because of the difficulty in arranging for it to be done under general anaesthesia at Southland Hospital, it was decided that Master A would be transferred to Christchurch Hospital under paediatric care (with orthopaedic input).

34. The transfer letter to the Paediatric Department at Christchurch Hospital notes the "Diagnosis" as "Refusing to mobilise on [left] lower leg, MRI showed ? infection ? tumour of [left] tibial shaft". The nursing transfer letter notes family circumstances that had not been documented in Master A's medical notes previously — specifically, that Master A was living at home with his mum, his father had a restraining/parenting order, and that his mother's new partner was on home detention.

35. There is no documentation indicating that any of the nursing and medical teams had discussed the possible cause or significance of Master A's injuries or had any concerns about Master A's care or protection.

Admission to Christchurch Hospital

36. During 6 and 7 October 2015, Master A was reviewed by the Paediatric Team at Christchurch Hospital. A repeat plain X-ray of Master A's left leg confirmed a diagnosis of a tibial spiral fracture. The following additional injuries were also documented:

> "Has 2 black fingernails [and] 2 damaged fingernails on [right] hand. Mum says repeatedly shut fingers in door — accidentally.

> Missing left bottom tooth incisor — no history of witnessed trauma.
>
> Bruises over both left [and] right iliac crests[10] [and] up trunk over ribs of right chest wall in axillary line.
>
> Light pink discolouration over [right] lower quadrant of abdomen — Mum states it is a birthmark."

37. The Paediatric Team at Christchurch Hospital also recorded Master A's family circumstances in detail, including the fact that his mother's new partner was on home detention for assault, and that he had permission to be in their home. Due to the number of unexplained injuries noted on Master A, an Unexplained Injury Process was initiated. A Report of Concern was sent to Oranga Tamariki (previously Child Youth and Family), and a referral was made to the Child Protection Team. This was communicated to the Police and the Social Work Team at Southland Hospital. As part of the investigation into the suspected non-accidental injury, a skeletal survey was also planned.

38. A consultant paediatrician at Christchurch Hospital contacted Dr C at Southland Hospital, and it was agreed that Master A would be transferred back to Southland Hospital to undertake the skeletal survey.

39. Master A was discharged from Christchurch Hospital with the following diagnoses:

> "Primary Diagnosis
>
> - Left tibial spiral fracture ?cause
>
> Secondary Diagnosis
>
> - Right lateral incisor missing ?cause
> - Right fingernail haemorrhages secondary to trauma
> - Contusions on back and buttock ?cause."

[10] The crest of the ilium is the curved outer border of the hip bone.

Transfer back to Southland Hospital

40. Master A was transferred back to Southland Hospital on the evening of 7 October 2015. Police and Oranga Tamariki staff met Master A and Ms A at the airport and accompanied them to the hospital, where a one-to-one patient watch was commenced. The plan for Master A on readmission was a skeletal survey and a senior paediatric medical review the following day.

Skeletal survey

41. A skeletal survey was performed on the morning of 8 October 2015.

42. Dr C told the HDC that during the day, she was in email communication with a paediatric radiologist from Dunedin Hospital, Dr D, to discuss Master A's skeletal survey.

43. At 8.59am, Dr C emailed Dr D requesting a review of Master A's skeletal survey. At 12.21pm, Dr D emailed Dr C her review comments:

> "I have reviewed the skeletal survey on [Master A]. He has a fracture of the tip of the terminal phalanx of the right index finger. I think the lower femoral irregularity is a normal ossification[11] variant and not a metaphyseal fracture. He is really too old to have classic metaphyseal fractures. I am disappointed I was not called earlier about this child. …"

44. Dr C replied to Dr D at 1.06pm as follows:

> "There was an issue with orthopaedics taking over and also with the child being sent home before [Dr H] could review him during the one admission. The MRI was also ortho-directed without much input from us. And then the report of femur fracture right at the beginning, which [radiology], [paediatrics] and [orthopaedics] said with certainty was not a fracture."

Skeletal Survey X-Ray — Medical Imaging (Southland Hospital) policy

[11] The formation of bone or of a bony substance, or the conversion of fibrous tissue or of cartilage into bone or bony substance.

45. Southland Hospital's policy states that for non-accidental injury in children, "an on-site radiologist must be involved".

46. Following these events, the defendant completed a Serious Adverse Event[12] Report ("SAER") into Master A's care. The SAER found that at the time of these events, the policy was unable to be followed, as two of the Southland Hospital radiologists, including the radiologist site leader, were on leave, and the third radiologist did not read skeletal surveys for non-accidental injury.

47. The SAER also noted that although Dr C expected Dr D to report on the skeletal survey formally, Dr D understood the request simply to be an informal review of the images. Dr D stated that she was not routinely reporting on films from Southland Hospital. She added that the different patient archiving and communication system between Dunedin Hospital and Southland Hospital made it difficult for cross-hospital reporting to occur, and she would not consider doing so unless expressly asked by the clinical leader of Southland Hospital Radiology.

48. Southland Hospital's medical radiology technicians ("MRT") were expecting Dr D to formally report Master A's skeletal survey. When the charge MRT became aware that reporting Master A's skeletal survey was not the understanding of Dr D, they contacted the District clinical leader (who had started work five weeks previously). The District clinical leader reviewed the skeletal survey images but did not issue a formal report, as she understood that skeletal surveys were to be double read.

49. The defendant's SAER found that leave cover arrangements when both the DHB paediatric radiologists were absent were not clear to the radiologist service in either Southland Hospital or Dunedin Hospital. As

[12] A serious adverse event is an event with negative reactions or results that are unintended, unexpected, or unplanned. In practice, this is most often understood as an event that results in harm to a consumer.

a result of the above, although Master A's skeletal survey was discussed and results passed to Oranga Tamariki on the day of the survey, it was not formally reported on until 20 October 2015 — 12 days after it was performed on 8 October 2015.

Discharge

50. Dr C advised the HDC that she was at an out-of-town clinic when Master A was discharged on 8 October 2015. During a break in her clinic, she spoke to Master A's assigned Oranga Tamariki social worker and told her of the skeletal survey findings. Dr C asked the Oranga Tamariki social worker to write a safety plan and send it to the Paediatric Ward, and also spoke to the Paediatric Ward Manager to advise her that Master A could be discharged once the safety plan was available.

51. The hospital social worker documented the following plan in Master A's notes:

> "[T]o be discharged today …
> CYF and Police involvement.
> Safety Plan to be completed by CYF prior to discharge.
> No further involvement for hospital social worker."

52. At 12.30pm, the hospital social worker documented: "[Oranga Tamariki] to contact Children's Ward to advise decision about discharge".

53. At approximately 3pm, a further entry is made in Master A's notes by a paediatric SHO stating: "Police detective arrived on ward and stated he was happy to release Master A … home. No medical issue preventing discharge."

54. Master A was discharged from hospital on the afternoon of 8 October 2015.

55. Dr C told the HDC that when she returned to the Paediatric Ward after her clinic, Master A had been discharged despite a safety plan not being available. Dr C told the HDC that this was done without her knowledge.

Memorandum of Understanding*[13] - *Schedule 1: Children Admitted to Hospital with Suspected or Confirmed Abuse or Neglect

56. Under the heading "Multi-Agency Safety Planning Prior to Discharge", the MOU outlines the following:

> "• All children admitted with suspected or confirmed abuse or neglect will have a Multi-Agency Safety Plan in place prior to discharge from hospital. [Oranga Tamariki] have a key responsibility for the development and implementation of this plan.
>
> • The core elements of this plan will be developed prior to the discharge planning meeting, in consultation between [Oranga Tamariki], the paediatrician under whose care the child was admitted and key contact persons from other agencies involved.
>
> • The DHB will convene a discharge planning meeting prior to discharge, to include key staff, agencies and parents/caregivers involved in the care of the child before or after discharge …
>
> • The Multi-Agency Safety Plan will be documented on the agreed standard template, and will include:
>
> — Names and contact details of those involved in making the Safety Plan.
>
> — Names and contact details of key contact people including [Oranga Tamariki] social workers, the DHB key contact person and the Police Investigating Officer.
>
> — Identification of who will care for the child after discharge, including such details as names, addresses and other contact details.
>
> — What and how support will be provided to the child and the child's caregivers after discharge.
>
> — Safety arrangements after discharge.
>
> — Health and rehabilitation needs after discharge …
>
> — Any barriers to service provision after discharge, and how these will be addressed.
>
> — Arrangements for monitoring and review of the plan."

[13] MOU between Oranga Tamariki, Police, and DHBs.

57. The final discharge planning and procedures in the MOU were not followed in relation to Master A. Dr C told the HDC that the DHB policies were in "a state of flux". The MOU was not required reading at the time of the events, and was not uploaded onto the defendant's document control system.

Subsequent events

58. Sadly, Master A sustained further injuries following discharge and was found deceased on 13 October 2015.

Findings from SAER

59. The defendant's SAER of Master A's care found the following:

- The first X-ray report was inconclusive but a paediatric radiologist was not involved in discussing this or to plan further imaging. This resulted in erroneous conclusions and unnecessary imaging requests.
- Incomplete history taking, including social history and consideration of risk factors for the presence of non-accidental injury.
- Incomplete differential diagnosis, non-accidental injury not documented as a possible concern despite clinicians being aware this was a possibility.
- Inconsistent communication and sharing of information within and between clinical teams including in the clinical details section of radiology request forms.
- There was a different understanding between the charge MRT and paediatric radiologist about who was responsible for reporting the skeletal survey.
- Some radiologist staff were unclear about the arrangements for paediatric radiology cover when both were on leave.
- A national multi-agency safeguarding (MOU) was not followed prior to discharge following Master A's readmission from Christchurch Hospital.

EXPERT EVIDENCE

60. The HDC obtained independent expert advice from an ED expert, a paediatric expert, an orthopaedic expert, and a paediatric radiology expert, who variously stated that:

a. There is little if any evidence that trauma, inflicted or otherwise, was on the differential diagnosis for Master A. Throughout the multiple presentations at Southland Hospital there was no noted consideration of the possibility of a non-accidental injury. The lack of consideration was systemic across all services.

b. While the delay in diagnosing the spiral tibial fracture itself was not a departure from accepted standards, there was a significant delay in the diagnosis of possible non-accidental injury and there were a number of warning signs in the presentations for the diagnosis of non-accidental injury to be considered.

c. There was a general lack of documentation regarding the social circumstances of Master A and his family.

d. It was inappropriate to discharge Master A on 19 September and 8 October 2015. In the context of proven or suspected child abuse, the child should not be discharged home until the clinical team has the undertaking from Oranga Tamariki that the child is going to a place of safety.

BREACH OF RIGHT 4(1) AND RIGHT 4(5) OF CODE

61. Right 4(1) of the Code states: "Every consumer has the right to have services provided with reasonable care and skill".

62. Right 4(5) of the Code states: "Every consumer has the right to co-operation among providers to ensure quality and continuity of services".

63. The defendant acknowledges that it is responsible for the operation of the services it provides and that a series of failings in assessment, communication, documentation, and coordination of care, and that a failure to adhere to policies and procedures prevented earlier diagnosis of Master A's spiral tibial fracture and non-accidental injuries.

64. The defendant accepts that in this instance its systems did not encompass an adequate safeguard for Master A, and that there was a systemic failing on its part with tragic outcomes for Master A and his family.

65. The defendant accepts that it breached Rights 4(1) and 4(5) of the Code for the following reasons:

a. The diagnosis of non-accidental injury was not considered adequately across multiple presentations to hospital, resulting in a delayed diagnosis. This was reflected in poor documentation of social history, cause of injury, and family violence screening.

b. The important policies and procedures around family violence screening and non-accidental injury were not followed by numerous staff. The defendant did not have robust systems in place to ensure that the policies could be followed.

c. The defendant failed to ensure quality and continuity of services. The inadequate documentation led to an incomplete clinical picture, critically as to risk of harm, being passed on between different teams and departments, and this contributed to a delay in Master A's diagnosis.

d. Master A's journey through the Paediatric, Orthopaedic, and Radiology teams was inadequate, and included two inappropriate discharges from hospital and delayed reporting of his skeletal survey.

e. Across all disciplines, there were systemic failings in the care provided to Master A within teams, and across services.

Kerrin Eckersley
Director of Proceedings

Date:

I, _____, agree that the facts set out in this Summary of Facts are true and correct

For or on behalf of
Southern District Health Board

Date: