A combined Victorian Institute
of Forensic Medicine and
State Coroner's Office publication.

# CORONIAL COMMUNIQUÉ

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## EDITORIAL

Welcome to the first edition of the Coronial Communiqué for 2008! This year marks the beginning of a new era at the helm of the State Coroner's Office. It is with fond memories that the Clinical Liaison Service remembers the outgoing State Coroner, Mr Graeme Johnstone who was pivotal in establishing the Clinical Liaison Service in conjunction with the Victorian Institute of Forensic Medicine in 2002.

The Clinical Liaison Service congratulates and welcomes the new State Coroner, Judge Jennifer Coate. We look forward to a productive and collaborative relationship that continues to focus on improving patient safety.

We have also had a few staff changes and are very pleased to welcome Fiona Kitching as our administration officer. Other recruits are Drs Nicola Cunningham and Helen Parker who join the Clinical Liaison Service team.

We have added a new 'Readers' Feedback' section to this edition that highlights interesting discussion points raised by our readers. Our subscribers are always encouraged to contribute verbal and written comments about the content of the Coronial Communiqué. The recent editions have prompted a significant increase in comments and we believe these now deserve their own section. We hope you enjoy reading and using these contributions to stimulate your own discussions and policy developments.

This edition continues the tradition of case summaries, the first case, summarised by Amanda Charles, highlights that things can still go wrong even when reasonable preventative interventions are put in place. The second case, summarised by Adam O'Brien, describes a catastrophic cascade of events following a brain biopsy after which the hospital created robust preventative procedures to avoid any similar recurrences.

Thanks to all our subscribers who participated in the evaluation survey of the Coronial Communiqué last year. We are currently finalising the analysis of the responses and should be in a position to provide a summary report later this year.

## OPEN DAYS

We will be hosting two Open Days this year at the Victorian Institute Of Forensic Medicine which are open to all health professionals for whom coronial matters are relevant.

- Monday 16th June 2008 Open Day for Metropolitan attendees.
- Friday 10th October 2008 Open Day for Rural attendees.

These Open Days are designed to allow clinicians and allied staff a snapshot of the processes and services offered by both the State Coroners Office and Victorian Institute of Forensic Medicine. If you wish to attend, please send an email to cls@vifm.org. Places are limited. Further details regarding these sessions will be available in the next publication of the Coronial Communiqué.

## FEEDBACK

The CLS team is keen to receive feedback about this communication especially in relation to changes in clinical practice.

Please email your comments, questions and suggestions to: **cls@vifm.org**

## REPRODUCTION



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All publications produced by the Specialist Investigations Unit, including the Residential Aged Care Coronial Communiqué and WORKWISE can be found on our website at **http://www.vifm.org/n961.html**

# TIMELY COMPLETION OF FALLS RISK ASSESSMENTS

**CASE NUMBER**: 1187/05

**Case Precis Authors:** Amanda Charles RN, CLS

### CLINICAL SUMMARY

A 58 year old male was admitted to the ED (Emergency Department) of a small rural hospital two days following an alleged fall at home. According to statements he had been drinking and had started behaving erratically so an ambulance was called at 16:45 hours. On arrival of the ambulance officers his GCS (Glasgow Coma Score) was noted to be 12/15 and his heart rate was 80bpm. He was transferred to a metropolitan hospital where he arrived at 17:23 hours after requiring sedation and restraint for the transfer.

Shortly after his arrival at the hospital he was found to have fallen to the floor at 18:15 hours. Following this, a reddened area was noted to the back of his head, and his GCS was documented as 11/15. His condition continued to deteriorate. He had a CT scan of his brain at 18:47 hours which revealed a right subdural haemorrhage and transfer was arranged to a tertiary hospital for neurosurgical intervention. He was intubated prior to transfer and his blood alcohol concentration was noted to be 0.15%.

His condition continued to deteriorate following surgical evacuation of the haemorrhage and treatment was withdrawn following consultation with his family. He died three days after first presenting to hospital.

### PATHOLOGY

A full autopsy was performed at VIFM. The cause of death was:

1(a) Head injury associated with two separate incidents

### INVESTIGATION

The death of this man was reported to the State Coroner's Office due to the death occurring as a result of an accident or injury, in this case a head injury. The forensic pathologist opined that there was a temporal association between the second fall in the ED and the subsequent deterioration. A statement from the acting unit manager of the ED was obtained which clarified the circumstances of the deceased's presentation to the ED. She also outlined the Acute Falls Risk Assessment Tool which formed part of the assessment on admission of all patients. It was also stated that although the risk assessment had not been formally completed, interventions that would have been in place if the Falls Assessment had been completed were actually in place. These included the cot-sides on the trolley being in a raised position, the patient being in an area of visibility, security guards in attendance whilst he was awake and that his initial observations had been recorded.

### CORONER'S COMMENTS

The Coroner was satisfied that the management of the deceased was reasonable. It was also taken into account that although the formal Falls Risk Assessment Tool had not been completed, the necessary interventions had been put in place.

### RECOMMENDATIONS

The findings were made by means of a Chambers Finding by the Coroner. One of the recommendations made by the Coroner was that EDs review their Falls Risk Assessment Tools regarding the timely completion of a full assessment when warranted. An abridged "tick box" could document the implementation of interventions prior to the formal Risk Assessment Tool being completed.

### AUTHOR'S COMMENTS

This case demonstrates that even when interventions are put in place as per the guidelines in the Falls Risk Assessment Tool, an adverse event such as a fall may still occur.

### KEY WORDS

emergency department, fall, policy, protocol, risk assessment

## WHERE'S IT GONE?

**CASE NUMBER**: 938/03

Case Precis Authors: Dr Adam O'Brien FACEM, CLS

### CLINICAL SUMMARY

A 53 year old female developed limb numbness, headaches and dysarthria. A CT brain scan revealed a possible glioma. A neurosurgeon performed a biopsy soon afterwards which diagnosed cortical dysplasia, a developmental abnormality. The patient later developed seizures which were managed with anticonvulsants and radiological monitoring of her cerebral lesion.

Her seizures were well controlled for three years before they worsened. An optometrist noted significant visual field defects, indicating that her cerebral lesion was likely to be a low grade infiltrating glioma rather than cortical dysplasia.

After a further three months the deceased agreed to a second biopsy. Three MRI guided biopsies were taken by a registrar under consultant supervision and placed in one specimen bottle. The deceased recovered well from the procedure, however, the specimen bottle containing the biopsy samples was lost. There was no record that the specimen container left the operating theatre. The neurosurgery registrar was the last person known to have seen it during the completion of the pathology request form.

The deceased subsequently had severe seizures. The neurosurgeon performed a further biopsy for the purpose of directing management and a diagnosis of an astrocytoma was made. The biopsy procedure however was complicated by haemorrhage caused by injuring an artery. The deceased didn't regain consciousness and died six weeks later.

### PATHOLOGY

A full autopsy was performed at VIFM. The cause of death was:

1(a) Bronchopneumonia and cerebral oedema in a woman who sustained complications following a neurosurgical procedure (brain biopsy)

1(b) Inoperable brain tumour (diffuse astrocytoma – WHO grade 2)

### INVESTIGATION

A number of statements were taken from medical and surgical specialists, and nursing staff were also heard at the inquest.

### CORONIAL COMMENTS AND FINDINGS

The coroner was unable to conclude that the patient's long-term prognosis was significantly influenced by the loss of the brain biopsy specimens or the haemorrhage that occurred during the third brain biopsy.

Despite requiring all sterile instruments used during surgery to be counted, the sterile specimen jars and biopsy specimens were not recorded on the Peri-operative Nursing Care Record. The first time that nurses were expected to document the specimen jar was when they arranged for its transmission to the Pathology Department.

Following a Root Cause Analysis, a red basket was located in the same position in each operating theatre and these were used to collect specimens during procedures prior to transportation to the Pathology Department.

Additionally, it was "identified that there needed to be an absolutely clear line of responsibility for [the samples]." The final responsibility for ensuring specimens were dispatched was specifically allocated to the Instrument Nurse. The Instrument Nurse either dispatched the specimen or delegated another nurse to ensure that the specimen was sent to the Pathology Department.

The coroner noted that in the document "Key Principles for the Management of Specimens for Pathological Diagnoses" published by the Victorian Surgical Consultative Council the following was enunciated:

"*1.1 All facilities should have documented policy or procedure for the management of specimens...*"

### CORONIAL RECOMMENDATIONS

1 A review of policies regarding management of pathology specimens in operating theatres with a view to clarifying any ambiguity in the dual roles of the surgeon and surgery registrar when there is no functional assistant surgeon to perform ancillary tasks such as completing written requests for pathology analyses.

2 Consideration be given to whether separate specimen bottles should be used for samples to minimise the likelihood of loss.

3 The Department of Human Services ensure that other health services where biopsies are performed in operating rooms are aware of the need to develop clear protocols which define procedures and responsibilities for ordering and transport of biopsy specimens.

### KEY WORDS

Biopsy, RCA, neurosurgery, specimens

## RECENTLY CLOSED CASES

**4542/05**: A 32 year old woman suicided on propranolol (which she purchased via the internet). Recommendations around regulatory authorities considering restricting the availability of drugs through the internet and tightening guidelines governing relationships between psychologists and doctors were made.

**2597/05**: A 48 year old man with a known history of an allergy to penicillin went to his GP with a 3 day history of fever, cough, sore throat, hoarseness, rhinorrhea and congestion. The GP diagnosed pharyngitis and administered IM procaine penicillin. The patient went home and collapsed and was unable to be resuscitated by the paramedics. The cause of death was anaphylaxis.

**1215/05:** A 52 year old woman was reported missing by her family. She was found in a car calling for help 11 days later and was taken to hospital. She was transferred to a larger facility the next day due to acute liver failure and admitted to her family that she had overdosed on paracetamol. She died two weeks later. There was no history of depression.

## READERS' FEEDBACK

Several readers have responded to our invitation to comment on the content of the Coronial Communiqué. We thank those readers and encourage others to do the same. The following commentary is the view of the readers and is not intended to be clinically or legally binding.

### 1890/03: HEAD INJURIES IN THE ANTICOAGULATED ELDERLY (MAY 2007)

A cardiologist noted that the manufacturers of warfarin do not discuss the increased risk of subdural haematomas in those sustaining head injuries. The cardiologist's practice is to inform patients that if they have even a minor head injury (enough to give them a laceration, a bruise, a headache or loss of consciousness) they should seek immediate medical attention to consider if a CT brain scan is necessary and whether warfarin should be temporarily ceased. It was suggested that one might stop warfarin for two days for a patient with a prosthetic valve and for four days in a patient with atrial fibrillation.

Readers are referred to the following reference for detailed guidelines: Baker RI, Coughlin PB, Gallus AS, et al. Warfarin reversal: consensus guidelines. MJA; Vol 181 No 9; 1 November 2004.

### 60/05: NFR (FEBRUARY 2007)

It was argued by a reader that it was not always appropriate to expect that "medical staff ensure that consultation with the family occurs in relation to any decisions made, and that wherever possible, the NFR orders are discussed with the patient at a time when they are capable of making an informed decision as recommended by the coroner".

In some situations (e.g. advanced age, multiple co-morbidities, end-stage disease), resuscitation is going to be futile, and on this basis can be withheld by medical judgement rather than requiring formal consent. Equally these patients would not be offered a renal transplant or coronary artery bypass surgery, but doctors are not expected to discuss these individual 'decisions' one by one with the patient and / or family.

It was agreed that health services needed a policy relating to these issues, with the reader citing a health network's policy, which put more emphasis upon clinician judgment than extensive discussion. Of course there is room for discussion in less clear-cut situations and where patients may have a wish to be more actively involved in planning.

### GENERAL COMMENTS

An emergency physician observed that most cases in the Coronial Communiqué appeared to involve EDs and wondered if this reflected a coronial focus on ED activity or the clinical experience of the CLS staff. This prompted a review of the six most recent publications which found that of 18 Case Summaries, 4 involved EDs exclusively and 2 involved the ED and another specialty. There is no targeting of ED practice by the Coronial Services Centre or the Clinical Liaison Service. We do find, however, that most cases reported to the Coroner have had ED input. This is reflective of the reality that most patients enter hospitals via the ED.

## RECENTLY CLOSED CASES continued

**4464/03:** A 62 year old woman with a history of chronic pain from spinal nerve root compression, obesity, asthma, arthritis and depression was found unresponsive by her husband. Paramedics were unable to resuscitate her. An autopsy revealed death was due to an accidental polypharmacy overdose.

**579/05**: A 22 year old male with a long history of depression committed suicide by hanging. His brother had suicided three months earlier. Issues associated with depressed patients presenting to EDs without psychiatric services and the delay in commencing assessment of the patient by the CAT team were discussed.

**1905/05**: A 48 year old man with a history of depression, back pain and migraine died of a combination of drugs (morphine & diazepam) and ischaemic heart disease. The patient had been seeing two different GP's over 15 years and getting drugs from both sources. The HIC Prescription Shopping Project was raised as it had failed to detect the problem.

**2620/05:** A 91 year old man with a history of motor neurone disease and stroke was admitted and placed on a trial period of nasogastric feeding due to deteriorating physical condition and functioning. Tube position was noted as OK but found one hour later to be dislodged. The patient subsequently died 10 days later from aspiration pneumonia.

*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.*