MIDCENTRAL HEALTH

A division of MidCentral District Health Board providing specialist health and disability services

Phone (06) 356 9169
Fax (06) 350 8818

Postal Address:
Private Bag 11036
Manawatu Mail Centre
Palmerston North 4442
New Zealand

Physical Address:
Ruahine Street
Palmerston North
New Zealand

17 August 2015

Attention: Elise
EMAIL: fyi-request-2954-4ad283c0@requests.fyi.org.nz

Dear Elise

Please find attached a list of the misdiagnosed patients where death has resulted in the last five years. There have been no deaths caused by medical negligence in the past five years for MidCentral District Health Board (MDHB).

These cases have been reported to the Health Safety & Quality Commission as per MDHB requirements.

Yours sincerely

Susan Murphy
Manager
Quality & Clinical Risk

Serious	Death of a 4yr old following re-insertion of a mickey button which resulted in food/fluid being released into the peritoneum leading to overwhelming sepsis.	Feeds and medication given through an unrecognized dislodged gastrostomy tube, which resulted in gastric contents being introduce into the abdominal cavity, causing overwhelming sepsis and death. Causal factors: Insufficient knowledge and inadequate guidelines for the acute management (less than 6-8 weeks) of a dislodged gastrostomy tube. Failure to recognise a potentially serious diagnosis/condition.	• Establish the process for management of acute (less than 6-8 weeks old) and established (over 6-8 weeks) gastrostomy tubes in children, which includes determining the specific tests and actions required to be completed, post dislodgement of tube. • Develop and implement an education package of best practice, for management of gastrostomy in children, for clinical staff. Incorporate the package in to orientation to the children's unit. • Determine and implement an effective tool that assists in the assessment of pain and distress in the cognitively impaired/non verbal child.
Serious	Mis-diagnosis of patients condition which resulted in death	Patient had intellectual difficulties which made assessment of his condition complicated. Patient was inappropriately treated for acute MI when dental abscess was the cause. Inappropriate referral and admission under medicine. Delay in drainage of abscess.	• Review of appropriate pathways of care for sepsis patients and consideration of shared care arrangements.
Serious	Undiagnosed condition and death of twin	Delay in diagnosis of a cord occlusion of one twin which resulted in the physical condition deteriorating to a pre-morbid outcome and life threatening for the other twin. This twin was terminated. No root cause found	• Strengthen and formalise inter-departmental, functional working relationships, between Obstetricians, Radiologists and Sonographers. • Obstetric patients deemed as 'high risk' need a clearly documented plan of clinical care readily accessible to other departments of key contribution, including specialist services (Tertiary), • Cardiology and Medical Imaging departments to review the system of ultrasound appointment bookings • Complete the process to ensure scans are recorded and stored in RIS and PACS. Radiology department to provide the initial training and

			administration to Obstetric clinical and clerical staff. • Review the Intra-DHB referral system to specialist Maternal Fetal Medicine (MFM) centres, giving consideration to the development of a care pathway approach appropriate to initiating urgent uptake, after hours. • Evidence of clinical diagnoses in high risk and complex cases should be clearly documented to enable timely treatment and actions.
Serious	Fetal distress and death	The CTG was read and interpreted as normal and so discontinued. On review it was agreed that there were some signs on the CTG recording that indicate the CTG was not reassuring; variable/reduced FHR baseline, loss of contact, period of low heart rate and unsure if this was maternal pulse or FHR. Therefore the CTG recording should have been continued until such time as a reassuring trace was obtained. If the CTG was not reassuring, then continuous CTG monitoring should have taken place.	• Recommend that MidCentral explore a process to enhance the FSEP by the development of a process for 'bed-side' clinical interpretation for practitioners. To also explore the recommendations from RANZCOG for hospitals to combine annual education and assessment with regular CTG meetings to build on knowledge and communication skills. • Recommend the use of the partogram documentation for all labours. Consideration for the Observations in Labour – Partogram, Clinical Guideline (MDHB-6404) to be updated to a procedure and communicated via multiple methods. Recommend that Practitioners are educated on the use of the MCIS auto-populated partogram when it becomes available in 2015. • Recommend discussion with Paediatric Team on cord lengths for those babies who are likely to require admission to neonatal unit with a view to include this in the appropriate guideline for medical and midwifery practitioners.

			• Recommend that the Placental Histology – clinical guideline (MDHB-6444) is reviewed to explore the keeping of all placentas for a designated time frame and updated to a procedure and communicated via multiple methods. • Recommend a review of the current communication and access processes around policies, procedures and guidelines to ensure medical and midwifery practitioners have the most current information available. For example, develop a process for practitioners including LMCs to access these remotely. • Recommend that the orientation package provided by MidCentral Health to Lead Maternity Carers is reviewed and updated to include orientation for key policies, procedures and guidelines. Recommend that a process is developed to ensure new LMCs are appropriately orientated. • Recommend for a formal speciality orientation package to be provided to new Medical staff to Women's Health (Registrars & Consultants) and a process is developed to ensure new Medical staff are appropriately orientated. • Recommend that there is a review of the process and resourcing of Medical staff to ensure that the on-call consultant does not have clinical responsibilities of either operating theatre or outpatient clinics (including rural clinics) and is available on delivery suite during normal business working hours Monday – Friday.