Te Whatu Ora
Health New Zealand
Counties Manukau

6 October 2022

Dr Pete Watson
Interim District Director
Te Whatu Ora Counties Manukau

Dear Pete

RE: Death of patient who presented to ED with headache

I have received two independent reports regarding the death of a patient who presented to the Middlemore Hospital Emergency Department in June 2022, but who was not triaged or assessed prior to leaving Emergency Department (ED), only to represent in extremis a few hours later.

This case is clearly tragic and distressing, and I acknowledge the grief and loss experienced by the family of the deceased.

Both reviewers conclude that triage at the time of the original presentation was unlikely to have altered the outcome. Both reviews stress that no fault is attached to the patient or her family for the decision to leave the Emergency Department. I echo these conclusions.

Despite the likely outcome being no different had the patient been triaged at the first time of presenting, there are important issues raised in the Emergency Department review that we are working to address.

Neurosurgery

The key question asked of the expert Neurosurgical reviewer was whether or not the delay at the time of the first presentation altered the patient's outcome?

The expert Neurosurgical reviewer concluded that "putting all the information together I do not believe the delayed admission had any significant impact on (the patient's) pathology and final outcome".

Emergency Department

The expert Emergency Specialist reviewer's report has emphasized the fundamental problem of the overcrowding of the Emergency Department and the risks to patients caused by this. The reviewer noted that data shows Middlemore Hospital Emergency Department has been under considerable pressure for a sustained period.

Two major flow issues are noted by this reviewer – surge demand for care as very high numbers of patients presented to the Emergency Department, and the effects of extremely high in-patient occupancy. Data shows it has been taking excessively long for some patients to be assessed (as evidenced by the ED "6-hour target" data) and that for those admitted, the time to leave the ED has also, on average, been too long.

The reviewer notes staffing pressures, and notes that staff acted with the best of intentions. The reviewer also recognises the skills and dedication of the ED teams to function in the face of these significant challenges; I endorse the reviewer's comments about the dedication and skills of our staff to minimise these risks.

Conclusion:

I accept the external review expert opinion that the patient was very unlikely to have survived this catastrophic medical event if they had remained in the Middlemore Hospital Emergency Department, been triaged, assessed and received care.

There are however a number of recommendations concerning the Emergency Department which I accept, and we are working to address. Managing periods of high surge demand at Middlemore Hospital Emergency Department through supporting access to care for after-hours medical care, improving ED processes and enhancing hospital patient flow are areas of on-going review and work, as is workforce support and improving communication to patients.

Other than redactions for reasons of privacy, the reports are presented in full. I have redacted the names of the reviewers as any enquiries should, I believe, be made to Te Whatu Ora Counties Manukau.

Kind regards

Andrew Connolly
Acting Chief Medical Officer