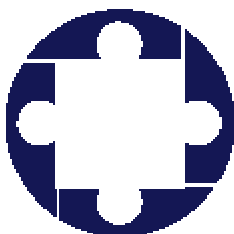

Office of the Health Complaints Commissioner 2007

0608028 – Public hospital – failure to diagnose

s. 23 (1)(d) – ***a health service provider failed to exercise due skill*** **–finalised February 2007**

The health service user had attended the Emergency Department of the LGH on 2nd and 4th July 2006 and on each occasion had been diagnosed with gastro-oesphageal reflux. The clinical examination was essentially normal except for systolic hypertension (BP 172/86). His electrocardiograph and chest x-ray were normal and a specific blood test for heart attack (troponin) was also normal. The consumer underwent an upper gastro-intestinal endoscopy on 13 July and died at a friend's place the next day.

The provisional cause of death was cardia arrhythmia secondary to 50% atheromatous narrowing of left anterior descending Coronary artery. Subsequent information provided by the pathologist to the Coroner gave the cause of death as "cardiac arrhythmia related to coronary artery atherosclerosis, epilepsy and asthma". The hospital undertook a further investigation and advised the Coroner of the revised cause of death.

The complainant was the legal wife of the consumer but separated from him and he had named his current partner as his next of kin. A complaint was lodged by the legal wife countersigned by the son of the deceased as the hospital were reluctant to provide information to her as to the treatment provided by the hospital and the cause of death of her spouse. The LGH were reluctant as the deceased had nominated is current partner as the next of kin. She made no enquiry as to the cause of death and the complainant and the deceased's adult children were concerned that the death may have arisen as a consequence of a failure by the LGH to make a correct diagnosis. The Commissioner may under s.22 (k) accept a complaint if in the circumstances of a particular case a person other than a person referred to in s.22 (a) to (j) inclusive should be entitled to make a complaint and in this instance the complaint was accepted by the Commissioner. The Hospital then provided a report to this office with the Coroner's Certificate reporting the provisional cause of death. The final certificate issued and a copy was provided to the complainant who accepted the cause of death as reported and was prepared to accept the explanation of the treatment provided by the Hospital.

The matter was closed pursuant to s.25 (5)(g) of the *Health Complaints Act* 1995, which provides that: *"The complainant has been given reasonable explanations and information and there would be no benefit in further entertaining the complaint"*.