STATE CORONER VICTORIA

CORONIAL COMMUNIQUÉ

Clinical Liaison Service – Connecting Clinicians with Coroners

VERITAS OMNIA VINCIT

State Coroner's Office and Victorian Institute of Forensic Medicine (Monash University, Department of Forensic Medicine)

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Contents

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Free Subscription

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Copies are also accessible on the web at: **http://www.vifm.org/communique.html**

Next Edition: November 2006

Open Day reminder

Coronial Services Centre
Monday, 23 October 2006
1:30 to 4:30pm

Editorial

Welcome to the third issue of the Coronial Communiqué for 2006. This issue describes complex cases that are part of our daily work in health care and sadly highlight recurring issues that lead to patient harm.

The case of "Overriding a Patient's Wishes" is a challenging situation where the clinical staff are faced with managing a medical emergency in a patient who is unable to grasp gravity of the situation. This case highlights the need for comprehensive systems to be in place at hospitals and clinics to assess a patient's competency to understand and make decisions about their care. Also it illustrates the gaps in most health services in managing and documenting these situations.

The second case "Checking the Position of Nasogastric Tubes" is a sad reminder that we still have much more work ahead of us to make health care safe. This is a recurring nightmare for our patients and clinical staff. Deaths from misplaced tubes have been reported before in Victoria, throughout Australia, and internationally. The Clinical Liaison Service contributed its experience to the National Patient Safety Agency (NPSA) who issued new advice to the NHS on reducing the harm caused by misplaced naso-gastric feeding tubes - 22 February 2005 http://www.npsa.nhs.uk/display?contentId=3550.

The third case 'Too Busy to Keep Up-to-Date?" is a tragic case from South Australia which illustrates the consequences of practising in clinical isolation and the importance of continuing clinical review and education.

Whilst on the topic of education, the Clinical Liaison Service will host another Information Session-Open Day in October that is open to all health professionals for whom coronial matters are relevant. If you wish to attend, please send an email to zoed@vifm.org by the 1 October 2006. The schedule for next year is in the planning stage and we expect to host an information session in February 2007 that will focus on maternal health issues.

Finally, we welcome Caroline Rosenberg who will take charge of re-designing the format of the Coronial Communiqué so it becomes more contemporary in style.

DISCLAMER

All cases that are discussed in the Coronial Communiqué are public documents. A document becomes public once the coronial investigation process has been completed and the case is closed. We have made every attempt to ensure that individual clinicians and hospitals are de-identified. However, if you would like to examine the case in greater detail, we have also provided the coronial case number.

Overriding a Patient's Wishes

Case Number: 2569/04
Author: Dr Adam O'Brien FACEM

Clinical Summary

A 55 year old male with paranoid schizophrenia had become disassociated from family and friends. At approximately 11:00hrs at his workplace after lifting a bag of flour he felt unwell with a sudden onset of back pain. Work colleagues endeavoured to persuade him to seek medical treatment, but he refused the offer. They acceded to his wishes until approximately 15:45hrs when, in spite of his protestations, an ambulance was called.

The deceased was conveyed to a tertiary hospital emergency department where he was diagnosed with an acute Type A aortic dissection with intrapericardial blood and cardiac tamponade. It was considered that emergency surgery was his only chance of survival. However, the deceased refused to believe that he was sick.

A concern was held that the deceased's inability to appreciate the seriousness of his condition and the need for an emergency procedure was related to his diagnosed mental illness. The on-call psychiatric registrar was asked to assess whether his stated refusal to consent to surgery was an informed decision.

It was concluded that the deceased was insightless due to his mental illness and therefore was "unable to consider the severity of his clinical situation" and dismissed the need for treatment. There was no formal document wherein the detail of the basis of the assessment of non-competence was spelt out. Notations in the medical records signed by the psychiatric registrar and the consultant psychiatrist were found.

Coronial Investigation

The cardiothoracic surgeon stated that "there was great difficultly obtaining consent for the emergency operation as the patient was a known paranoid schizophrenic and despite our cardiac surgical fellow being able to talk to him in his native tongue…., and with us discussing with him in English, the patient refused to believe that he was sick and would be best served by emergency operation."

The coroner commented that "a medical practitioner overriding a conscious patient's opposition to surgery (especially where the patient does not survive) is a decision of great moment. The mere fact a patient is suffering a life threatening condition and refuses surgery is not itself a valid basis to override the patient's decision".

Findings

Overriding the deceased's objection to surgery was warranted in the circumstances. The cardiothoracic surgeon observed that the "management of this patient was made extremely difficult because of his parlous state at presentation, the delays because of difficulty in obtaining consent, and the rather severe nature of his pathology which in fact may have precluded survival in any case under best conditions. All available measures were used to ensure his survival." This was accepted by the coroner.

There was no formalised document for 'Consent In Lieu'. Because of the significance of the decision and to facilitate a subsequent assessment of the efficacy of that decision, when a conscious patient refuses a medical procedure, especially major surgery, and that refusal is overridden due to the patient being deemed incompetent due to perceived mental illness to make an informed decision, then the precise basis or bases upon which that assessment was made should be very formally documented.

Recommendation

That the Chief Psychiatrist develop and implement a FORMAL document of 'Consent-in-Lieu Due to Mental Incompetence' in which the precise bases of incompetence are spelt out and which is signed by the psychiatrist or psychiatric registrar making the assessment and the person who then consents in lieu of the patient to the treatment proceeding.

Checking the Position of Nasogastric Tubes

Case Number: 866/03

Case Précis Author: Ms Carmel Young

Clinical Summary

Mr C was an 87 year old male who was admitted to hospital with a head injury following a fall. His past medical history was extensive and included dementia and ethanol abuse. During his hospital stay he required nasogastric feeding. He was restless and agitated and needed many nasogastric reinsertions. Following one of the reinsertions by two nurses, the position was confirmed by auscultation and the aspirated secretions were shown to be acidic, indicative of gastric contents. An x-ray of the nasogastric tube's position was cleared by an intern. His feeds were therefore recommenced. Shortly afterwards he developed respiratory distress. A repeat chest x-ray showed the nasogastric tube was in the right main bronchus. He was intubated and ventilated and admitted to ICU but deteriorated and died.

Investigation

At autopsy his cause of death was found to be bronchopneumonia secondary to a head injury. The hospital supplied the Coroner with its policy for checking the correct position of nasogastric tubes. It indicated that x-ray confirmation of correct tube positioning in the stomach should be completed for all high risk patients (those who are intubated, unconscious, missing gag reflex or otherwise debilitated) or if auscultation and aspiration is inconclusive.

Hospital Response

It remained unclear why the x-ray had been considered to show correct nasogastric tube position. Possibilities included the doctor's inexperience and the possibility that an incorrect x-ray was interpreted. The hospital stated it was in the process of implementing an electronic system for storage of x-rays that will ensure all x-rays are available in patient care areas at all times via the hospital computer system. It was thought that this would minimise the chance of an incorrect x-ray being mistakenly viewed.

Coronial Finding

The Coroner stated that "incorrect positioning of a nasogastric feeding tube is not uncommon, hence the need for protocols to guide correct procedure. X-rays are an essential part of that process. However in spite of an x-ray indicating incorrect positioning of the nasogastric tube in the lung, positioning was confirmed as being correct.

Coronial Recommendation

This case "may be a further indicator of the need for supervision of less experienced medical practitioners."

RECENTLY CLOSED CASES

1679/02: A toddler presented to the local hospital where he was diagnosed with a febrile convulsion secondary to otitis media. He was discharged with an antibiotic and paracetamol. He was found dead the next morning by his parents. An autopsy found the cause of death to be bronchiolitis in a child with a history of febrile convulsions and found face down on his pillow.

3233/02: A young male with schizophrenia was an involuntary patient in a psychiatric ward absconded twice and returned on his own volition. During his third absconding he jumped in front of a train. There was not an adverse finding as it was found that the deceased was not considered a high suicide risk.

3276/03: An elderly male with bipolar disorder had his community treatment order revoked. While an inpatient he died from multiple injuries after jumping off a bridge. Inconsistencies between medical and nursing notes regarding his suicidality were highlighted along with risk assessments that were ad hoc and often inadequate, and illegal permitting to leave the service without authorisation.

1325/04: An elderly female had a AAA for which she was awaiting a custom fenestrated graft. In the meantime the AAA ruptured and emergency surgery was unsuccessful.

2176/04: A teenage male, recently released from prison, died from the combined sedative effects of methadone, diazepam and olanzapine.

2234/04: An elderly male presented to a busy tertiary hospital ED having been unstable in the ambulance. Urgent venous gases revealed a very low blood count that was not acted on for over three hours. When his gastrointestinal haemorrhage was diagnosed he was unstable and died despite aggressive interventions. The hospital responded with changes in clinical practice.

2656/04: A young male with schizophrenia jumped from a height while on leave from a locked psychiatric facility. The leave from the facility had been planned and increased. A toxicology report indicating recent use of cannabis received on the day of leave had not been seen by any clinician. If it had been noted the deceased's leave would have been denied. The facilitie's response to this system failure was approved by the coroner.

3017/04: A middle aged male with an acquired head injury and behavioural problems was cared for in a supported residence. He required chlorpromazine and physical restraint for violent outbursts. On one such outburst the deceased was restrained in a prone position for fifteen minutes after which he calmed down and, after another five minutes pushed himself up a short distance before having a cardiorespiratory arrest.

4196/04: An elderly female was admitted to hospital for a chest infection. While in hospital she had a fall striking her head resulting in an intracranial haemorrhage. She became confused and was found to have an INR of 6.5. Her warfarin was withheld and she was given vitamin K. Three days later a repeat CT of her head found an increased amount of intracranial blood. Conservative management continued to be recommended by the neurosurgeons. However following an acute deterioration she was taken to theatre for neurosurgery and then ICU where she was given FFP. Changes in the hospital's reversal of anticoagulation protocol were noted.

4359/04: A middle-aged female with osteoarthritis of her back and knee had several surgical procedures to relieve her pain which remained unrelenting. Following two admissions to a psychiatric facility she suicided by placing herself on railway tracks.

213/05: A middle-aged male with a history of chronic pain and intravenous drug use for which he took methadone was found to have accidentally overdosed on heroin. The coroner again warned about the need for extreme care in prescribing oxycodone and other potent opiate analgesics.

550/05: A female developed chronic fatigue syndrome and depression. Following an overdose she was admitted to a psychiatric facility and then transferred to a second psychiatric facility resulting in social isolation. Following failed requests to be moved to another facility she hanged herself. The coroner commented about the insensitivity of the transfer between facilities.

607/05: A middle-aged male with schizophrenia and significant ischaemic heart disease died from complications of his cardiorespiratory illnesses while an involuntary patient in a psychiatric facility.

2083/05: A young male with dyslexia and illicit drug use was diagnosed with schizoaffective disorder. He died from heroin toxicity after a period of abstinence.

2312/05: An elderly female with a significant medical history including bipolar affective disorder was found hanging by the singlet type sleeve of her nightgown from the toilet door handle. An accidental cause was considered more likely than a suicidal cause.

2451/05: A baby was cared for in a neonatal intensive care unit having been born at 31 weeks gestation. She required mechanical ventilation until three days of age. During the fourth day she had an acute pulmonary haemorrhage from which she couldn't be resuscitated. The cause of the haemorrhage was multi-factorial.

2704/05: An elderly male had a caecal tumor removed at laparotomy. It was complicated by an injury to a mesenteric vein from which bleeding could not be controlled.

2921/05: A teenage female died from uncontrolled haemorrhage during a thoracotomy for treatment of a haemothorax. She had had refractory nephrotic syndrome for which she was treated with immunosuppressants. This was complicated by severe pneumonia requiring ECMO.

3166/05: An elderly female with significant medical problems collapsed secondary to a thoracic aortic dissection. Despite her dire condition an endoluminal repair was attempted, but was complicated by rupture of the external iliac artery and haemorrhage.

3977/05: A young male with a history of depression hung himself after reassuring clinicians he had no intent to do so. His partner, however, was concerned. Again, the need for clinicians to pay higher regard to the unique knowledge families have about a patient's patterns of behaviour, thinking and mental state, and to incorporate this into history taking, treatment planning and key decision-making was highlighted.

To Busy to Keep Up-To-Date?

Case Number: South Australian Coroner's Case
Case Précis Author: Dr Adam O'Brien FACEM

Clinical Summary

A 29 year old previously well female consulted her general practitioner (GP) with a sore throat and muscular aches. The GP prescribed penicillin and ibuprofen. The following day her GP saw her at home at about 1830h as she had remained unwell with a headache and vomiting. He considered that her propensity for migraine had been exacerbated by the infection. He administered morphine 30mg and metoclopramide 10mg intramuscularly.

By about 0030h the deceased started to vomit again. The GP arranged for her admission to the local regional hospital. He telephoned the hospital and informed a nurse that the deceased was being admitted with a migraine for which he ordered a further dose of morphine 30mg with prochlorperazine 12.5mg. He stated that he would have then spoken to the other nurse on duty about the medication order. However, the coroner found that the GP only spoke with the enrolled nurse and not the registered nurse on duty, a departure from usual nursing practice. The enrolled nurse admitted the deceased to a single room and it was decided that four hourly observations would be appropriate.

Part of nursing duties at the hospital during the night shift included hourly checks of all patients during 'rounds.' There was no method of recording whether these 'rounds' were done or not. Despite that, it was found that the deceased was reviewed by the registered nurse for the first time 2¼ hours after the previous 'rounds.' She was found deceased and despite aggressive resuscitation measures she died.

Coronial Investigation

A post-mortem examination found that she had infectious mononucleosis at the time of her death causing enlargement of both tonsils and significant narrowing of the upper airway. Toxicology results revealed the presence of 0.16mg/L morphine in the deceased's blood.

An independent pharmacologist focussed upon the dangers of unsupervised, high doses of morphine administration. Although the morphine level found at autopsy was generally considered to be a 'therapeutic concentration', it may well have been a toxic level in a morphine naïve person such as the deceased.

MIMS states that the maximum usual dose for adults was 20mg and that it was not calculated by reference to weight. Furthermore, the independent expert emphasised that the starting dose of morphine "is governed by age rather than weight and for a 29 year old, should have been between 7.5mg and 15mg by the subcutaneous or intramuscular routes every two hours as required." This is also recommended in the Australian Medicine's Handbook 2003 and at tertiary hospitals.

The GP was astonished when he received the expert's report. The expert explained that a weight based calculation method applied perhaps fifteen years ago for morphine but changed over to the age based formula. The coroner stated that it was not difficult to understand that someone with the GP's hectic workload might not have much opportunity to keep up to date with changes in medical practice. But given the common use of morphine as a powerful pain relieving medication, it was surprising that the GP had not familiarised himself with the appropriate method of dose calculation.

According to the expert, patients given morphine should be closely monitored at least hourly to look for adverse effects by measuring the level of sedation and respiratory rate.

The cause of death was found to be respiratory depression caused by morphine intoxication on a background of upper airways narrowing which was a consequence of infectious mononucleosis.

Coronial Recommendation

"The development of "systems" which minimise harmful outcomes for patients is to be encouraged. Medical practitioners and nurses will inevitably make unintentional errors in the course of their work from time to time. It is in everyone's interests to explore ways of minimising errors by devising supportive systems where possible".

It was also recommended "that the minister for health give consideration as to how the department might provide assistance in the regular dissemination of information to Directors of Nursing in regional hospitals concerning developments relevant to patient safety and welfare in a manner which would promote consistency of practice between the larger hospitals and smaller regional hospitals".