MEDICAL PRACTITIONERS DISCIPLINARY TRIBUNAL

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DECISION NO:	167/01/76D
IN THE MATTER	of the Medical Practitioners Act 1995
	-AND-
IN THE MATTER	of a charge laid by the Director of Proceedings pursuant to Section 102 of the Act against **EDMOND FREELAND WALFORD** medical practitioner of Tauranga

BEFORE THE MEDICAL PRACTITIONERS DISCIPLINARY TRIBUNAL

TRIBUNAL: Mr G D Pearson (Chair)

Ms S Cole, Dr A M C McCoy, Dr F McGrath, Dr A D Stewart (Members)

Ms G J Fraser (Secretary)

Mrs G Rogers (Stenographer)

Hearing held at Wellington on Tuesday 14 August 2001

APPEARANCES: Ms T Baker for the Director of Proceedings

Dr E F Walford.

ORAL DECISION

The Charge

1. Dr Walford faces a charge of professional misconduct, presented to the Tribunal in these terms:

"That pursuant to ss 102 and 109 of the Medical Practitioners Act 1995, the Director of Proceedings has reason to believe that a ground exists entitling the Tribunal to exercise its powers against you and charges that:

1. Between on or about 25 January 1999 and 28 January 1999, whilst treating your infant patient Miss Danielle Hellier you, being a registered medical practitioner, acted in such a way that amounted to professional misconduct.

IN PARTICULAR:

1.1 You prescribed Codeine Linctus to your infant patient to be taken in 5 ml doses up to every 4 hours.

AND/OR

1.2 When prescribing Codeine Linctus you failed to specify the strength of the medication to be dispensed.

AND/OR

1.3 You failed to refer your patient to hospital immediately on diagnosing sedative/hypnotic poisoning.

The conduct alleged in paragraphs 1.1 to 1.3 amount to professional misconduct and paragraphs 1.1 to 1.3 inclusive either separately or cumulatively are particulars of that professional misconduct."

2. Dr Walford pleaded guilty to the charge, and the Director of Proceedings presented a summary of facts. Not all of the summary of facts was accepted by Dr Walford, and for that reason there has been evidence called dealing with the facts in the disputed area.

The summary of facts stated:

"1. These proceedings have been brought by the Director of Proceedings under the Health and Disability Commissioner Act 1994 after the investigation by the Commissioner of a complaint by Mrs Jeanette Hellier, formerly of Kati Kati, now of Taramakau Settlement in Westland.

2. At all relevant times Dr Edward Walford was a registered medical practitioner, holding a current practising certificate and working as a general practitioner in Tauranga and on Matakana Island, which is an island in the Tauranga Harbour.

3. At that time Danielle Hellier was a seven-week-old baby, living on Matakana Island with her parents, Sherina and Russell Hellier and her two older brothers. Danielle's grandmother, Mrs Jeanette Hellier and her husband, Brian Hellier lived at Kati Kati.

4. On 24 January 1999 Danielle's mother, Sherina Hellier asked her mother-in-law, Mrs Jeanette Hellier, to have Danielle to stay. This was because Danielle was not well. She was suffering from a cough, vomiting and diarrhoea. Mr and Mrs Hellier often had their grandchildren to stay when they were sick because there was no resident doctor on Matakana Island. Danielle had been most unwell the night before and Sherina Hellier had had very little sleep.

5. On 25 January 1999 Mrs Jeanette Hellier took Danielle to Dr Walford's clinic in Tauranga. Mrs Hellier was most concerned about her granddaughter who still had a cough, vomiting and diarrhoea. Dr Walford was the family doctor for Sherina Hellier's family. He ran a weekly clinic on Matakana Island. Therefore if Jeanette Hellier ever took any of her grandchildren to the doctor in Tauranga, she consulted Dr Walford. He was not the doctor that she consulted for herself.

6. Dr Walford prescribed Codeine Linctus, a cough mixture, and an antibiotic, amoxycillin. The Codeine Linctus was to be taken in 5 ml sos toqh4. The strength of the mixture was not specified. Mrs Hellier took the prescription to her usual pharmacy and had it filled.

7. *Mrs Hellier gave her granddaughter Danielle two 5m1 doses of the codeine linctus that day. The doses were given no more frequently than was prescribed. That evening Danielle slept better, but at one stage she appeared to stop breathing. Mrs Hellier had to pick her up to get her breathing again.*

8. *The following morning Danielle was still coughing and sick, so Mrs Hellier gave her another dose of the codeine linctus. That day Mrs Hellier and her husband took Danielle to Matakana Island for Danielle's brother's birthday party. At lunchtime Mrs Hellier noticed that Danielle was very limp and did not look well. She gave Danielle a further 2.5 ml dose of codeine linctus.*

9. *Mrs Sherina Hellier and her sister-in-law, Ms Letitia Lewis, took Danielle back to Dr Walford. This second consultation on 26 January took place at Dr Walford's Matakana Island clinic, not at his surgery in Tauranga.*

10. *Danielle was very sleepy and Dr Walford recorded this in his consultation notes. Dr Walford thought that Danielle might have been drugged. Ms Lewis told Dr Walford that Danielle had appeared to stop breathing for a few seconds the previous day. He told them that they should have taken Danielle straight to the hospital when this had happened. He told them that if she stopped breathing again they should go straight to the hospital.*

11. *Dr Walford asked to see the bottle of cough mixture. Sherina Hellier went home to get it while Letitia Lewis remained at the surgery with Danielle.*

12. *Dr Walford then telephoned the dispensing pharmacist and was informed that the strength of the codeine linctus was 15 mg/5 mls. This is the adult strength of the cough mixture.*

13. *Dr Walford diagnosed a codeine overdose and advised Mrs Hellier and Ms Lewis that the effects of the medicine would wear off in about four hours. He did not tell them to take her to the hospital. He did not tell her to stop administering the medication. He told them to reduce the dosage. He altered the dosage by writing on the bottle. He crossed out "5ml" and wrote "1.5 ml".*

14. *Dr Walford told Mrs Hellier and Ms Lewis that they could ring him any time and he provided them with his telephone number.*

15. *Jeanette Hellier and her husband returned to Kati Kati with Danielle. Danielle was not given any more Codeine Linctus. By about 5.30pm Danielle appeared no better. Mrs Hellier telephoned the number that Dr*

Walford had provided but was unable to contact Dr Walford. After ringing her daughter, Letitia, she telephoned the hospital and spoke to a nurse.

She described Danielle's symptoms and the events of the past two days. The nurse went and got further advice. She came back to the phone and was told to bring Danielle into hospital straight away.

16. Mr and Mrs Hellier took Danielle to Tauranga Hospital where she was attended to immediately. Danielle was admitted on the evening of 26 January 1999.

17. Danielle was diagnosed with mild/moderate codeine overdose and viral gastro-enteritis. That night and over the next few days she had to be under constant surveillance. Jeannette and Bruce Hellier sat with her all night. Sherina was unable to get to the hospital until the following morning because she had to wait for the barge to cross on to the mainland.

18. Later Dr Walford telephoned Danielle's father, Russell Hellier and was told that Danielle was in hospital. Dr Walford was most upset and apologetic. He wrote a letter of apology and also forwarded the sum of $50.00 to help with expenses.

19. Danielle was discharged from hospital on 27 January 1999, but returned on 28 January when Mrs Sherina Hellier was worried about Danielle. She still had vomiting and diarrhoea. Danielle was finally discharged on 29 January 1999.

20. Mrs Sherina Hellier continued to take her family to Dr Walford because he was the only doctor who ran a clinic on Matakana Island. The families have now relocated to Taramakau Settlement in Westland.

21. The family members were all rocked at the time by this event. For Mrs Jeanette Hellier, in particular, it was a very harrowing time. She thought that her granddaughter might die and she kept wondering if she was to blame. Danielle appears to have sustained no long-term effects from this incident. She is now three years old."

3. The facts are at the lower end of a charge of professional misconduct. Indeed, counsel for the Director of Proceedings directed submissions initially to conduct unbecoming, and sought the penalty of censure and costs, although counsel later realised that the charge was at the

level of professional misconduct and suggested that there should be a fine also, and a "more punitive" approach taken.

4. The disputed area of the facts concentrated primarily on the question of what Dr Walford was told in the course of the consultation when the patient was brought back after the codeine overdose. That element of the facts is significant as it had an impact on Dr Walford's response when the child returned, and he realised that there had been a codeine overdose.

5. We heard evidence from the patient's aunt, Ms Lewis, and Dr Walford. We have considered all of the evidence and have concluded that Dr Walford was told that the child had stopped breathing for a few seconds. Ms Lewis had a particular reason to recall this, as she had family discussions concerning the seriousness of the child having stopped breathing. There is no question of Dr Walford having been deceptive; it seems clear that the issue "failed to register" with him, and it should have.

6. Now we turn to the issues that influence penalty:

- It is a medical practitioner's obligation to determine that a prescription is safe.
- There are special dangers when prescribing for a child under three months of age.
- Dr Walford was obliged to consider very carefully the appropriateness of prescribing codeine, and the dose for this patient.
- Dr Walford on this occasion, for reasons that are unclear – indeed the reasons are still unclear to Dr Walford – did not appreciate the danger.
- When Dr Walford recognised that the patient was suffering from codeine overdose, he did not respond adequately.

7. Dr Walford has recognised these issues in his plea of guilty.

8. While the errors were serious, and posed a significant risk to the patient, the Tribunal none-the-less recognises that they did not proceed from either indifference by Dr Walford to his patient, or failing to apply himself. In the circumstances, despite the errors being serious, this is not a case where a harsh or a deterrent penalty is called for.

9. The penalty imposed by the Tribunal is that:

   - Dr Walford is censured, and
   - He is required to contribute $4,000 to the costs of the prosecution. That is to be divided two-thirds to the Health and Disability Commissioner/Director of Proceedings, and the other one-third to the Tribunal.

10. There are other matters that the Tribunal wishes to comment on.

11. Dr Walford made a mistake, and he has recognised that. The consequences for Dr Walford have been out of all proportion to the mistake. Unfortunately, the investigation and prosecution of the proceedings has been very protracted and, clearly, it has taken a significant toll on both the Hellier family and Dr Walford.

12. The Tribunal wants to make it very clear that it does not see this mistake as one for which Dr Walford should lose confidence in his ability, or that it demonstrates that he is not a competent practitioner. All practitioners make mistakes, and good practitioners can, and do, make serious mistakes from time to time. Good practitioners go on and learn from those mistakes.

13. Dr Walford has indicated that he has stopped practising and has asked to have his name removed from the Register, but apparently that has not yet been done. He also indicated that he does not intend to resume practice, and that is as a result of this charge. The Tribunal hopes that Dr Walford will reconsider this decision.

14. The Tribunal is conscious of the impact that an event of this kind has on patients and their families, and also doctors and their families. Participants in disciplinary proceedings often have mis-perceptions that can be very damaging to them. The Tribunal hopes that Dr Walford will seek collegial advice and support to assist him to move forward.

15. While in no way detracting from the error Dr Walford has acknowledged, the Tribunal recognises that both published and electronic material should include more information about the available codeine strengths, and contraindications, and will notify the software companies of the Tribunal's concerns.

DATED at Wellington this 21st day of August 2001

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G D Pearson

Deputy Chair

Medical Practitioners Disciplinary Tribunal