MEDICAL PRACTITIONERS DISCIPLINARY TRIBUNAL

PO Box 5249, Wellington • New Zealand
Ground Floor, NZMA Building • 28 The Terrace, Wellington
Telephone (04) 499 2044 • Fax (04) 499 2045
E-mail mpdt@mpdt.org.nz

DECISION NO: 208/01/86D

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 **BODIABADUGE CAMILLUS LEONARD ANNESLEY PERERA** medical practitioner formerly of Whangarei but now of Melbourne, Australia

BEFORE THE MEDICAL PRACTITIONERS DISCIPLINARY TRIBUNAL

TRIBUNAL: Miss S M Moran (Chair)

Mr P Budden, Dr L Ding, Dr F McGrath, Dr L F Wilson (Members)

Ms G J Fraser (Secretary)

Mrs G Rogers (Stenographer)

Hearing held at Whangarei on Tuesday 4, Wednesday 5 and Thursday 6 June 2002

APPEARANCES: Ms M A McDowell for the Director of Proceedings

Mr A H Waalkens for Dr B C L A Perera.

The Charge

1. The Director of Proceedings pursuant to section 102 of the Medical Practitioners Act 1995 charges **Bodiabaduge Camillus Leonard Annesley Perera**, formerly of Whangarei but now of Melbourne, Australia, Medical Practitioner, that in the course of his management of Paree Jan Nicholas during the course of her admission to Northland Health (Whangarei Hospital) on 17 July 1999, acted in such a way that amounted to professional misconduct in that:

   (a) He failed to investigate, or adequately investigate, causes of Paree Nicholas' clinical presentation at any time following the Computerised Topography (CT) scan of her head

   And/or

   (b) He failed to act upon suspected meningococcal disease and/or meningitis by commencing treatment with the administration of antibiotics

   And/or

   (c) Between 4.00 and 6.00am on 17 July 1999 he failed to consult with, and/or transfer care of Paree Nicholas to an appropriately qualified specialist in a timely manner

And/or

(d) Prior to leaving the hospital between 5.00 and 6.00am on 17 July 1999 he failed to adequately communicate his diagnosis and management plan to family and staff.

(e) The conduct alleged in paragraphs (a) to (d) hereof either separately or cumulatively amount to professional misconduct.

The Plea

2. Dr Perera denied the charge.

Onus of Proof

3. The onus of proof is borne by the Director of Proceedings.

Standard of Proof

4. With regard to the standard of proof, the Tribunal must be satisfied that the relevant facts are proved on the balance of probabilities. The standard of proof varies according to the gravity of the allegations and the level of the charge. The facts must be proved to a standard commensurate with the gravity of what is alleged.

Ongley v Medical Council of New Zealand [1984] 4 NZAR 369.

Brake v Preliminary Proceedings Committee (Full Court, High Court, Auckland, 169/95, 8 August 1996 at page 8).

Witnesses for the Director of Proceedings

5. The Director of Proceedings called six witnesses:

5.1 The complainant Diana Margaret Korach, the mother of the late Paree Jan Nicholas.

5.2 Dr Nicolas Graham Routledge, a registered medical practitioner currently practising as a general practitioner in Auckland but who at the relevant time was employed at Northland Health in the Emergency Department as a Senior House Officer and was on duty on 16/17 July 1999.

5.3 Ms AB, a registered nurse who was the Duty Manager on duty on the night of 16/17 July 1999.

5.4 Mr CD, a registered nurse who was working in the Intensive Care Unit (ICU) at Whangarei Hospital on the night of 16/17 July 1999.

5.5 Ms Christine Marie Cranch, a registered nurse employed at Whangarei Hospital and who was working in the Intensive Care Unit on the night of 16/17 July 1999.

5.6 Dr Ross Callum Freebairn, a Senior Medical Officer (Consultant) at Hawkes Bay Hospital employed by Healthcare Hawkes Bay as an Anaesthetist and Intensivist. He was called as an expert. He gave evidence as a medical practitioner, providing intensive care services in a provincial hospital, and as a senior medical officer (consultant) without the direct assistance of Resident Medical Officers - a situation which he described as similar to that of Dr Perera's when he was employed by Northland Health.

Witnesses for Dr Perera

6. Dr Perera gave evidence on his own behalf.

Background Events and Evidence

7. Ms Korach is now an anaesthetic technician, having qualified at the end of 2001. She has been an enrolled nurse for 15 years. In July 1999 she had been working at Whangarei Base Hospital for about four years. At that time, she was in the first year of the anaesthetic technician's course and had been working in the operating theatre as an enrolled nurse. She knew Dr Perera and had worked with him professionally. She knew the staff at the hospital and in particular knew the staff in the Emergency Department. In all, she said she knew how things worked at the hospital.

8. On Wednesday, 14 July 1999, Ms Korach's daughter, Paree Jan Nicholas, then aged 14 years (born 30 January 1985) had an accident at school. During a PE class, her friend let go of a barbell which landed on the bridge of Paree's nose. Despite this, Paree continued to attend classes that day and the rest of the week. Paree appeared to be well.

9. On Thursday, 15 July 1999, during the evening Paree complained of a headache. She took some Panadol and was fine in the morning.

10. On Friday, 16 July 1999, during the morning Ms Korach spoke to the school regarding her concerns that it had not informed her about Paree's accident.

11. That same afternoon at 1pm Ms Korach took Paree to see Mr Chris Seeley an ENT surgeon at Whangarei Hospital. This was to allay both Paree's and Ms Korach's concerns that Paree's nose was broken as there appeared, to Ms Korach, to be a slight deviation in it. Mr Seeley confirmed the nose was not broken.

12. Following this consultation, Ms Korach took Paree to the hospital canteen where she ate some food. She appeared to be well at that stage. On the way home in the car, Paree complained of having a slight headache. At her mother's suggestion she had a sleep during the latter part of Friday afternoon.

13. Later still, Paree awoke and seemed alright although a little irritable. At around 8pm Paree ate a healthy-sized hot meal. She entertained herself on the computer and was watching television when her mother retired to bed for the evening.

14. At around midnight Ms Korach awoke to hear Paree vomiting. She went to the bathroom where she found Paree vomiting into the basin. She said Paree looked "*awful*" and complained of her head being "*so sore*".

15. Ms Korach's partner, Mr Neville Brunker, advised that they should take the matter seriously. Ms Korach wondered whether Paree was suffering from delayed concussion. At about 12.30am, Ms Korach called the Emergency Department of Whangarei Hospital (the hospital). She spoke to a nurse there whom she knew, Ms Joan Harding, and relayed what had occurred. She was advised that she could give Paree some Panadol to see how she went or she could take her in. She told Ms Korach that as it had been more than 36 hours since the accident with the barbell it was unlikely to be concussion.

16. Following this call, Ms Harding spoke to Dr Nicolas Routledge who was the Senior House Officer in the Emergency Department on duty that evening, he having commenced his shift at midnight. Ms Harding told Dr Routledge that Ms Korach had rung through and had asked whether her daughter should attend the Emergency Department as she had an increasingly severe headache for the previous few hours. He advised that she should attend for assessment if Ms Korach was concerned.

17. Ms Korach gave Paree some Panadol but she was sick again and looked "*dreadful*". As she was not able to hold her head up by herself, Ms Korach held it while she was being sick.

18. At about 12.40am Ms Korach again telephoned the Emergency Department at the hospital and spoke to Ms Harding who told her that it was reasonably quiet. She made the decision to take Paree in to the hospital. The decision was not made lightly.

19. As Paree by then was unable to walk unaided, Mr Brunker carried her to the car. He also commented during the drive to the hospital that he had noted that Paree's bedding was wet. Ms Korach sat in the back of the car with her daughter holding up her head. She noted that she was very hot to touch although being mid-winter at the time it was cold outside. Paree remained unwell during the drive to the hospital.

20. On Saturday, 17 July 1999 at approximately 1.40am they arrived at the Hospital. Paree was conscious but not able to walk. She was put in a wheelchair and once inside the hospital was put onto a bed but kept rolling into the wall.

21. Paree was triaged by Ms Harding, the Emergency Department nurse who first saw her. Paree was coherent in her speech at that stage but did not want to talk. She did not complain about her neck but said her head hurt and she could not hold her head up by herself.

22. Paree's blood pressure was very low. Ms Korach helped Ms Harding to tilt the foot of the bed in an attempt to raise her blood pressure. When Ms Harding took Paree's temperature with a temperature probe it did not record a high temperature. Ms Korach was surprised as she knew Paree was very hot, sweaty and restless. Ms Harding commented that the temperature probe did not work too well. Ms Korach then took Paree's temperature with a thermometer under the arm which recorded 37°. In Ms Korach's experience this would probably mean it was about a degree higher.

23. At around 2am Dr Routledge saw Paree. He noted that when Paree had arrived in the Emergency Department she had had normal observations for blood glucose, oxygen saturation, respiratory rate, heart rate, and temperature. Her temperature had been checked twice and her Glasgow Coma Score was initially 13/15. Her blood pressure was recorded in the notes initially as 74/49. The triage history stated that Paree had been hit with a weights bar two days previously and felt unwell, was vomiting and had headaches since the previous evening. Mrs Harding's notes showed a deteriorating GCS score: at 0200 it was 12, at 0340 it was 6, and then 5.

24. At that time at Northland Hospital, the initial triage was performed by nurses who requested assistance from the on-call Emergency Department Consultant/Registrar if a patient was triaged as a 1-2.

25. Dr Routledge said he examined Paree at about 2pm for approximately 20 to 30 minutes. He took a history mainly from Ms Korach as Paree did not want to talk. Dr Routledge stated that his examination of Paree was unremarkable, with no signs of respiratory problems or shock. He recorded her blood pressure as having changed from 74/49 on admission to normal at 112/72 at the time of his examination. The skull examination revealed no evidence of a skull fracture. There was no cerebro-spinal fluid leaking from Paree's nose which would have indicated a definite skull fracture. At that time she had a Glasgow Coma Score of 12. Her conversation was confused. He tested her for the Brudzinski Sign, which was absent. That is a test where, if one flexes the patient's neck, the body spasms and the legs bend up. He could not recall if he tested for Kernig's Sign which is similar. Both tests he stated are usually done together to test for meningeal irritation. There was no neck stiffness and he found no rash on Paree's body. He asked specific questions regarding meningitis symptoms. Ms Korach told him that there had been no previous neck stiffness or rash. His abdominal examination revealed no abnormality, and there was no evidence of peritonitis.

26. Ms Korach stated that from the time of their arrival at the Emergency Department until 2am when Dr Routledge saw Paree, Paree's condition had "*gone downhill*". Her blood pressure had dropped significantly and she was much more restless.

27. Dr Routledge considered that Paree's deterioration in consciousness, was probably due to a space-occupying lesion, most likely a haemorrhage, or perhaps a brain tumour. Dr Routledge had qualified in 1992 in England. At the time this matter arose, Dr Routledge had been working at Northland Hospital in the Emergency Department as a Senior House Officer for approximately 3 weeks. He had been told that meningitis was prevalent in Northland and it was his second differential diagnosis but he felt it was unlikely in view of the history of head trauma, normal temperature and absence of haemorrhagic rash or neck stiffness.

28. Ms Korach stated that at Ms Harding's suggestion Dr Routledge put an IV leur into Paree's hand. IV access was obtained at around 2.20am. He had some trouble doing this, taking two attempts. Ms Korach assisted him by holding Paree's hand because she was pulling away.

29. Dr Routledge discussed the possibility of a head injury and decided Paree needed an urgent CT scan. He had never organised one before at Whangarei Hospital and asked the nursing staff how to arrange it. On their advice he telephoned the radiologist, Dr Colin McLeod, at around 3am and asked him to come in from home. He arrived promptly. By now, the Glasgow Coma Score was 10 out of 15, indicating a worsening level of consciousness.

30. While Dr Routledge was arranging the scan and they were awaiting the arrival of Dr McLeod, Paree's condition deteriorated further. The nursing staff decided to transfer Paree from one of the cubicles to the resuscitation room. According to Ms Korach, Paree was restless and becoming incoherent. She also appeared to be having some form of seizures or spasms. While lying down, her arms and legs extended out rigidly and she made strange groaning noises. She believes this happened at about 3am.

31. While waiting for the CT scan, Dr Routledge said he saw Paree once or twice as a result of the nursing staff's concern for her condition. At one stage he observed some decerebrate posturing. He also saw Paree spasm once.

32. Ms AB, the Duty Manager for the hospital during that shift, was busy assisting with a patient backlog in other parts of the hospital. She returned to the Emergency Department between 3.15am and 3.30am. On learning that Ms Korach's daughter was in the resuscitation room she went there in order to support Ms Korach as a colleague and member of staff.

33. Ms Korach said that by this time Paree was not responding to verbal commands. She and Ms Harding were concerned about whether Paree was able to breathe adequately on her own. Her oxygen saturation level was poor. They decided to put in a guedal airway to assist Paree to breathe. It was around this time that the Duty Manager , Ms AB arrived.

34. The Duty Manager said when she saw Paree she was shocked as she appeared to be very unwell. The Duty Manager stated that while Paree felt hot, her temperature was checked and was within a normal range. She added it is not unusual to feel hot but have a normal temperature. She stated Paree did not respond to her and did not want to be touched. Her neck was arching and she was moving around in a combative way but not purposefully. Paree would have a session of abnormal movements and then appear to sleep again. She lifted Paree's top to check for a rash on her abdomen but found none.

35. She went to talk to Dr Routledge as she was concerned about Paree. He told her that he had organised a CT scan with Dr McLeod. She asked Dr Routledge if he had called an anaesthetist. When he said he had not, she suggested that this would be appropriate as Paree would need intubating and ventilating in order to manage the CT scan. Paree was too restless to lie still for a long enough period.

36. Dr Routledge then telephoned the on-call anaesthetist, Dr Perera, who agreed to attend the hospital from home and anaesthetise Paree for the CT scan. Dr Routledge stated that although this request is recorded in his notes at 3.45am he believed he called him 10 to 20 minutes earlier but could not be sure of the precise time.

37. The Duty Manager stated in her evidence that she could not remember if she had had a discussion with Dr Routledge regarding meningitis but she knew it was in her mind and she knew that she would have given Dr Routledge the impression that she did not think it was a head injury but that as a nurse it was not her role to make diagnoses.

38. She stated that organising a CT scan at night can take some time because one needs to get both a radiologist and a radiographer. Also, the CT scanner has to be warmed up. At that time, the "A & E" consultant position was a new concept for Whangarei Hospital and it was normal to call an anaesthetist when intubation was required.

39. The radiologist, Dr McLeod, arrived in the Emergency Department promptly and waited with the others for Dr Perera to arrive who according to Ms Korach seemed to take a long time coming.

40. The Duty Manager stated that after they had waited for Dr Perera for about 25 minutes she telephoned the operator who told her that Dr Perera was in the CT Unit. Dr Perera said that was where he expected Paree to have been taken. He said he telephoned the operator who was unable to locate where Paree was.

41. Dr Routledge stated he was sure he told Dr Perera to attend at the Emergency Department as Paree was too unstable to move without an anaesthetic.

42. The Duty Manager said she asked the operator to tell Dr Perera to go to the Emergency Department as that was where Paree was and could not understand how the confusion could have arisen. When Dr Perera still did not arrive she went to the CT Unit with Dr Routledge to get him. She stated in evidence she said to him "*Annesley, you need to come now. This girl is very sick*".

43. She stated that when Dr Perera went to the Emergency Department her impression was that he could see immediately how sick Paree was. She said he intubated her very quickly and got her history at the same time.

44. Dr Perera in his evidence said that once at the Emergency Department he immediately assessed Paree and conducted a physical assessment. He stated that on examination she was in extreme extensor spasm and in decerebrate rigidity. He noted her Glasgow Coma Score to be 4-5/15. He said he looked at her face and those areas not covered by clothes but could not see any rash.

45. Ms Korach said she assisted Dr Perera to intubate Paree, that is, insert an endotracheal tube. She said she was sure she tied the tube in securely at 23 centimetres and that it should not have been able to move. Paree was attached to a portable ventilator.

46. Dr Perera stated he was aware from Dr Routledge a Full Blood Count test had been taken but he did not see those results as he had not expected they would be immediately available.

47. Dr Perera, Dr Routledge, Dr McLeod, and an Emergency Department nurse accompanied Paree, Ms Korach and Mr Brunker to the CT Unit.

48. According to Dr Routledge, the CT scanning started about 4am and was completed at 4.25am. The Tribunal accepts this timing. Ms Korach stated Dr Perera supervised Paree during this procedure. Dr Routledge stated that he personally looked at the scan and wrote up the results in his notes, which were confirmed by Dr McLeod. He stated that he and Dr McLeod discussed the results which were that it was a normal scan, there was no compression of the brain, no evidence of bleeding, and the ventricles were normal.

49. As they were moving out of the CT unit Ms Korach recalled a male voice saying while Dr Perera was present that Paree must be suffering from some sort of infection. She asked "*what sort of infection?*" but no-one responded. Dr Perera said he had no recollection of that being said at that time.

50. Dr Routledge stated he was surprised at the time that the scan was normal and asked Dr Perera if a lumbar puncture for meningitis was indicated. Dr Routledge recalled Dr Perera's reply was "*no, not at the moment*". The reason Dr Routledge had suggested a lumbar puncture was in order to diagnose meningitis or a sub-arachnoid bleed. He asked what would happen now. Dr Perera said he would take Paree to the Intensive Care Unit where she would spend the night ventilated.

51. Paree was transferred to the Intensive Care Unit (ICU) where she arrived some time between 4.30 and 4.40am. She was accompanied by Dr Perera, Ms Harding, Ms Korach and Mr Brunker.

52. The Duty Manager stated that she saw Paree being returned from the CT Unit on her way to ICU as it was necessary to go through the Emergency Department in order to reach ICU. On their way past she asked what the findings were and was told that the CT showed no indication of a head injury. Her immediate reaction was that this was bad news because if

there were no head injury then Paree was obviously suffering from some other pathology. She said she did not enquire as to what the diagnosis was. She knew Paree was going to ICU which she thought was the safest place for her.

53. Christine Cranch is, and was at the relevant time, an experienced Intensive Care nurse. She had been told earlier by the Duty Manager that Paree had the potential to deteriorate and might require ICU monitoring as her level of consciousness was deteriorating.

54. Another nurse, Mr CD, who was new to the ICU at that time, was also on duty. He believed that because it had been said that Paree would be in for intubation for a short time only and for wake and wean in the morning it was considered appropriate to assign her to his care.

55. When Paree arrived in the ICU, Ms Cranch helped to transfer her from the Emergency Department bed to the ICU bed. She noted that Paree did not respond to being moved. She enquired about Paree's sedation and was told she had been given no further sedation since being intubated. She thought it unusual that the patient did not respond to being moved if she had not received further sedation.

56. Because of Paree's failure to respond, Nurse Cranch checked her pupils. They were dilated, 4mm in diameter and reacted sluggishly. She connected Paree to the ECG monitor leads and printed out one or two ribbon strips. Her heart rhythm was sinus tachycardic (a normal beat but a fast rate) with ventricular ectopics (where every 3rd or 4th beat was abnormal). Ms Cranch was concerned as it was unusual for a previously fit and well young person to have a heart rhythm like that in the absence of any underlying heart condition.

57. Paree was connected to a non-invasive blood pressure cuff (NIBP) which showed a very high blood pressure of 180/110 and mean arterial pressure (MAP) of 130.

58. Ms Cranch noted that Dr Perera administered intravenous morphine and intravenous labetolol following which Paree's blood pressure dropped to 150/93, MAP 115.

59. Ms Cranch stated that Nurse CD connected Paree to the ventilator on admission. There was an oxygen saturation probe on her finger which showed saturation levels of 100%. Paree's temperature was 37 in the axilla.

60. She observed occasional twitching of Paree's limbs. Paree had no response to noxious stimuli.

61. Ms Cranch brought the ECG trolley to Paree's bed as she wanted a 12 lead ECG to obtain base line data of Paree's heart rhythm given that it was in runs of normal and abnormal rhythms. She said that Dr Perera asked her what she was doing and why. She said she explained and Dr Perera replied that Paree was now in a normal rhythm and told her not to activate this. She said she showed him a copy of the heart trace but no orders were given.

62. She requested an arterial and central line be inserted into Paree and brought the necessary equipment trolleys to the bedside. She explained that an arterial line gives a continuous blood pressure reading as well as a port for drawing blood. The NIBP can be read every minute. Paree had only one peripheral line in her left arm on arrival and Ms Cranch thought it would be better to insert a central line as it would give a wider line in a blood vessel to give fluids or drugs to the patient. She explained most drugs to control heart rate must go through a central line.

63. She stated that Dr Perera declined to insert the lines saying that Paree was to be ventilated for a short time only and that she would be weaned and woken in the morning.

64. She said she asked Dr Perera "*weaned from what?*" to which he did not answer and walked away. She said she asked that question because Paree was not on a sedation infusion and she was concerned about Paree's condition at that stage. Paree had frequent runs of abnormal heart rhythm, was hypertensive, had dilated sluggish pupils and was deeply unconscious despite the absence of sedation. Those signs were of concern to her and the management plan of "*wake and wean*" did not, to her, seem congruent with Paree's condition. All she was aware of regarding Paree was that her CT was normal and she was for wake and wean in the morning.

65. She said she had to leave Paree's bedside following her question to Dr Perera of "*weaned from what*" as she had to attend to a critically unstable patient who was under her care.

66. When Dr Perera was asked by his Counsel to comment on Nurse Cranch's evidence he said he did not recall seeing her nor hearing anything from her.

67. With regard to Nurse Cranch's evidence regarding her concerns and assessment regarding Paree's condition, Dr Perera did not share them. He said in his view Paree was critically ill but stable.

68. Mr CD in his evidence stated that when Paree arrived in the ICU, he gained the impression that Dr Perera thought Paree was not that sick and was not very concerned about her. He explained that by "*concerned*" he meant that Dr Perera could not have thought it was "*life-threatening*".

69. He also stated that Paree was for "*wake and wean*". He too noted that Paree was sedated and unconscious but was twitching. He had not seen twitching before in sedated patients. He remembered the nurses commenting on it. He said he knew it was mentioned while Dr Perera was still in ICU. He said Paree's pupils were 3-4mm in size and reacted sluggishly.

70. Mr CD said it was apparent before Dr Perera left the ICU that Paree had very high blood pressure, her heart rate was tachycardic with some ectopic beats which, to him, was a sign of concern in a 14 year old child and that those readings were evident from the screen monitor to which she was connected. He said he expressed his concern about Paree's blood pressure to Dr Perera who then gave Paree an anti-hypertensive drug and more sedating and paralysing drugs.

71. He stated that other nurses asked Dr Perera to insert an arterial line and an in-dwelling catheter and a nasogastric tube but that Dr Perera declined saying that those measures were not necessary because the patient was for wake and wean in the morning.

72. Mr CD commented that while most ICU patients have at least an arterial line, a catheter and more than one IV line, that was a decision for Dr Perera to make.

73. Ms Korach stated that on arrival at ICU, the nursing staff were ready with all necessary emergency equipment but Dr Perera said that Paree's oxygen saturation levels were fine and there was no need for an arterial line. She said he told her that Paree "*was fine*" and that she would be woken in the morning. She said that was the only plan she knew of and that Dr Perera did not say anything further to her about Paree's condition nor make any mention of meningitis.

74. She said that at the time, Dr Perera was talking to Mr CD, the nurse assigned to Paree's care, about ventilation settings. She felt safe at that stage. She decided to stay the rest of the night in case Paree woke and wanted her and shortly after went to the toilet. When she returned Dr Perera had gone - she did not know he was going - and the alarm bells on Paree's monitoring machines were ringing.

75. For his part, Mr CD could not remember what happened with Paree's Emergency Department notes which did not appear to accompany her when she was taken to ICU.

76. He said that he was not told of a diagnosis and had no views regarding one. They had been told that Paree had had a bang on the head a couple of days earlier and had had headaches. He said he was quite busy at the time getting Paree settled when he suddenly realised Dr Perera was not in the Unit. He did not know that he was leaving and first became aware he had left the Unit about 20 minutes after Paree had arrived in ICU. He was uncomfortable that Dr Perera had gone without telling him and without talking to him about Paree's condition. He did not feel that Dr Perera had completed things and he was not really sure what he was supposed to be doing. He said Dr Perera did not give him any management plan. He checked the medical notes but found Dr Perera had not left him any instructions there either.

77. After Dr Perera had left, Mr CD continued to examine Paree. Her pupils were dilated and barely reacting. Her pulse was high (160bpm) and her blood pressure was very high. He

became so concerned he consulted the other ICU nurses. He said he felt like he had been "*dumped in it*". He took the advice of other nursing staff and telephoned Dr Perera at home. Mr CD said he communicated his concern about Paree's blood pressure increasing again. Dr Perera confirmed in his evidence Mr CD phoned him because Paree's *"blood pressure was up and she was bucking on the tube*". Dr Perera told him to administer morphine and labetalol and to keep the mean arterial pressure at 80. Mr CD felt uncomfortable with the telephone instructions as usually two nurses are involved but on this occasion they were too busy with other patients.

78. He administered the doses of both drugs at the lower end of the range following which Paree had wildly fluctuating blood pressure, either very high or very low. As there was no arterial line, monitoring had to be done with a cuff but the readings were not recorded in the notes, as Mr CD was occupied with trying to care for Paree. Her pupils were virtually non-reactive and appeared to be enlarging slightly.

79. Mr CD consulted Nurse Cranch who asked him what Dr Perera had to say. He told her Dr Perera had gone but that he had telephoned him and had obtained a telephone order for drugs. She told him to ring Dr Perera again and tell him to come back to ICU. Mr CD did so. From then on other senior nurses assisted in Paree's care. Nurse Cranch catheterised Paree and collected a urine sample. She explained it is usual to monitor the input and output of fluids in a critical patient. As she did this she noticed for the first time a small cluster of little red spots on Paree's inner right thigh. On noticing the spots she immediately got blood culture bottles to collect a sample as she wanted baseline data. On returning to Paree's bedside she noticed that Paree's oxygen saturation level had dropped and that there was white frothy liquid in her endotracheal tube. She said frothy aspirate is an indication of a pulmonary oedema. She immediately suctioned Paree and obtained a large amount of white frothy aspirate which quickly dissolved into dirty brown liquid. She collected a sputum specimen. She noticed that Paree's blood pressure was very labile – 180/110 to 65/25.

80. Dr Perera arrived within 10 minutes. He returned to ICU between 5.40 and 5.50am. He asked Nurse Cranch what she was doing and she explained. Paree's oxygen saturation reached 100% after being suctioned. Dr Perera listened to Paree's chest, said it was clear

and told her to put the suction catheter away. At that point he commenced to manually ventilate Paree. More liquid was noted in the endotracheal tube and Paree was suctioned again. Some more of the same liquid came out.

81. Nurse Cranch suggested a chest x-ray be done in order to ascertain underlying cause and obtain baseline data. A radiologist was called.

82. Nurse CD during this period recalled Ms Korach saying "*She's going to be all right isn't she*" to which Dr Perera replied "*I hope so*".

83. A suggestion was made that Dr Vicky Tyrrell, the paediatrician who was on call, be contacted for help.

84. Nurse Cranch tried to connect the 12 lead ECG again in order to obtain baseline readings of Paree's heart rhythms. As she was connecting the leads, Paree's heart rhythm deteriorated dramatically and began a very slow ventricular rhythm. Resuscitation was commenced immediately.

85. The paediatrician, Dr Vicky Tyrrell, was called around 6am and arrived around 6.15am. She took charge. After the first resuscitation Nurse Cranch pointed out the spots on Paree's thigh to Dr Tyrrell who immediately diagnosed meningitis. Treatment of intravenous antibiotics was then commenced.

86. During the second resuscitation Nurse Cranch asked for the Duty Manager to be phoned in order to watch over other ICU patients while staff were involved in Paree's resuscitation. Other staff arrived to provide help and support. Between 6.15am and 7am there were four resuscitations. Sadly, Paree did not stabilise and, at around 10.50am, was pronounced dead.

87. Nurse Cranch finished her shift at 7.30am and returned home. She was so concerned at the lack of management surrounding Paree's care that she rang her Charge Nurse to seek

advice on what she should do. As a result, at 9.30am she wrote down everything she could remember about what had happened.

88. Nurse Cranch told the Tribunal she felt extremely uncomfortable with Dr Perera's management of Paree. She was concerned that he had "*tunnel vision*" in relation to the head injury history and was not thinking laterally about the causes for Paree's condition which she regarded as critical and deteriorating, hence her attempts to obtain data such as ECG, urine specimen, tracheal aspirate specimen, blood cultures and her request to insert arterial and central lines.

89. She stated that Dr Perera seemed uninterested and gained the impression that he thought the nursing staff were making a big fuss over a straightforward situation. She also felt Dr Perera was annoyed with her. She said she had called him three times previously that night, twice in relation to another critically ill patient for whom she was caring, and once on behalf of another nurse. She said that all of those concerns were outlined in her "*recollections of duty*" which she wrote up at 9.30am following the conclusion of her shift that morning.

90. The following day, 18 July 1999, she voluntarily completed an incident form which she gave to the Charge Nurse.

91. On 14 December 1999 Ms Korach made a complaint to the Health & Disability Commissioner regarding the care which Paree received while at Whangarei Hospital on 17 July 1999 and which subsequently gave rise to this charge.

The Law

92. Dr Perera has been charged with professional misconduct, the test for which is well-established.

93. A repeatedly cited test is to be found in *Ongley* (above) at pages 374 to 375 where Jeffries J stated:

> *"To return then to the words "professional misconduct" in this Act. In a practical application of the words it is customary to establish a general test by which to measure a fact pattern under scrutiny rather than to go about and about attempting to define in a dictionary manner the words themselves. The test the Court suggests on those words in the scheme of this Act in dealing with the medical practitioner could be formulated as a question: Has the practitioner so behaved in a professional capacity that the established acts under scrutiny would reasonably be regarded by his colleagues as constituting professional misconduct? With proper diffidence it is suggested that the test is objective and seeks to gauge the given conduct by measurement against the judgment of professional brethren of acknowledged good repute and competency, bearing in mind the composition of the tribunals which examine the conduct. Instead of using synonyms for the two words the focus is on the given conduct which is judged by the application to it of reputable, experienced medical minds supported by a layperson at the committee stage."*

94. In *B v The Medical Council* (High Court, Auckland, 11/96, 8/7/96), (in the context of a charge of conduct unbecoming), Elias J stated:

> *"In the case of diagnosis or treatment, conduct which falls short of the mark will be assessed substantially by reference to usual practice of comparable practitioners.*

95. As has been stated on previous occasions, the relevant principles which can be distilled from these statements are:

95.1 A finding of professional misconduct or conduct unbecoming is not required in every case where a mistake is made or an error proven.

95.2 The question is not whether an error was made, but whether the practitioner's conduct was an acceptable discharge of his or her professional obligations (in all the circumstances of the particular case).

95.3 The departure from acceptable standards and/or the failure to fulfil professional obligations must be "s*ignificant enough*" to attract sanction for the purposes of protecting the public.

96. Following the decisions of *Ongley* and *B* - which were given in the professional disciplinary context and on appeal from specialist tribunals - the question is whether Dr Perera's conduct was conduct which is culpable, i.e. conduct deserving of discipline.

The Decision

97. In reaching its decision, the Tribunal has given full and careful consideration to all of the evidence presented to it together with the documents produced and the helpful submissions made by both Counsel. It has also assessed the credibility of each of the witnesses. The Tribunal has not found it necessary to refer to the submissions of Counsel in full or to all items of evidence. At this stage, the Tribunal records it found all the witnesses called on behalf of the Director of Proceedings were credible. However, it had reservations about the reliability of some aspects of Dr Perera's evidence.

98. The Tribunal is satisfied that the allegations contained in each of particulars 1, 2, 3 and 4 have been proved to the requisite standard and that either separately or cumulatively they amounted to professional misconduct.

99. Accordingly, in relation to particulars 1, 2, 3, 4 and 5 the Tribunal finds Dr Perera guilty of professional misconduct in terms of section 109(1)(b) of the Act.

Reasons for Decision

Dr Perera's Responsibility For Paree

100. Dr Perera, in his evidence and through his Counsel's submissions, claimed that his responsibility for Paree in both the CT Unit and the Intensive Care Unit was confined to Paree's airway management and circulation and did not include diagnosis and management.

101. Dr Perera said the Intensive Care Unit at Whangarei Hospital operated as both a closed and open unit. He said that at the time Paree was admitted, the ICU had been regrouped under four senior doctors in the hospital who provided intensive care coverage on most days of the

week amounting to approximately 80% of the time but that at other times it fell on the anaesthetist on call *"to take up the slack"*. He said that when any of those four doctors were on call for the ICU, the patients were admitted under the doctors' collective names as intensive care patients. He described the ICU, when it operated in this way, as a closed unit. He said that when any of those four doctors were not on call, the patients were admitted under the primary care physician, whether it was a surgeon, physician or paediatrician. On this basis the ICU operated as an open unit. He said that when Paree was admitted to ICU on 16 July 1999 none of those four doctors was on call and the patients who were admitted at that time were therefore admitted to the ICU not as a closed unit but as an open unit under the care of their primary care physician.

102. Dr Perera said it was his understanding that when a house surgeon directly telephoned an anaesthetist after hours to go in to the hospital, the house surgeon would only be doing so at the request of the senior consultant. Dr Perera maintained in his evidence that he assumed when Dr Routledge had telephoned him, Dr Routledge had consulted and referred the patient's care to the surgical consultant (Dr McGirr) who was on call that evening.

103. Dr Perera stated that he had anaesthetised Paree in a shared-care situation but there were several items of evidence which contradicted this contention:

103.1 The senior house officer on duty, the ICU nurses involved with Paree's care, the Duty Manager and Paree's mother all believed that Dr Perera was the responsible clinician and the senior medical officer in the ICU.

103.2 Ms Korach, herself an enrolled nurse, stated in her evidence that Dr Perera was clearly in charge of Paree's care and that he said to her *"I'll take her to ICU, ventilate her overnight, and wake her in the morning*".

103.3 Dr Routledge stated that as Paree had left his care he thought Dr Perera would either contact the paediatrician or would appropriately treat Paree himself in the ICU. He was not involved with Paree's care in the ICU and accordingly was not able to comment on events which took place thereafter.

103.4 The Duty Manager stated that on the night of 16/17 July 1999 Dr Perera was the ICU consultant in charge of the ICU.

103.5 It was Nurse CD's view that Dr Perera was the responsible consultant; and in addition to that, once ventilated, Paree was the responsibility of the person who ventilated her. In this case it was Dr Perera.

103.6 Dr Perera was the senior medical officer on the roster on call for the ICU during that shift.

103.7 Dr Perera was the anaesthetist who anaesthetised Paree and was responsible for her until he discharged her to another clinician.

103.8 Dr Perera stated he had put in place a management plan which provided for lumbar puncture later that morning and also in his evidence stated that he was planning on referring her to a paediatrician and would have referred her on to the neurosurgical unit in Auckland had they planned on transferring her.

104. From 1983 to 1986 Dr Perera was the Director of the Intensive Care Unit at Taranaki Hospital. From 1996 to 1999 he was the Clinical Director of Anaesthesia at Whangarei Hospital. As such, he was aware of the policy documents of the Australian and New Zealand College of Anaesthetists which outline the responsibilities of the anaesthetist in the post-operative period. The standards of the College (a copy of which was produced in evidence) record the responsibilities as including:

> *"2.2 Availability to deal with any unexpected problems or ensuring that another nominated anaesthetist is available and has necessary information about the patient.*
>
> *2.3 Ensuring that the patient remains in the recovery facility until safe for discharge to a ward. Where transfer to an intensive care unit or high dependency unit is necessary, responsibility for care remains with the anaesthetist until this transfer is complete."*

105. When asked by the Director of Proceedings if he accepted that he had primary responsibility for Paree that evening he said he thought "*in hindsight it was by default*".

106. The Tribunal does not accept that Dr Perera's role, while in ICU, was confined to providing technical assistance with ventilation, circulation and sedation.

107. The Tribunal agrees with the opinion of Dr Freebairn who stated in his evidence:

> *"Dr Perera did not transfer the care for Paree to any other senior medical officer, nor did he ensure that anyone else did so. Until the arrival of Dr Tyrrell, no other senior medical officer was aware of her admission or responsible for her care. Paree remained sedated and ventilated after the CT scan under the influence of the anaesthetic. Therefore, Dr Perera continued to have prime responsibility for the care of Paree, and an obligation to provide adequate care for the child until that care could be discharged to another clinician."*

108. The Tribunal, having considered all the evidence, finds that Dr Perera, having anaesthetised Paree and transferred her to the Intensive Care Unit, was the senior medical officer primarily responsible for her care while she remained in the ICU unless and until he transferred her care to another senior medical officer. She was therefore his primary responsibility between 4am and 6am on 17 July 1999.

Particulars of the Charge

109. The charge states that Dr Perera acted in a way that amounted to professional misconduct in one or more of several respects.

Particular 1 – He failed to investigate, or adequately investigate, causes of Paree Nicholas' clinical presentation at any time following the computerised topography (CT) scan of her head.

110. In relation to particular 1, the Tribunal is satisfied that this allegation is proved to the requisite standard of proof.

111. The purpose of the CT scan was to exclude late intra-cranial bleed or other space occupying lesion as the cause of Paree's decreasing level of consciousness. The CT report showed that the ventricles were normal with no midline shift. Dr McLeod, in his report to the Health and Disability Commissioner, confirmed that there was "*no evidence of intra-cranial head injury and no abnormality shown to account for the patient's clinical state*".

112. As Dr Freebairn stated in his evidence (which the Tribunal accepts), progressive decrease in consciousness, after a reasonable lucid interval, could not be caused by diffuse axonal injury in the absence of cerebral oedema. The absence of intra-cerebral bleeding or cerebral oedema should have raised the possibility of an alternative diagnosis.

113. As the medical practitioner primarily responsible for her care, Dr Perera had an obligation to consider the causes for Paree's condition, investigate the cause and/or treat those reversible causes. If Dr Perera thought this was beyond his clinical ability, then he should have consulted with a suitable colleague.

114. In his written brief of evidence Dr Perera stated that, despite the absence of any obvious pathology on the CT scan, the rapidity of Paree's clinical decline since admission to the Emergency Department was of concern to him but, in the absence of more extensive intra-cranial pressure monitoring, he could not confirm his clinical suspicion of intra-cranial hypertension. He was therefore not prepared to do a lumbar puncture at that point as his next investigative procedure. Instead he opted for a period of ventilation and stabilisation and expected to perform a lumbar puncture after a few hours of monitoring.

115. While the Tribunal accepts it would not be unreasonable for Dr Perera to leave a stable ventilated patient in the ICU, the evidence established that Paree was not stable and that this should have been readily apparent to Dr Perera.

116. He said that he actually wrote his clinical notes at around 4.45pm while in the ICU although 4am is the time recorded at the start of the entry. They record the following:

17/7/99 0400 GA for CT scan.
GCS 4-6 (Glasgow coma score)
Diprivan 80mg, Esmeron 30mg ET 7 cuffed
Ventilated with Logic CT head clear
For Ventilation overnight in ICU
?Head injury ?meningitis ? for L.P. in AM
ICU – Midazolam 5 mg IV.
For morphine I.V. titrate to settle
D/saline 80mls/hr
Review in AM. For Extubation

117. Ms Cranch stated she had checked Paree's notes shortly after her ICU admission. She recalled seeing a note by Dr Perera "*CT NAD [no abnormality detected] Wake and Wean Mane*." She said that there was no such notation in the medical notes made available for these proceedings and could not explain why they were not included. Dr Perera denied he had made such a note.

118. Ms Cranch referred to the second occasion when Dr Perera attended at the ICU. She said that following the first resuscitation of Paree she pointed out the spots on Paree's thigh to Dr Tyrrell. She then saw Dr Perera walk over to where the notes were and write something in them. On checking the notes a few minutes later she saw he had written "*?meningitis*" under the notation "*CT NAD wake and wean mane*".

119. Dr Perera denied this.

120. The Tribunal could not be certain about this aspect of the evidence and therefore must give the benefit of the doubt to Dr Perera..

121. The Tribunal had reservations as to whether Dr Perera wrote his notes when he said he did and even whether he wrote them prior to leaving the ICU on the first occasion.

122. Dr Perera also stated in evidence that he had charted drugs of Midazolam, Morphine, Pancuronium and Labetalol prior to leaving the ICU on the first occasion.

123. Nurse Cranch stated no drugs were charted.

124. Mr CD implied the same in his written brief of evidence, although he was uncertain when cross-examined due to the time lapse of three years. However, it was established in re-examination that his written brief of evidence followed his record of interview with the Health and Disability Commissioner's Office on 11 April 2000, a time much closer to the incident, when the matter would have been fresher in his mind.

125. Again, the Tribunal could not be sure when Dr Perera wrote the orders in the drug chart, which had no patient label on it.

126. Dr Perera stated that as he had planned to maintain Paree on ventilation until after a review by the paediatrician, he requested a bolus injection of morphine and labetalol to ensure that her pain levels were effectively managed for the remainder of the night.

127. Dr Perera stated that as the CT scan of Paree's brain did not show surgically remediable lesion, in the differential diagnosis he considered:

127.1 Toxic encephalopathy;

127.2 Metabolic encephalopathy;

127.3 Non-convulsive status epilepticus; and

127.4 Meningo-encephalitis

128. The Tribunal does not accept that Dr Perera considered these matters. His evidence is not credible in this regard and his behaviour at the time does not support that he was considering all those diagnoses.

129. Dr Perera stated he considered cerebrospinal fluid analysis as the next step in investigating her unconsciousness. Despite the CT findings, he said he was worried about the possibility of intracranial hypertension (ICH) (as the CT was not an invariably positive test for mild-moderate elevation of intracranial pressure). He therefore decided to stabilise Paree's state for a few hours and provide her with standard therapy for ICH. He said his intention was to seek a review by the surgical team (given as her consultant on the patient label, and under whose care he said Paree was admitted) and invite the paediatrician to assess her after a few hours of therapy focused on cerebral protective strategy.

130. Again, the Tribunal does not accept this evidence as credible. This was not corroborated by Dr Perera's clinical notes; nor did he tell anyone of these alleged considerations or his intentions. The Tribunal considers that if he really had these matters in mind and that was his diagnosis and his intention, he would have followed through with the appropriate investigations and management.

131. If his diagnosis was Raised Intracranial Pressure, then stabilising Paree for a few hours was not standard therapy. We agree with Dr Freebairn's evidence that standard therapy for this diagnosis includes nursing in a 30º head up position, IV fluids not containing dextrose, use of the diuretic mannitol and continuous monitoring of the end tidal carbon dioxide. Dr Perera did not do any of those things.

132. Dr Perera stated he certainly considered meningococcal disease in his differential diagnosis. Even though there was no evidence Paree had an intracranial bleed in the CT scan and little or no evidence of raised intracranial pressure, he stated he still considered a head injury was the most likely explanation for her condition. He considered it was appropriate to wait until after the cerebrospinal fluid analysis before empirical antibiotic therapy.

133. Dr Perera added that he also considered the following:

> *"Meningococcal disease: however, as above, there was no clinical stigmata of meningitis, such as fever, rash, photophobia or neck stiffness; nor was there a history of contact with patients with meningitis. As Northland has had a high incidence of meningococcal meningitis, meningitis had to be excluded and a*

> *lumbar puncture was vital for that. Yet the real possibility of a medullary coning was a deterrent to performing a lumbar puncture without a period of initial stabilisation in the ICU.*
>
> *Diabetic keto-acidosis: as the blood sugar level on admission was 10, diabetic keto-acidosis was not likely as a possible diagnosis for her deteriorating level of consciousness.*
>
> *Drug overdose: a drug overdose was a remote possibility and there was no history to suggest it. Nevertheless, a blood sample was sent for a toxicology assay.*
>
> *Acute psychosis: an acute psychosis was a remote but possible explanation which needed further evaluation at a subsequent time, if appropriate, by someone more experienced in the field of psychology.*"

134. Again, the Tribunal does not accept this evidence is credible and Dr Perera's behaviour at the time does not support he was considering those diagnoses.

135. As to waiting until after a CSF analysis before commencing empirical antibiotic therapy, Dr Freebairn, whose evidence the Tribunal accepted, stated that would be clinically appropriate only if Dr Perera were going to undertake a lumbar puncture immediately, but not if he were going to wait until the morning.

136. The Tribunal does not accept Dr Perera's evidence regarding "*the real possibility of medullary coning*". The risk was very small, as Dr Freebairn confirmed in his evidence:

137. Regarding a "*drug overdose*", there was no evidence beyond Dr Perera's statement, that "*a blood sample was sent for a toxicology assay*". There was no request in the patient record, it was not reported by the nurses, and there was no documentation of any request to or report or result from the laboratory.

138. Dr Perera stated he believed the diagnosis was either head injury or meningitis and that Paree was settled on the ventilator.

139. The Tribunal does not accept that Dr Perera had proper grounds for believing Paree was stable.

140. Paree had an abnormally elevated blood pressure, had a rapidly declining level of consciousness and a diagnosis that was unclear.

141. The Tribunal agrees with Dr Freebairn's opinion that the charting of labetalol (an anti-hypertensive) for blood pressure control as a routine is not general accepted practice for ventilated patients. A more definite cause for the hypertension should have been sought. Most hypertensive patients on ventilators require either a specific intervention or require more sedation and/or more analgesia.

142. As Dr Freebairn stated:

> "*Whether Paree was stable is difficult to ascertain, as there is no physiological data recorded during the general anaesthetic for the CT scan, and only one blood pressure recorded from before 0600 in the ICU. Dr Perera by his own admission did not investigate any further to establish Paree's stability by checking or ordering blood results. Even if the diagnosis was as first thought, "Head Injury", a number of baseline investigations should have been carried out. Dr Perera neither tracked down previously ordered tests, ordered additional tests, nor arranged for them to be done. As such he could not be sure of the stability or otherwise of the patient. His departure from ICU in these circumstances was, therefore, premature*."

143. Dr Perera, in his letter of 9 February 2000 to the Health and Disability Commissioner stated that,

> "*On admission to the Intensive Care Unit, the patient was well settled and the ventilator settings were satisfactory. Her blood pressure was around 140-150 systolic and oxygen saturation 99-100%. Seeing that the patient was well settled and after ascertaining that the Nurse in charge of the patient was comfortable with the instructions, I returned home which was only about five minutes away from the hospital*."

144. However, as Dr Freebairn stated, there was neither an admission note nor a contemporaneous record of Dr Perera's actions in the unit recorded by him. There were no chest x-ray L.P. or blood tests ordered or performed. The time that Dr Perera departed was not recorded. The morphine and labetalol charting was completed but there was no

other care plan apart from a note to keep MAP (mean arterial pressure) at 80. It seems that morphine was to be used as a sedative for ventilation with midazolam, morphine, pancuronium and labetalol as bolus medication to maintain ventilator compliance.

Lumbar Puncture

145. The Tribunal agrees with the opinion of Dr Freebairn that there was no clinical reason not to proceed with a lumbar puncture. *"There was no evidence reported on the CT scan of raised intra-cranial pressure. Therefore, if lumbar puncture was to be performed there was no reason to delay it"*.

146. If blood cultures had been obtained and antibiotic therapy commenced, then it would have been possible to leave the lumbar puncture until later in the morning without altering good care. As Dr Freebairn stated, most texts suggest that after blood cultures are taken then a third generation cephalosporin (a broad spectrum antibiotic) should be administered to cover like organisms, including meningococcus.

147. The Tribunal agrees with Dr Freebairn's evidence:

> "*However, if he was going to delay it [lumbar puncture] for technical reasons, including that it was 5 in the morning, it would be necessary to cover the differential diagnosis of meningitis with a broad spectrum antibiotic at that time.*"

Blood tests

148. Paree was a 14 year old unconscious child. Dr Perera had recorded in his notes differential diagnoses of head injury and meningitis. In those circumstances, a full blood count and other blood tests should have been performed at the time of admission to an intensive care unit. As Dr Freebairn stated, conventional routine investigations would include measure of glucose, electrolytes, arterial blood gases, blood count and examination of a blood film. Coma without a clear cause would also require a liver function test, toxicology screen, paracetamol and ethanol level, if available.

149. Dr Perera did not hand over the care of Paree to any other medical practitioner. He was therefore obliged to investigate and/or treat other reasonable conditions that Paree may have had. He should have ordered a full blood count, arterial blood gas and an electrolyte count at admission to intensive care, if they had not been performed previously, and arrange to have the results forwarded to him.

150. In fact, at approximately 3.30am, Dr Routledge had requested a full blood count, urea and electrolytes from the laboratory. He stated that although the request was recorded in his notes at 3.45am he believed his request occurred 10 to 20 minutes earlier. We agree with this because documentary evidence produced to the Tribunal showed that the samples were taken from Paree at 3.30am.

151. The evidence established that those results were available on the hospital computer by 4.33am.

152. Dr Perera had initially maintained, in his letter of 9 February 2000 to the Health and Disability Commissioner, that with regard to the blood test results, he did not order the investigation and "*had no way of knowing that the investigation had been ordered*". However, during cross-examination by the Director of Proceedings before the Tribunal, Dr Perera retracted that statement. His initial explanation for the change in his evidence was that he did not have access to the medical notes at the time he wrote that letter but later in the cross-examination conceded that it was most likely that he did have access to medical notes and stated that he was moving to Australia about the time he wrote the letter, implying this could have been the cause of why he had made that statement which he now retracted.

153. During his cross-examination before the Tribunal, Dr Perera conceded that what he had said in his letter to the Health and Disability Commissioner was completely the opposite of what he was telling the Tribunal and that "*on reflection [he] knew blood tests had been ordered*".

154. He also accepted that there was a computer terminal in the ICU which he could have accessed for the blood results or he could have asked someone else to do it for him. He

accepted that he did not follow up those blood results and that he had an obligation to do so.

155. The blood results recorded an elevated white blood cell count of 18.9 billion/L, the significance of which suggested a systemic inflammatory process. As Dr Freebairn stated in his evidence, in a previously healthy young girl, that was likely to be the result of infection, although other causes might require further investigation or exclusion. In Paree's case the elevated white cell count would be due to meningitis. The decrease in consciousness made a central nervous system involvement highly likely, but other sites of infection needed to be considered.

156. If the Tribunal is to accept the clinical notes in which Dr Perera recorded that his differential diagnoses were head injury and meningitis, then the results of the blood tests (had he followed them up) could have and should have given him evidence of the likely diagnosis of an infective process which then would have assisted him in choosing between the two provisional diagnoses.

What Dr Perera should have done

157. Dr Perera failed to appreciate the significance of the results of the CT scan and the need to investigate urgently his alternative diagnosis of meningitis.

158. He failed to do any other investigation which might have elucidated the cause of Paree's deep unconsciousness and he failed to follow up the results of an investigation which had already been carried out (the blood tests ordered by Dr Routledge) and which would have assisted in deciding an appropriate management plan.

159. What Dr Perera should have done but failed to do were:

159.1 Order and view a chest x-ray. The Tribunal agrees with Dr Freebairn's evidence that a chest x-ray was indicated to confirm tube placement. If impractical, it could have been left until the morning if the ventilation of the left and right lungs were equal,

the tube was secured and the lungs auscultated. However, that would be a departure from the normal standard of care and chest examination was not noted. In the absence of a diagnosis, a chest x-ray should have been performed to exclude potential causes (e.g. pneumonia or sepsis) of a decreased level of consciousness.

159.2 Insert an arterial line. As Dr Freebairn stated "*A blood gas analysis was mandatory for the exclusion of metabolic cause of a decreased level of consciousness.*" This is important for the purposes of diagnosis. "*The arterial Carbon Dioxide tension in the arterial blood is important in the treatment of head injury*". This was important in the context of the management of Dr Perera's differential diagnosis of head injury.

159.3 Check the laboratory data, or order more tests. As Dr Freebairn stated *"If the diagnosis of meningitis was being considered, at least blood cultures and a full blood count should have been taken. Likewise a blood glucose, electrolytes and arterial blood gas*".

Of these, the only one which was ordered was the blood glucose by Dr Routledge when in the Emergency Department.

159.4 The charting of medication for this case was minimal and did not involve a management of any underlying process.

159.5 Record the results of examinations. A chest and cardiovascular examination should have been completed on admission to ICU, after intubation. This should have been recorded.

160. Dr Perera stated in his evidence he expected Paree to wake by morning. In Dr Freebairn's opinion it may have been reasonable to forgo invasive procedures on that expectation but not in the circumstances where Dr Perera "*had not taken reasonable care to establish a clear diagnosis nor exclude important other diagnoses which could have been reasonably treated*."

161. If Dr Perera thought Paree had sustained brain damage due to a head injury then it had to be very serious given her deepening level of unconsciousness.

162. Dr Freebairn was asked to comment on Dr Perera's brief of evidence in which he referred to lack of symptoms indicating that Paree had meningitis. Dr Freebairn responded "*… The disease is a difficult disease to diagnose; it presents in a variety of fashions and not all, in fact initially very few symptoms may be there. However an unconscious child, who requires airway management and ventilation, requires the diagnosis to be excluded, unless there is strong evidence of another diagnosis*".

163. When asked by the Director of Proceedings to comment on the reasonableness of Dr Perera's diagnosis of head injury in comparison to other possible diagnoses, Dr Freebairn replied: "*I think the diagnosis was not clear and he needed to perform further investigations to seek an alternative diagnosis that could explain her unconsciousness. Those investigations included checking for blood count, arterial blood gas, looking for a metabolic cause. There was none of those things done or followed up on.*"

Particular 2 – He failed to act upon suspected meningococcal disease and/or meningitis by commencing treatment with the administration of antibiotics.

164. The Tribunal is satisfied that the allegation contained in this particular is proved to the requisite standard.

165. Dr Perera's clinical notes recorded meningitis as a second differential diagnosis. This is confirmed in his written brief of evidence in which he stated "*I certainly considered meningococcal disease in my differential diagnosis*".

166. When elaborating on his written brief of evidence and asked by his counsel what consideration, if any, he gave to meningitis at the time he stated "*It was a remote possibility*". He further stated "*It was quite clear to me, although there was the possibility of meningitis being looked at, that it was not evident without the clinical features to accompany it*".

167. When asked by the Director of Proceedings during cross-examination "*So you were mindful of the diagnosis of meningitis at 4am*" … Dr Perera replied "*Possible diagnosis*".

168. He further accepted during cross-examination that meningitis was reaching epidemic proportions in Northland at the time; that it was well publicised in Northland; that it was more prevalent in the winter months; and that if a patient presented to him with the possibility of meningitis he would have an high index of suspicion. He further confirmed that meningitis was his "*second diagnosis*" and agreed that it is potentially both a fatal and a treatable illness.

169. Dr Perera further accepted during cross-examination that, as a matter of first principles, at the time of considering meningitis as a possibility he had a duty to try and exclude it as a diagnosis and that the way to have done that would be to have done a lumbar puncture.

170. One of Dr Perera's explanations for failing to commence treatment with antibiotics was, that even though Paree showed no evidence of intra-cranial bleed in the CT scan and little or no evidence of raised intra-cranial pressure, he still considered a head injury the most likely explanation for her condition. He said he considered it appropriate therefore to wait until after the lumbar puncture before empirical antibiotic therapy.

171. However, lumbar puncture procedure should not delay the administration of urgent antibiotic cover for bacterial meningitis. If the lumbar puncture were to be delayed, and meningitis was a potential diagnosis, then Paree should have been administered some intravenous antibiotics at the time that the diagnosis of meningitis was first considered and as soon as possible after intra-cranial mass lesions were excluded. That would have been by 4.30am or shortly thereafter.

172. Dr Perera was unable to advance any reasonable explanation why he failed to commence treatment of antibiotics in view of his own admissions that meningitis was his second differential diagnosis.

Particular 3 – Between 4am and 6am on 17 July 1999 failed to consult with, and/or transfer care of Paree Nicholas to an appropriately qualified specialist in a timely manner.

173. The Tribunal is satisfied that the allegation contained in this particular is proved to the requisite standard.

174. The Tribunal has already found that Dr Perera was the senior medical officer primarily responsible for Paree's care while she remained in the ICU unless and until he transferred her care to another senior medical officer.

175. At the time Dr Perera first saw Paree at 4am, she was a very sick child. She had a Glasgow coma score of 4-6/15. From the time of her admission at 1.40am it had deteriorated from 13/15. She was incoherent. She had had abnormally low blood pressure on arrival in the Emergency Department which by 4.20am had been increasing steadily upwards. This information was readily accessible by Dr Perera from the clinical notes and from the handover from Dr Routledge. Dr Perera stated in his own evidence that at the time he first saw Paree she had decerebrate and decorticate rigidity. He also stated he was aware of her history from Dr Routledge.

176. The Tribunal accepts the evidence of Nurse Cranch and Nurse CD that on admission to ICU Paree was "*twitching*", that she had failed to respond to noxious stimuli, that she had non-reactive sluggish pupils, a raised temperature, and was deeply unconscious when her sedation would have been expected to no longer be acting. Nurse Cranch also stated that Paree did not respond to being moved.

177. The Tribunal finds that this clinical presentation should have been clearly apparent to Dr Perera.

178. He stated that the abnormal heart rhythms were not brought to his attention but Nurses Cranch and CD said they were. The Tribunal prefers the evidence of Nurses Cranch and CD and finds that they were brought to Dr Perera's attention.

179. The Tribunal has already found that there was a failure on the part of Dr Perera to investigate or adequately investigate the causes of Paree's clinical presentation at any time following the CT scan of her head.

180. His management of Paree with either of his two provisional diagnoses (as recorded in his clinical notes) of head injury or meningitis was inadequate.

181. As he was the only senior medical officer with knowledge of Paree's case, he was responsible for her care from the time of his assessment until such time as he transferred her to another colleague.

182. In the face of her rapid decline, he needed to engage other specialist advice either from the general surgeon on call at Whangarei Hospital (Dr McGirr), from the paediatrician on call (Dr Vicki Tyrrell), or from the neurosurgical unit in Auckland.

183. Dr Perera maintained that he had assumed that Dr McGirr, the general surgeon on call, would have been informed about this matter by Dr Routledge prior to Dr Routledge asking Dr Perera to come into the hospital to anaesthetise Paree.

184. There was no evidence before the Tribunal to establish such an assumption could be safely made. There was no evidence that Dr Routledge or any other health professional involved had spoken with Dr McGirr; or conveyed to Dr Perera any such impression. Dr Perera himself had not spoken to Dr McGirr, following the negative CT scan, nor enquired as to who was primarily responsible for Paree's care.

185. Dr Perera claimed that he had anaesthetised Paree in a shared-care situation and that on the evening in question the IC Unit was operating as an open unit rather than a closed unit. If that were the case, then he had an even greater responsibility to communicate with the clinician who was the primary consultant. He agreed he did not and should have. Dr Perera accepted in a response to a question from a member of the Tribunal that either he or Paree's primary consultant needed to be investigating the reason for Paree's rapid deterioration and that if he were not responsible, then her primary consultant had every reason to be doing so.

The evidence records the following exchange between a member of the Tribunal and Dr Perera:

> "*If you were sharing care … the deterioration in her level of consciousness, the negative CT finding and the other signs that were apparent by the stage of her admission to Intensive Care Unit …*"
>
> "*That isn't exactly what my question was though, it is that there was information that you had that Dr Routledge did not have by the time this patient was admitted to ICU, and by the time you went home, I was asking what was your responsibility in a shared care situation to communicate with the primary consultant about the information that you had which was the negative CT scan, her level of consciousness, the fact that she was unconscious and the other signs which were blood pressure and various other signs we have gone through … I should have rung Mr McGirr and asked was he happy with it with reference to ventilating her over the next few hours and I should have told him of the negative CT scan, that was an oversight on my part.*
>
> *It seemed either you or her primary consultant needed to be investigating the reason for her rapid deterioration … True.*
>
> *And if you weren't, weren't you responsible [to ensure] that her primary consultant had every reason to do that … True.*"

186. At the point that Dr Perera left the ICU he was the only doctor who had up-to-date knowledge of Paree's condition.

187. In his written brief of evidence Dr Perera stated that when under his care Paree deteriorated further, he handed over her management to the on call paediatrician as he considered that appropriate.

188. In his oral evidence, however, Dr Perera stated he requested an immediate review by the paediatrician who was on call, Dr Vicki Tyrrell.

189. The Tribunal is satisfied that neither of these contentions is correct.

189.1 did not request an immediate review by the paediatrician who was on call. The suggestion that Dr Tyrrell be called came from an ICU nurse, namely, Nurse Judy Mardon, not Dr Perera and not during his first attendance at the ICU but during his second attendance.

189.2 Dr Perera did agree to the suggestion, but there is nothing to indicate he even considered the possibility before the suggestion was made by Ms Mardon following his second attendance at the ICU when he was manually ventilating Paree.

189.3 The first occasion Dr Perera suggested he was contemplating a surgical or paediatric review was when he gave oral evidence before the Tribunal, well after he had ample opportunity to explain his conduct.

189.4 Further, Dr Perera's notes are not conclusive of his alleged intention. They refer only to "*Review in AM. for extubation.*"

190. Dr Perera did not transfer the care for Paree to any other senior medical officer nor did he ensure that anyone else did so. Until Dr Tyrrell arrived, no other senior medical officer was aware of Paree's admission or responsible for her care.

Particular 4 – Prior to leaving the hospital between 5am and 6am on 17 July 1999 failed to adequately communicate his diagnosis and management plan to family and staff.

191. The Tribunal is satisfied that the allegation contained in this particular is proved to the requisite standard.

Communication with family

192. Dr Perera stated he thought that he had communicated adequately with Ms Korach and that, due to her involvement with Paree's management, he believed that she was well aware of the management strategy and the treatment plan.

193. With regard to Ms Korach and family, he stated it was an unusual situation to have the family representative (Ms Korach) present throughout the management and care of Paree. As a member of the staff she was permitted to remain present where, in other circumstances, the family representative would have been asked to wait in the waiting room. In that more common situation, he explained, it was always his practice to communicate with the family and explain his diagnosis, as much as it was known, and management plan to family in attendance. He referred to Ms Korach being a Trainee Anaesthetic Technician in his Department who was, from the outset, involved in assisting with Paree's management. Although she was not on duty, Dr Perera said she wished to assist and in fact help him place the endotracheal tube and accompanied him to the CT suite for the scan. He said she was involved in the discussion that took place during the procedure and thereafter accompanied him back to the ICU where she helped him with setting up an additional intravenous access and attaching Paree to the mechanical ventilator. He said she was also present when he prescribed the ventilator settings and the attendant medication. He said he believed that Ms Korach was well aware of the management strategy and the treatment plan, having been actually involved with her daughter's management.

194. It can be inferred from this evidence that Dr Perera assumed that Ms Korach, having had some involvement with her daughter's management and having been present, was well aware of the management strategy and the treatment plan.

195. Ms Korach was present, not as an involved health professional, but as an anxious mother with a very sick child. She was not responsible for Paree's management. Though she did assist Dr Perera in placing the endotracheal tube, and was advised of his intention to have Paree transferred to the ICU, ventilated overnight and wakened in the morning, her involvement in Paree's treatment was minimal and peripheral.

196. Dr Perera had a responsibility to communicate with the family his understanding of the seriousness of Paree's illness, the difficulty with a diagnosis, and his planned approach. His assumption that, by reason of her involvement, Ms Korach was adequately informed, does not meet the standard of a reasonable communication in the given circumstances nor did it discharge his responsibility to communicate those matters to her.

197. That is confirmed by Ms Korach's evidence that she was not aware of Dr Perera's provisional differential diagnosis of meningitis, his plan to do a lumbar puncture in the morning, or his plan for paediatric or surgical review. For his part, Dr Perera conceded his provisional diagnosis should have been communicated to her, that he did not do so in words and that he could not recall having told her of his intention to have surgical and paediatric review.

198. The Tribunal finds Ms Korach, as the mother of her deeply unconscious daughter, was entitled to receive this information from Dr Perera. She did not.

Communication with staff

199. Dr Perera stated that no-one queried him about the management plan and, at the time, he thought that the staff were aware of and comfortable with the management plan before he left the ICU.

200. Dr Perera said he was surprised at the criticism that others did not know of his management plan.

201. There are two methods of communicating with staff, that is, orally and in writing.

202. In a seriously/critically ill patient both methods should be used.

203. The written record should be in one place and should clearly indicate the patient's state and the clinician's assessment, the investigations ordered, the possible diagnoses, and the management plan including all instructions.

204. This should then be communicated orally to the nurse in charge of the patient.

205. The clinician should ensure that the nurse in charge understands the instructions and is able to carry them out.

206. The Tribunal accepts that Dr Perera believed his entry in the patient notes and the medication instructions on the drug chart constituted a management plan.

The Tribunal does not, however, accept that these were an adequate record of either the anaesthetic administration, or that the entries conveyed an adequate approach to the diagnosis and management of the patient, and it does not accept that no staff queried the management plan at the time.

207. During cross-examination, Ms Cranch was challenged about whether she had asked the question of Dr Perera "*weaned from what?*" at all and that if she did, whether it was possible Dr Perera had not heard her. She believed he had but conceded, fairly, that when Dr Perera walked away she could not be sure it was deliberate on his part, although it was her genuine belief that he had chosen to ignore her.

208. The Tribunal thought Ms Cranch was a credible witness genuinely concerned for the welfare of Paree. It accepts her evidence that the requests she made of Dr Perera, his refusals, and the verbal exchanges between them (referred to at paras 61 to 64 above) did take place. The Tribunal also accepts she did ask Dr Perera "*weaned from what?*" but, as she had to leave at that point to attend to another patient, he may not have heard this.

209. The Tribunal also accepts that Nurse CD expressed his concerns about Paree's blood pressure to Dr Perera. He also confirmed the request by Nurse Cranch about inserting an arterial line, an indwelling catheter and a nasogastric tube, but that it was Dr Perera's view that these measures were not necessary because Paree was for wake and wean in the morning.

210. The Tribunal finds that the plan which Dr Perera communicated to Nurse CD was that Paree was for "wake and wean" in the morning, but that Dr Perera did not mention to him a differential diagnosis of meningitis nor, indeed, any differential diagnosis.

211. In his evidence-in-chief Nurse CD said that he did not know Dr Perera was leaving the ICU and first became aware that he had left about 20 minutes after Paree had arrived there. He

did not know how long Dr Perera had been gone at the time that he was no longer in the ICU and that he was uncomfortable that he had gone, and without talking to him about Paree's condition. He felt as though he had not completed things and was not really sure what he was supposed to be doing.

212. In cross examination, Nurse CD was told by Dr Perera's counsel that Dr Perera would say he did not remember speaking with him when he left but that it is always his practice when he leaves a scene such as this to say "*I'm going home now*" and asked whether it was possible he had said that to Nurse CD who had no recollection of it. Nurse CD said it was possible. In re-examination he stated that, in terms of communicating with the nursing staff the normal or usual practice of a consultant in the ICU before leaving is that most would ask if they were happy with everything and if there was anything they would like clarified; and he did not recall this happening with Dr Perera on this occasion.

213. The Tribunal concluded that on this occasion Dr Perera did not tell Nurse CD he was leaving the ICU.

214. While Dr Perera stated that he recorded his management plan in the clinical notes at around 4.45am, the Tribunal is satisfied that the plan contained within those notes was not communicated orally to Nurse CD.

214.1 Nurse CD said that Dr Perera did not give him any management plan.

214.2 In cross examination, Dr Perera conceded that it was important he communicate his provisional diagnosis of meningitis to the nursing staff, because it could progress rapidly and nursing staff need to be able to look out for the signs, and accepted their evidence that they knew nothing about his provisional diagnosis of meningitis.

214.3 Dr Perera also conceded that he had not conveyed to nursing staff his management plan included referring Paree for paediatric and surgical review in the morning.

215. Having regard to all the evidence, the Tribunal concluded that, at best, the staff was given a partial management plan, that is of extubating Paree and waking and weaning her in the morning.

Other Issues

Inadequacy of Anaesthetic Records kept by Dr Perera

216. The details of the anaesthetic administered by Dr Perera are contained in his notes.

217. Among the documents produced in evidence was a printout from an automatic monitor recording the blood pressure, pulse and arterial oxygen saturation, which started at 03.00 and finished at 04.20. It is possible that the automatic monitor went with Paree to the CT suite, and that the 4.10 and 4.20 recordings were taken during the anaesthetic. There are no other written notes relevant to the anaesthetic.

218. In response to questions from the Tribunal, Dr Perera stated that Paree was ventilated with nitrous oxide and oxygen, which he agreed was not stated anywhere, that Paree was in the CT unit about 20-25 minutes, and his reason for not filling in the details of the anaesthetic in the appropriate form was "*I couldn't find an anaesthetic chart*" and "*I was thinking of getting an anaesthetic chart when I left the CT suite*". However, he did not do the latter. He agreed that the automatic monitor could have gone with Paree to the CT unit, and that the 4.10 and 4.20 readings could have been taken during the anaesthetic. He queried the veracity of the readings, stating that "*you can often get dynamaps giving you erroneous readings*". However, he did not offer any other blood pressure values that were correct. He also acknowledged that there were no recordings of the end tidal carbon dioxide level, although knowing that level is essential for care of a patient during anaesthesia with possible head injury.

219. Using the Australian and New Zealand College of Anaesthetists Policy Document on "Minimum Requirements for the Anaesthetic Record" as the standard against which the documentation of the anaesthetic should be measured, Dr Freebairn stated that the record of the anaesthetic given by Dr Perera for the CT scan had no mention of the physiological

response and condition (blood pressure, pulse, end tidal carbon dioxide, oxygen saturation, temperature) of Paree during that scan; the anaesthetic technique was not recorded and there was no record of intravenous therapy, or position of the patient or any monitoring used.

Tiredness

220. While Dr Perera did not rely on tiredness as a defence, the matter was referred to in the evidence of both Dr Freebairn and Dr Perera and was addressed by his counsel. Dr Perera said that he had worked on Friday 16 July 1999 from about 8am to 5pm as an anaesthetist, having done two operating lists. He said he was on call that evening and on the occasion he had been telephoned by Dr Routledge to carry out the anaesthetic for Paree's CT scan it would have been "*about the fifth time [he] had been woken up that night*".

221. Dr Freebairn stated that the decisions made by Dr Perera and others were during the period 4am to 7am. He believes that patients are entitled to access to acute care as required rather than restricted to office working hours and that provision of those services should not be unduly delayed because of the hour of presentation. Although difficult, the decisions not to further investigate the cause of Paree's decreased consciousness could not be delayed until the following morning.

222. Dr Freebairn stated that he was aware of the effect of repeated disruption of sleep, which can interfere with both decision-making and interpersonal relationships, and that the requirement to perform optimally at a time when, normally, rest would be taken places a significant strain and responsibility upon individuals. He stated that the brevity of conversation with staff and family by Dr Perera might have reflected this and should be considered, and that the hour of the day when the services were delivered should also be taken into account. When cross-examined by Dr Perera's counsel that the time of night could have an impact on the adequacy of care an anaesthetist could provide, Dr Freebairn said he did not say that. What he did say was that it might interfere with interpersonal relationships but that he would like to think the care would be the same but some of the niceties might not be attended to (and in that respect, he referred to the interview with

Paree's mother that may have been briefer than one would have at 2 o'clock in the afternoon) and that there might be a tendency to deal with these things briefly because there were other factors such as getting clinical care right and then rest.

223. The Tribunal accordingly took those matters into account when considering and reaching its decision.

Overall Circumstances

224. Mr Waalkens submitted that the timeframe which the Tribunal must consider was a "*very narrow window*" and that the whole basis of the Director's case was predicated on the basis that Dr Perera "*and others*" were concerned with head injury and the need to exclude it.

225. The Tribunal accepts that the timeframe was narrow but that is not determinative by itself.

226. The Tribunal does not accept that "*others*" were in fact solely concerned with head injury. The only other doctor involved in Paree's management, Dr Routledge, suggested a lumbar puncture in order to exclude (or confirm) meningitis or meningococcal disease once the CT scan was reported as clear. Dr Perera vetoed this suggestion. Dr McLeod's role was limited to undertaking the scan. Nurse AB (the Duty Manager) did not think it was a head injury but did not speak out because she did not consider that, as a nurse, it was her role to make diagnoses.

227. Mr Waalkens submitted that while Dr Perera did not blame the system at Whangarei Hospital, this case highlighted systemic inadequacies and resource issues at the hospital. The Tribunal has taken those matters into consideration. The Tribunal also considered the apparent failure of staff training to ensure that the Senior House Officer in the Emergency Department was conversant with the protocols for involving a consultant in the diagnosis and management of a seriously ill patient. In the Tribunal's view they do not affect Dr Perera's culpability in this particular case but rather are mitigating factors.

228. Mr Waalkens submitted that "*the clinical picture as Paree presented [was] plainly important*", that meningitis is a "*gross, appalling illness*", that "*it is notoriously difficult to diagnose clinically short of a lumbar puncture*", and that "*cases involving lack of meningococcal disease symptoms are unfair on all concerned*".

229. While the Tribunal is not unmindful of this submission, it agrees with the submission of the Director of Proceedings that this was not a case about the mis-diagnosis of, or failure to diagnose, meningitis or meningococcal disease. It was, rather, "*about the failure to undertake basic, fundamental investigations as to the cause of Paree's clinical presentation. It [was] also about the failure to act on suspected meningitis, the failure to refer appropriately and in a timely manner, and the failure to adequately communicate with other healthcare providers and the family*."

Conclusion and Orders

230. The Tribunal is satisfied that the charge laid against Dr Perera in all its particulars is established. Dr Perera is guilty of professional misconduct as follows.

(a) He failed to investigate, or adequately investigate, causes of Paree Nicholas' clinical presentation at any time following the Computerised Topography (CT) scan of her head

And/or

(b) He failed to act upon suspected meningococcal disease and/or meningitis by commencing treatment with the administration of antibiotics

And/or

(c) Between 4.00 and 6.00am on 17 July 1999 he failed to consult with, and/or transfer care of Paree Nicholas to an appropriately qualified specialist in a timely manner

And/or

(d) Prior to leaving the hospital between 5.00 and 6.00am on 17 July 1999 he failed to adequately communicate his diagnosis and management plan to family and staff.

(e) The conduct alleged in paragraphs (a) to (d) hereof either separately or cumulatively amount to professional misconduct.

231. The names (only) of the Duty Manager and the male nurse assigned to look after Paree in the Intensive Care Unit on 16/17 July 1999 are not to be disclosed.

232. The Director of Proceedings is to lodge submissions as to penalty not later than 14 days after the receipt of this decision.

233. Submissions as to penalty on behalf of Dr Perera are to be lodged not later than 14 days thereafter.

DATED at Wellington this 12th day of August 2002

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S M Moran

Deputy Chair

Medical Practitioners Disciplinary Tribunal