

Investigation report

The quality of healthcare services provided to a patient by Royal Brisbane and Women's Hospital



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Investigation report— The quality of healthcare services provided to a patient by Royal Brisbane and Women’s Hospital

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1. Background

This matter was referred to me as part of the transitional process from the Health Quality and Complainants Commission (HQCC) following legislative changes on 1 July 2014.

2. The complaint

On 23 August 2013, the patient presented to Rockhampton Hospital complaining of acute headache and left side weakness. The patient's history included a known right thalamic lesion for 10 years. A magnetic resonance imaging (MRI) scan taken on 28 August 2013 reported a right thalamic enhancing lesion may be neoplastic and should be reviewed by a neurosurgeon. Dr E, a neurosurgery registrar from Royal Brisbane and Women's Hospital (RBWH), was conducting a neurosurgery outpatient clinic at Rockhampton Hospital and reviewed the patient and the MRI. He advised urgent transfer of the patient to RBWH due to suspected early development of hydrocephalus.¹

On 28 August 2013, the patient was transferred to RBWH and admitted at 11.45 pm under the care of Dr T, a consultant neurosurgeon, with a plan to repeat the MRI and biopsy the lesion with possible shunt insertion.

The patient was reviewed during ward rounds on 29 and 30 August 2013 and his condition continued to deteriorate. On 31 August 2013, the patient's condition deteriorated significantly and two calls for the Medical Emergency Response Team (MERT) were made at 9.20 am and 11.25 am. At the time of the second MERT call, the patient had become comatose and was subsequently intubated, had a head computed tomography (CT) scan and was admitted to the intensive care unit (ICU). An external ventricular drain (EVD) was inserted to relieve the pressure and fluid build-up in the brain, but no cerebral spinal fluid (CSF) sample was taken at the time. A subsequent CSF sample taken several hours later confirmed the presence of a streptococcal infection and the patient was urgently operated on, undergoing stealth guided and frameless drainage of a right thalamic brain abscess at 10.00 pm on 31 August 2013. The patient experienced poor neurological recovery since the incident and was transferred back to Rockhampton Hospital for ongoing care and rehabilitation on 5 December 2013.

On 27 March 2014, the mother of the patient (the complainant) lodged complaints with the HQCC regarding the treatment provided to her son by Rockhampton Hospital and RBWH.

¹ Hydrocephalus is a rare medical condition in which there is an abnormal accumulation of cerebrospinal fluid (CSF) in the brain.

The complainant raised the following concerns about the treatment provided to her son and identified the following issues for investigation:

- The delay in diagnosing her son's condition and a further delay to initiate treatment contributed to the poor outcome.
- Poor communication between her son's treating medical teams contributed to poor coordination in care and a poor outcome.
- Fragmented and poor communication between RBWH staff and her and her family.
- Delays in recognising her son's seizure activity and delay in providing treatment.

The complaint regarding Rockhampton Hospital was not progressed as the initial assessment did not identify any concerns with the manner in which Rockhampton Hospital managed the patient. The complaint regarding RBWH was progressed to investigation and was transferred from the HQCC to my office on 1 July 2014.

3. Health service provider

The RBWH is a 929 bed quaternary and tertiary hospital within the Metro North Hospital and Health Service (HHS).

RBWH provides high-quality care over a comprehensive range of specialties including medicine, surgery, orthopaedics, obstetrics, gynaecology, neonatal intensive care, and trauma services. It is the largest tertiary referral hospital in Queensland.

4. Investigation scope

A review of the original written complaint and initial information provided from HQCC identified the following issues for investigation.

Issue one—The alleged delay in diagnosing and initiating treatment contributed to the poor outcome for the patient:

- The failure to consider an alternative diagnosis to that of the patient's known history, despite progressive neurological deterioration.
- Significant delay in further investigation and treatment, including insertion of EVD, despite the patient becoming comatose.

Issue two—The alleged poor communication and coordination of care between treating medical teams contributed to the poor outcome for the patient:

- Failure to identify and manage a critical clinical deterioration of the patient in line with RBWH medical emergency call criteria protocols.
- Inconsistent and brief documentation in recording observations on the patient's different charts failed to appropriately record the seriousness of his condition and progressive neurological deterioration.

- Failure to communicate critical information to all members of the treating team.
- Lack of protocol and policy at RBWH to inform senior medical officers and treating consultant of clinical deterioration or concerns.
- Family being provided limited or conflicting information causing confusion and frustration.

Issue three—The alleged delays in recognising and providing treatment for the patient’s seizure activity:

- Failure to action concerns raised by the family regarding further deterioration and seizure-like activity between 20 September 2013 and 23 September 2013 following insertion of a shunt on 19 September 2013.

5. Inquiries by the Health Quality and Complainants Commission

The complaint was made to the HQCC on 27 March 2014, and the HQCC obtained the following information from RBWH:

- 2 May 2014—a submission in response to the allegations
- 21 May 2014—the patient’s medical records
- 22 May 2014—the root cause analysis (RCA) document.

6. Inquiries by the Health Ombudsman

The information transitioned from the HQCC was reviewed and outstanding information identified. At that stage, an additional issue was found—the quality of the clinical records made by RBWH staff in relation to the patient in which inadequacies and inconsistencies were identified.

In August 2014, additional medical records were requested for the patient relating to the treatment and care provided to him from his admission to Rockhampton Hospital on 23 August 2013, up to his discharge from RBWH in December 2013.

Inquiries undertaken by my office identified several practitioners involved at critical junctures in the patient’s treatment and statements were obtained in relation to their involvement with the treatment and care provided to the patient.

Additional information was obtained from the complainant in relation to her concerns and the events that took place at RBWH. This included the perceived failure of staff to take appropriate care of the patient or to adequately address or investigate concerns raised by the family regarding his deteriorating condition.

In September 2014, I requested an update from RBWH on the implementation of the RCA recommendations and lessons learned.

In January 2015, independent clinical advice was sought from a registered medical practitioner specialising in neurosurgery. The medical practitioner was asked to comment on the quality and timeliness of treatment provided to the patient. I received the advice in February 2015.

In May 2015, a final update on the status of the outstanding recommendations and lessons learned was requested and provided by RBWH.

7. Analysis of the evidence

The analysis of the evidence has been conducted and summarised for each issue in the investigation.

Issue 1—The delay in diagnosis and treatment contributed to the poor outcome for the patient

The patient presented to Rockhampton Hospital on 23 August 2013, with acute onset of headache and left side weakness. His clinical history included a known right thalamic lesion diagnosed in 2000, deemed inoperable due to its proximity to the brain stem. On 28 August 2013, he was reviewed by a visiting neurosurgery registrar from RBWH who recommended urgent transfer to RBWH on suspicion of early onset hydrocephalus.

Clinical records

The patient was transferred to RBWH on 28 August 2013 and was admitted at 11.45 pm with the presenting symptoms of acute onset of persistent headache, left side facial weakness, paresthesia² and progressive degeneration of neurological symptoms over the previous 48 hours. At the time of admission, the patient scored 15 on the Glasgow Coma Scale (GCS)³.

30 August 2013

At approximately 2.45 am, the patient's GCS decreased from 15 to 13. However, no MERT call was initiated. RBWH medical emergency call criteria states that a drop of two or more in a patient's GCS must initiate urgent clinical review or a MERT to assess the cause for the deterioration in consciousness.

At 9.49 am, a repeat MRI initially reported a finding of a mass in the right thalamus (known history). However, a review by a senior radiologist suggested a differential diagnosis of high grade neoplasm and abscess. The senior radiologist reported this to Dr B, the neurosurgery registrar on call, as per RBWH procedure. However, this critical information was not conveyed to the treating team, the consultant neurosurgeon Dr T, or recorded in the patient's progress notes to alert other treating teams to the

² Paresthesia is typically a tingling sensation (pins and needles) that, if chronic, is indicative of a neurological problem, ranging from a pinched nerve to a brain tumour.

³ The Glasgow Coma Scale is a neurological assessment tool that aims to give a reliable, objective way of recording the conscious state of a person. The patient is assessed against criteria of the eye, verbal and motor response and the resulting score gives a result of 3 to 15. As the criteria have different scales within each, the GCS is to be written 'GCS 9 (E2 V4 M3) at 07.35' so changes in any one criteria can readily be identified.

suspected findings of the updated MRI report. The radiology report containing this critical information was not uploaded to the radiology system until 2 September 2013.

31 August 2013

At 5.30 am, nursing staff observed the patient to have seizure-like activity with recurrent brief episodes of involuntary shaking of the legs.

At 7.30 am, a team was called to review the patient. However, shortly after they arrived to assess the patient, they were called to attend a MERT and the assessment of his condition was left for the morning team.

At 9.20 am, further shaking was observed and the resident medical officer on duty was notified and gave advice to the nursing staff to continue to observe the patient. The patient's GCS dropped to 12 and a MERT call was initiated. While the neurosurgery registrar attending the MERT noted the blood test results reported very high neutrophils, infection was not considered a possible cause. Treatment commenced on the basis that the seizure-like activity was a result of increasing hydrocephalus and the patient was commenced on anti-seizure medication. Appropriate tests were conducted and an EEG did not display any epileptic activity or indicators.

At 10.40 am, the speech pathology review noted the previous MERT call and discussed with the treating team the patient's vomiting and drowsiness/difficulty to rouse.

At 11.10 am, the family of the patient reported to nursing staff that he felt hot. He had a temperature of 38.5°C and a full set of observations were taken. When the observations were repeated at 11.20 am, his GCS was 3. Another MERT call was initiated and the patient was intubated and transferred to ICU.

At 1.28 pm, a repeat CT scan was conducted following which an EVD was inserted but no CSF sample was taken at the time.

At 8.30 pm, a CSF sample was obtained and sent for analysis.

At 9.30 pm, microbiology reported that the CSF was gram positive for streptococcus or enterococcus infection.

At 10.00 pm, the patient was booked for theatre and stealth guided frameless drainage of the abscess was carried out at approximately 11.20 pm.

Following the diagnosis and drainage of the abscess, the patient experienced poor neurological recovery. His GSC remains at 8–9, indicative of significant brain injury and subsequent brain scans show increased areas of infarct (dead tissue resulting from failure of blood supply).

Clinical advice

The independent clinical advisor stated that the diagnosis of the brain abscess was not delayed, as the diagnostic imaging was performed in a timely manner and the senior radiologist identified a suspected abscess on 30 August 2013. These findings were appropriately passed on to neurosurgery registrar

Dr B. However, there was a delay in confirming the clinical suspicion identified by the senior radiologist and commencing appropriate treatment with surgery, despite the progressive clinical deterioration of the patient.

The clinical adviser further stated that, following deterioration by the patient to a GCS of 3, there was still a delay of approximately 12 hours before definitive action was taken. While the clinical adviser agreed that it was appropriate to obtain a CT scan prior to insertion of the EVD, there still followed an unexplained delay from the time of the scan at 1.28 pm and the completion of the procedure sometime between 2.00 pm and 3.40 pm and obtaining a CSF sample at 8.30 pm, which ultimately confirmed the senior radiologist's suspicion of an abscess. The clinical adviser was of the opinion that these delays are likely to have contributed to the poor outcome for the patient.

Root cause analysis

The findings of the RCA were noted.

Statement—Dr T (consultant neurosurgeon)

Consultant neurosurgeon Dr T first learned of the patient's condition during his neurosurgery outpatient clinic at Rockhampton Hospital on 28 August 2013, when Dr E discussed the patient's case with him. He reviewed the recent imaging for the patient and identified a mild degree of hydrocephalus due to the fact the tumor was partially blocking CSF outflow from his third ventricle.

Dr T agreed to take over care of the patient and Dr E arranged urgent transfer of the patient to RBWH, based on a suspicion of early stage hydrocephalus.

On 29 August 2013:

- Dr T reviewed the patient and based on the known history of a diagnosed brain tumor in 2000 and his current presentation, examination, radiology and blood tests, Dr T concluded that the low-grade glioma had transformed to a more aggressive type of tumor.
- The patient advised that the dexamethasone treatment commenced on 28 August 2013 had improved his condition, with fewer headaches and increased strength in his left arm.
- Dr T advised the patient and his family that he wished to conduct further investigations prior to commencing treatment and planned for repeat MRIs and CSF flow studies to confirm if the tumour was low or high grade.

Prior to the patient's admission to the ICU on 31 August 2013, Dr T was not made aware of any concerns with, or deterioration in, the condition of the patient.

On 31 August 2013, Dr T was on-call and was contacted via telephone by the neurosurgery registrar on duty at that time Dr J. Dr T was advised that the patient had been transferred to ICU as a result of the decrease in his level of consciousness to a GCS of 3. Dr T advised via telephone that an urgent CT scan should be done and requested that he be contacted once it was completed.

The CT scan displayed worsening hydrocephalus and Dr T advised urgent insertion of an EVD. This was performed by Dr J as Dr T was not present at the hospital at that time. Dr T made his way to the hospital to review the patient and discuss his condition with the treating team.

Upon arrival at RBWH on the afternoon of 31 August 2013, Dr T reviewed all the available scans of the patient's brain to date. The MRI report available to Dr T during this review was the original report of the MRI taken on 30 August 2013, which did not have reference to the suspicion of abscess. The amended report containing the comments by the senior radiologist of a suspect brain abscess was not uploaded to the electronic reporting system until 2 September 2013.

Issue 2—Poor communication and coordination of care between treating medical teams contributed to the poor outcome for the patient

The complaint states that the poor communication and coordination of care provided to the patient contributed to the poor outcome.

Clinical records

The clinical notes for the patient are often brief and there are inconsistencies in the plotting and trending of observations on the different patient charts.

On 30 August 2013 at 2.45 am, the patient's GCC dropped by two points. However, this clinical incident was not escalated as per the RBWH medical emergency call criteria to an urgent clinical review or MERT to investigate the cause for the decrease in level of consciousness.

On 30 August 2013, the senior radiologist reviewed the MRI completed that morning and issued an additional report indicating the imaging was suspicious of an abscess and urgent aspiration was required. He conveyed this information to the neurosurgery registrar on duty Dr B, but this information was not escalated to the treating consultant neurosurgeon Dr T or recorded in the patient's notes. The additional report was not uploaded to the electronic system until 2 September 2013.

On 31 August 2013, there were two MERT calls for the patient. However, the treating consultant was not informed of the critical deterioration of the patient.

Clinical advice

The clinical advisor was of the opinion that the drop in the patient's GCS on 30 August 2013 and the MERT call on 31 August 2013 at 9.25 am were significant incidents and the failure to appropriately manage these incidents and trigger any consideration of an alternative diagnosis for the patient's progressive deterioration or escalate investigative action, such as the biopsy, contributed to the poor outcome.

The clinical advisor was of the opinion that, based on the information within the clinical notes, it appeared that critical information regarding the deterioration of the patient and the existence of, and the details within, the amended MRI report were not passed on to the consultant neurosurgeon Dr T.

Therefore, Dr T was not aware of critical information that may have given him the opportunity to consider an alternative diagnosis or escalate investigations that may have identified the abscess earlier.

Root cause analysis

The findings of the RCA were noted.

Statement—Dr B (neurosurgery registrar)

On 30 August 2013 at approximately 4.30 pm, Dr B received a call from the senior radiologist who informed her that he believed the MRI conducted on the patient that morning was suspicious of an abscess.

When Dr B received this call, she was on her way to handover with Dr E for the night shift. The senior radiologist asked Dr B for the patient's previous imaging from Rockhampton Hospital and what it had shown, as these films were hardcopy and not available to him. She advised that she would escalate his concerns to Dr E during handover:

When Dr E handed over the progress of events regarding the patient, I escalated Dr M's concerns and sought clarification of the patient's admitting complaint.

I recall asking Dr E if he could clarify the patient's history with me and whether he was sure that the lesion is a tumor, because Dr M said that it could be an abscess.

The impression I gained from my discussion with Dr E was that the prospect of an abscess being the lesion as opposed to a high grade glioma was therefore very unlikely considering the patient's history. As the issue had been clarified following discussion with the senior registrar, I did not escalate Dr M's concerns to Dr T.

It was her opinion, based on the clinical presentation of the patient at the time, that:

...there was insufficient clinical evidence at the time to suggest probably abscess and to justify taking the patient to theater for urgent drainage.

It is not uncommon for high grade tumors to have similar characteristics to abscesses on MRI. Due to this similarity, it is necessary to correlate the appearances on MRI against the patient's clinical presentation.

In this particular case, we knew (as at 30 August 2013), that the patient had a known lesion that appeared low grade over 10 years, his clinical presentation at that time, as confirmed in my discussion with Dr E, correlated with a likely high grade glioma; he was afebrile and his raised white cell count was explained by recent commencement of high dose steroids. Against this background, there was insufficient clinical evidence at the time to suggest a probable abscess and to justify taking the patient to theater for urgent drainage.

Statement—Dr E (neurosurgery registrar)

During the handover, she [Dr B] briefly mention to me that a radiologist had spoken to her with regards to the result of the MRI finding for the patient.

I did not review the scan. Nor did I give advice regarding to decision making for that person.

I did reiterate that she should review the patient and contact the Consultant involved which was Dr T.

I am not sure why she did not review nor [why] she did not contact Dr T that evening.

Statement – Dr T (consultant neurosurgeon)

Dr T was not made aware of the MERT calls for the patient on 31 August 2013 until the time the patient was admitted to the ICU.

Dr T telephoned the senior radiologist on 1 September 2013 to discuss the events of the previous day. The senior radiologist informed Dr T that he had contacted neurosurgery registrar Dr B, who was on call on 30 August 2013, and told her that he suspected the deep-seated lesion could be an abscess.

Dr T was not informed by Dr B that the senior radiologist had contacted her with this information. If this information had been passed on to him on 30 August 2013, he would certainly have taken steps to biopsy and aspirate the lesion that evening. Dr T does not know why Dr B did not forward this information on to him. Had Dr T known about these radiological findings he would have taken immediate steps to evacuate the abscess and start antibiotics.

The frequency of brain abscess is very low. Brain abscess occurs worldwide with an incidence of approximately four per million of the population. The patient was a generally healthy man without any history of sepsis, severe infection, AIDS, congenital cyanotic heart disease or chronic sinusitis which are commonly found aetiologies of a brain abscess. Accordingly, this was not a likely diagnosis for the patient.

Issue 3—Delays in recognising and providing treatment for the patient's seizure activity

The complainant states that following the insertion of a shunt on 19 September 2013, the patient began to experience seizure activity. However, nursing staff did not act on the concerns of the family.

Clinical records

There is significant variation in the level of detail recorded in the progress notes between 20 and 23 September 2013.

The first record in the progress notes following the insertion of the shunt on 19 September 2013 that mentions seizure activity is on the afternoon of 23 September 2013. The progress notes record that the

family rang for a nurse due to seizure-like activity having been observed. The neurosurgery registrar was called to review the patient at 5.50 pm. At 7.30 pm a MERT call was made due to ongoing seizure activity.

A nurse also recorded that the complainant was overheard to call Dr T and leave a message for him to 'do something before they kill my son'. In response to this, the nurse unit manager sent an independent observer down to the ward to observe how the situation was being managed. It was reported that the ward staff were managing the situation appropriately.

8. Metro North Hospital and Health Service response to draft report

Proposed recommendations

Section 86(5)(d) of the *Health Ombudsman Act 2013* provides that if the Health Ombudsman proposes to recommend in an investigation report that a particular entity take a particular action, the Health Ombudsman must consult with the entity about the recommendation before finalising the report.

On the basis of the information considered in the draft of this report, the Health Ombudsman proposed making the following recommendations aimed at mitigating future risk:

- Undertake an evaluation of the effectiveness of the implementation of the revised urgent clinical review procedure and response management of patient deterioration.
- Develop and implement an action plan to promote awareness among staff and consumers of Ryan's Rule.

Accordingly, on 4 January 2016, the draft investigation report was provided to Metro North HHS with an invitation to comment on the opinions and recommendations.

Submission from Metro North Hospital and Health Service

On 1 February 2016, the office received a written submission from Metro North HHS in response to the draft version of this report. The investigator carefully considered the submission and, where appropriate, made amendments or clarifications before finalising report.

The majority of the submission from Metro North HHS was an acceptance of the facts and proposed recommendations. Metro North HHS acknowledged that there were deficiencies in several policies and procedures and, since this incident, have taken definitive actions to mitigate future risk by implementing all recommendations that were identified in the RCA.

The submission further stated that given the findings of fact and Metro North HHS acceptance of the systemic issues identified at RBWH, the poor outcome for the patient resulted from the deficiencies in several procedures and protocols within the RBWH, rather than the actions or conduct of any individual.

The submission demonstrates that MNHHS has taken decisive action to address the issues highlighted by this incident and have implemented significant changes and improvements to their policies to mitigate future risk. These amended policies have been implemented across Metro North HHS.

9. Findings

The patient was a clinically complex patient with a long history of right thalamic lesion. However, his presentation to hospital and continued neurological deterioration was poorly managed.

Issue one—The delay in diagnosis and treatment contributed to the poor outcome for the patient

An analysis was conducted of the clinical records, clinical advice obtained and submissions from RBWH and individual practitioners.

The clinical advisor determined that while the diagnosis of the brain lesion was not delayed, he was of the opinion that confirming the clinical suspicion of an abscess and initiating treatment with surgery in the presence of progressive clinical deterioration was delayed.

The clinical advisor was critical that definitive treatment was not actioned until after there was severe deterioration in the patient's GCS, and that there was greater than 12 hours delay after the deterioration occurred before surgery was actioned.

The clinical advisor stated that this delay between severe deterioration of the patient to GCS 3 and surgery being undertaken, could have been avoided and was likely to have contributed to the poor outcome for the patient

Based on the statements provided, the clinical records for the patient, the findings of the RCA and the independent clinical advice, I am of the view that the allegation that the delay in diagnosis and treating of the brain abscess contributed to the poor outcome is substantiated.

Issue two—Poor communication and coordination of care between treating medical teams contributed to the poor outcome for the patient

An analysis was conducted of the clinical records, the clinical advice obtained from the independent clinical expert, and submissions from RBWH and individual practitioners.

Based on the statements provided, the clinical records, the findings of the RCA and the independent clinical advice, I am of the view that the allegation that the poor communication and coordination of care between the treating medical teams contributed to the poor outcome for the patient is substantiated.

Issue three—Delays in recognising and providing treatment for the patient's seizure activity

An analysis was conducted of the clinical records and the clinical advice obtained from the independent clinical expert.

The complainant states that the family reported concerns of seizure-like activity from 20 September 2013. However, there is no record within the progress notes to support this claim. There is reference to the family raising concern about the patient's unequal pupil dilation but the first reference in the progress notes to seizure activity is on 23 September 2013.

I note that one of the main allegations made by the complainant was that staff failed to acknowledge and act on concerns raised by the family. Given the inconsistency of detail recorded in the patient's progress notes, I am unable to determine if there were earlier episodes of seizure activity as claimed by the family that were not documented and not appropriately investigated and treated.

Seizure activity was recorded on 23 September 2013 and a neurosurgery registrar was appropriately called to review the patient. When the seizure like activity continued, a MERT call was made. I note that there are contradictions and inconsistencies in the notes by different staff involved in this incident. However, it appears that appropriate action was taken once the seizure-like activity was recorded on 23 September 2013.

Based on the information available, when seizure activity was recorded, appropriate action was taken to both manage and treat the seizures. Given the family's concerns with the treatment by staff, the nurse unit manager sent an independent observer to the ward to ensure the situation and concerns of the family were being appropriately managed.

The clinical records for the patient contain frequent entries during his admission to RBWH where the family expressed their frustrations at the level of information provided to them and the poor care they felt was being provided to the patient. RBWH implemented Ryan's Rule as of May 2014. However, the RRCD meeting on 21 April 2015 noted that Ryan's Rule was not well embedded at ward level, and is revisiting the implementation of this within the hospital to improve staff awareness.

Overall, it appears that RBWH has now taken appropriate steps to address the concerns of patients and their families through the implementation of Ryan's Rule. However, in this case there were deficiencies where several situations with the family of the patient were handled poorly which added to the family's frustration. Based on the information available, I cannot determine if there were earlier instances of seizures not reported and actioned. As a result, while I am of the view that there were deficiencies in the communication with the patient's family, it would appear that, when recorded, appropriate actions were taken to treat the seizure-like activity.

10. Conclusion

In making a decision under the *Health Ombudsman Act 2013*, the paramount guiding principle is to protect the health and safety of the public.

Taking all the evidence into consideration, I have formed the view that the overall care and treatment provided to the patient by RBWH was inadequate and the allegation that the delay in diagnosis and treatment of the brain abscess contributed to the poor outcome for the patient is substantiated.

While the patient was a clinically complex patient with a long history of right thalamic lesion, his presentation to hospital in August 2013 and subsequent progressive neurological deterioration was poorly managed. This was due to the lack of communication and poor coordination among treating teams, which was compounded by a lack of RBWH policy to require information to be escalated to treating consultants and failure to record consistently an appropriate level of detail regarding the patient's condition. The poor and inconsistent documentation failed to reflect, to the necessary degree, the seriousness and continued deterioration of the patient. Had it done so, it may have resulted in a better outcome for the patient.

The unexplained delay in taking a CSF sample has been adequately addressed through the revision of the EVD insertion guidelines to include the mandatory requirement to take a CSF sample at the time of insertion. The review was conducted by the Director of Neurosurgery and subsequently endorsed by the RBWH Critical Incident Committee. The new EVD guidelines were implemented in December 2014. This mitigates the risk of future delays in obtaining a sample and analysis being conducted to identify any potential infection.

Based on the statements provided, the clinical records and the independent clinical advice, the allegation that poor communication and coordination of care between the treating medical teams contributed to the poor outcome for the patient is substantiated. Further, I have found insufficient evidence to indicate professional misconduct or that the performance of any practitioner involved was below the standard reasonably expected, rather it was the systemic flaws within RBWH that contributed to the poor outcome for the patient.

11. Recommendations

The actions taken by RBWH to address the poor outcome for the patient appear to deal adequately with the key issues and to mitigate future risk.

To satisfy me that the health and safety of the public is protected in the future, and to determine whether the lessons learned from this incident and actions undertaken have effectively mitigated the risks, I have consulted with RBWH in regards to the findings within this report, and Metro North HHS has agreed to the following recommendations:

1. Recommendation 1—Metro North HHS undertake an evaluation to determine the effectiveness of
 - the implementation of the revised urgent clinical review procedure across the Metro North HHS

- the changes made to the revised urgent clinical review procedure in improving medical and nursing/midwifery response management of the deteriorating patient at the RBWH.
2. Recommendation 2—Metro North HHS develop and implement an action plan to increase staff and consumer awareness of Ryan’s Rule throughout the RBWH.

I have determined that *no further action* will be taken in relation to the matter and the investigation is now closed in accordance with section 44(1)(a)(iv) of the *Health Ombudsman Act 2013*.

Leon Atkinson-MacEwen
Health Ombudsman

14 October 2016

Please note: on 12 January 2018 information in this report was redacted and the amended report approved by the Acting Health Ombudsman Andrew Brown.