SUMMARY of the Decision of the Inquiries, Complaints and Reports Committee (the Committee)
(Information is available about the complaints process here and about the Committee here)

Dr. Nicolaas Gert Francois Cloete (CPSO #78675)
Family Medicine
(the Respondent)

INTRODUCTION

The Complainant contacted the College of Physicians and Surgeons of Ontario (the College) to express concerns about the Respondent's care and conduct when the Respondent assessed their newborn (the Patient) in the Emergency Department (ED). The Complainant attended the ED with the Patient due to concerns of lethargy, increased sleeping, decreased feeding, and a new grunting noise.

The Respondent assessed the Patient, ordered an x-ray, and discharged the Patient. The following day the Complainant took the Patient to another hospital ER where the Patient was diagnosed with bacterial meningitis and admitted. The Patient had a complicated course.

COMMITTEE'S DECISION

The Committee considered this matter at its meeting of November 21, 2024. The Committee required the Respondent to complete a specified continuing remediation and education program (SCERP) consisting of courses in medical recordkeeping and Pediatric Advanced Life Support (PALS) as well as self study in the assessment and management of a neonate (including the presentation of Group B streptococcal infection and sepsis).

COMMITTEE'S ANALYSIS

Complainant's concerns included that the Respondent failed to recognize the seriousness of a newborn with symptoms of a high heart rate, grunting, listlessness, poor feeding and increased sleeping; failed to conduct testing and brushed off the symptoms; and failed to diagnose bacterial meningitis/sepsis

The Committee's role is to determine if the Respondent's care was appropriate, rather than if the Respondent caused or contributed to a particular outcome, in this case, the fact the Patient suffered complicated meningitis.

The Patient was not obviously unwell when the Respondent assessed the Patient, and given this the Committee would not necessarily have expected the Respondent to

diagnose meningitis at that time. However, a serious illness, including meningitis and sepsis, can present in very subtle ways in the first few weeks of life.

Because of this, physicians need to maintain a broad differential diagnosis and consideration that the Patient might have early signs and symptoms of a serious illness should have been reflected in the Respondent's documentation, but it was not. Lethargy and tachycardia in an infant should always be evaluated with caution.

It may have been reasonable to discharge the Patient in the circumstances if the Respondent had confirmed that the Patient's heart rate had normalized before discharge and provided detailed instructions on what to look for and when to follow up, and documented this information in the chart, but this was not done.

The Committee was troubled by the Respondent's documentation, which was overly brief and very difficult to read. The Respondent did not document any of the following: an adequate medical history and examination, a differential diagnosis, a treatment plan, recheck of the Patient's heart rate before discharge, and discharge instructions. The poor documentation suggests the Respondent inadequately assessed the Patient.

The Committee was particularly concerned as the Committee previously identified deficiencies in the Respondent's records and required him to complete coursework to improve his record-keeping, yet the Respondent's records remain inadequate.

The Respondent showed little reflection or insight regarding this case in his response to the College or consideration of what he might have done differently.