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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Next Edition: February 2006

Editorial

We apologise for our recent hiatus, this was due to the Clinical Liaison Service (CLS) undergoing some recent staffing changes as well as having input to the current review of the Coroner's Act 1985 (VIC).

We expect to be back on track in the new year and would be pleased to hear from anyone with an interest in contributing to the Communiqué. Please contact us at cls@vifm.org.

The challenges of effective communication are highlighted by the cases reported in this issue.

Ms Newman's summary of case 2139/99 highlights the importance of communication between treating clinicians and the family of the patient. The CLS regularly reviews family letters which are related to communication issues with clinicians. It is quite clear to us that if they have a better understanding of their relative's illness and treatment and are given an explanation of how clinical decisions have helped family members to cope better with the death and reduce complaints about care.

Communication is again a prominent theme in the next case "Communication Issues in an Unrecognised Infection," summarised by Ms Beaty. In this case, the patient developed septicaemia after the initial infection went unrecognised. Several issues related to documentation and clinical follow up were noted.

In the last case, Dr O'Brien highlights the importance of adequate thromboprophylaxis management in what may appear to be a minor injury. Another communication issue was noted within this case. This time the issue was communication within the organisation and staff. The orthopaedic clinicians involved in the management of the deceased were unaware of the hospital's guidelines for the management of deep vein thromboprophylaxis. It is important for Medical Directors to convey the importance of clinical guidelines to all of their staff.

The last article in this edition summarises the new reviewable death legislation in Victoria. As of 1 January 2005, Victorian clinicians are required to report any death that is a second or subsequent death of a child in one family to the State Coroner. Details of the legislation are described here for clinician's information.

Once again, summaries of recently closed coronial cases have also been included at the end of this edition of the Coronial Communiqué. We have added an extra page summarising recent health-related findings that have been handed down since the February 2005 edition.

DISCLAIMER

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.

Management of Liver Failure

Case Number: 2139/99

Case Précis Author: Elizabeth Newman, Clinical Research Nurse, Clinical Liaison Service

Clinical Summary

A 44 year old woman was admitted to the base hospital with symptoms of hepatitis. Her condition deteriorated over the next eleven days necessitating transfer. The patient was transferred to a tertiary receiving hospital for treatment of acute hepatic failure.

The day after transfer she rapidly deteriorated requiring admission to the Intensive Care Unit and she was placed on the liver transplant waiting list ("urgent" classification).

Three days later a donor liver became available and transplantation occurred without complication.

Initially recovering well, a week later she deteriorated suddenly. Laparotomy revealed an ischaemic bowel. After discussions with her family regarding the irreversible nature of her condition active treatment was withdrawn. She died shortly thereafter.

Coronial Investigation

Investigation centred on how the patient acquired hepatitis; the recognition of the seriousness of her condition whilst in the base hospital and the timeliness of transfer to the tertiary receiving hospital (including subsequent listing for transplant).

The patient's sister submitted an extensive statement to the Coroner outlining perceived communication problems between family and the base hospital staff - the concerns included; a failure of staff to listen to the family and a lack of explanatory advice given to the family from the medical staff.

The cause of this patient's hepatitis was never discovered. There was a concern as to whether the patient contracted hepatitis after taking a herbal remedy (containing 'dipyrone' – a substance banned in Australia) supplied to her by a traditional Chinese medicine practitioner. This practitioner had also treated the patient with acupuncture. No definitive link was formed between either the herbal remedy or the acupuncture with this patient's liver failure.

An intensivist provided a written expert opinion for the family's solicitors and verbal opinion at the inquest. Although not overly critical of the management of the patient whilst in the base hospital, a major failure in management was the lack of communication with the Liver Unit at the tertiary receiving hospital. Had this occurred the patient's outcome may have been different. It was stated, however, that no particular guidelines were in existence to assist clinicians regarding this communication.

The hepatologist highlighted issues at the base hospital including the administration of clotting factors (disguising the true coagulation status) and the interpretation of one of the patient's liver function parameters.

The King's College Hospital Liver Unit's guidelines were discussed. The hepatologist stated these criteria are used predominantly by liver specialists. The base hospital could not be criticised for not applying them, however, had they done so the patient would have met transplant criteria.

Opinion was sought from an intensive care specialist who stated the base hospital could not be criticised in relation to their management in the setting of acute liver disease as it is known the liver has a considerable ability to regenerate and most patients do not require transplantation. With the benefit of hindsight, however, the patient could have been referred and transferred at an earlier date – possibly improving her outcome.

Opinion was sought from a gastroenterologist who stated the management at the base hospital was appropriate and earlier referral to the tertiary hospital would not have altered her outcome. It was noted that even if this patient had been referred and transferred earlier an appropriate donor liver may not have been available any sooner than it subsequently was.

Recommendations

The Coroner concluded that the patient's death may not have been preventable. Despite this he emphasised the following:

- Listening to the concerns of family members
- Being aware of/guided by the King's College Hospital Liver Unit's guidelines
- Raising the index of suspicion and seeking advice from an expert liver transplant unit at an early stage.

The Coroner also noted that although not directly implicated in this patient's hepatitis, that a herbal remedy available in Australia containing a substance banned in this country was a concern. He referred this matter to the Therapeutic Goods Administration, the Department of Human Services and the complementary medicine industry.

> Experience is not what happens to a man. It is what a man does with what happens to him."
>
> Aldous Huxley

Communication Issues in an Unrecognised Infection

Case Number: 1999/00

Case Précis Author: Marianne Beaty, Clinical Risk Manager, Alfred Hospital

Clinical Summary

A 68 year old physically fit and strong man was conducting a trail ride when he was witnessed to slump forward over the neck of his horse whilst cantering and fall heavily to the ground on his right side.
He immediately got up, complaining of pain. Help was sought immediately and he was transported to his local rural hospital by ambulance. Following X-rays, the patient's local doctor diagnosed a fractured scapula, fractured ribs and a right pneumothorax. An intercostal catheter was inserted, analgesia given and the patient transferred to a large regional hospital for investigation of his loss of consciousness (LOC).

The man was admitted as a private patient to a single room under the care of a surgeon. ECGs taken did not reveal a cardiac cause for the LOC and stress tests were planned post discharge.

The documentation of care during his stay at this hospital was scant, mainly consisting of notes made by the admitting doctor and the physiotherapists. Scant nursing notes identified that the man had a good intake of diet & fluids.

Daily physiotherapy visits which started on Day 3, identified that the patient had pain which limited his chest physiotherapy and resulted in low oxygen saturation levels. The patient was experiencing nausea and according to the family who visited daily for 5 hours, was not eating or drinking much. The patient was changed from parenteral to oral analgesia, and was refusing analgesia due to problems with constipation. He was seen daily by his treating surgeon, registrar and resident doctor. The amount of oxygen was gradually increased over the 10 days he was in hospital until the patient was on 60% oxygen continuously.

Physiotherapy and medical staff continually noted crepitations and reduced air entry into both bases of the lungs. By day 7, the registrar ordered a CXR and bloods to rule out the possibility of pneumonia. However, these results were not followed up. The patient rapidly deteriorated on day 10 and was transferred to ICU were he died of multi-system failure due to septicaemia, bronchopneumonia, lung abscess and intra-thoracic and intra-abdominal ascites, secondary to the trauma from the fall.

Coronial Investigation

The Coroner felt that this man's death was preventable had the infective process and his dehydration been identified and treated earlier. In his findings, the coroner noted the following as contributing factors;

- No clinical or medical notes made by any of the treating doctors (which would have provided the doctors with the ability to check what had previously transpired in relation to the patients care and aided their memory of events).
- The provision of test results that came in "hard copy" up to 72 hours following request over the weekend. He was concerned that this could happen in a large regional hospital.
- Lack of communication between all the members of the team looking after the patient (in particular nursing & medical staff).
- The lack of discussion of the patient's condition with the patient so that cooperation could be gained to enhance treatment outcomes.
- The fact that the most junior medical staff were the ones left to diagnose and investigate patients on a day-to-day basis.
- The stoicism of the patient was not fully appreciated.

The Coroner felt after hearing expert witness testimony, that the patient could have survived if IV re-hydration and antibiotics were started much earlier.

Authors' Comments

It is important to build a rapport with our patients to gain their cooperation with treatment. Senior staff need to closely supervise junior staff. Don't forget to document everything. If it wasn't written down how can you prove that it happened?

Correction:

Following a recent letter from a reader, the Clinical Liaison Service would like to apologise for any offence caused by referring to individuals as "schizophrenic" rather than "individuals with schizophrenia" within our February edition. As the reader rightly points out, the latter terminology recognises that the person has an illness rather than defining them by that illness.
The CLS appreciates feedback or questions from our readers. Please feel free to contact us at cls@vifm.org or via telephone at (03) 9684 4357.

DVT Prophylaxis or Not?

Case Number: 1987/98

Case Précis Author: Adam O'Brien, Consultant Forensic Physician

Clinical Summary

A 42 year old carpenter had a nail enter his left thigh when a nail-gun inadvertently discharged. An orthopaedic surgeon operated on him for 15 minutes to remove it. The only documented post-operative instruction was 'RIB' (Rest in Bed) and the physiotherapist did not have any involvement other than fitting crutches. He died approximately 60 hours after sustaining the injury.

Coronial Investigation

An autopsy revealed the cause of death to be pulmonary thromboembolism, bilateral calf deep venous thromboses (DVT) and immobilisation following a nail-gun injury to the left thigh.

The deceased had no prior risk factors for thromboembolic disease. The surgeon noted that lower limb surgery increased the risk of DVT but the operation in this case was a small operation and therefore did not consider prophylaxis necessary. He also stated that there was "no reason for the deceased to rest in bed and that he could have been up and about."

The surgeon was not aware of specific hospital guidelines.

The nursing staff noted that the deceased had been "very mobile in the bed" but "remained in bed over the weekend as per *the post-operative orders*". Exercises like deep breathing, coughing or toe wriggling were a normal part of management but not necessarily documented.

Expert Opinion

The surgeon opined that this was a "minor injury [and] what was done was appropriate with modern high standards of care." However, he thought that the "force of injury" may need reviewing and that with "more wisdom we would say it was a major injury..."

Coroner's Comments

The deceased was in a low risk group for developing a DVT and was appropriately managed in the hospital. However, through the family's submissions, it was suggested that:

• The documentation of a patient's exercising regime and compliance was important;

• Provision of information about DVT to patients and families may mean the family could assist by encouraging the patient to exercise;

• Clinicians should be aware of hospital policy. The family considered that it was necessary to develop and refine an overall hospital policy and to deliver sections of the policy to the various sectors working in the hospital (eg. nurses, physiotherapists, clinicians);

• Management of the low risk group should have a "primary focus on mobility" following an operation; and

• As injuries to the lower limbs have a greater risk, they may need to be treated differently - perhaps by the provision of compression stockings.

This case illustrated the potential tragic outcome consequent to a failure to maximise management techniques in the area of DVT prevention. It should be noted however, that even if the patient had been exercising outside his bed rest regime, there was no certainty the outcome would have been any different. Despite this, there still may be areas where there is potential to improve outcomes even in the low risk group.

It appears, from a coroner's perspective, that there may be some additional clues potentially demonstrating a need for re-consideration of the elevation of the category for the management of risk, in patients who are normally classified as of lower risk. These potential clues are that the patient is:

• On the border line of the category between low and moderate risk;

• It is a lower limb operation;

• Occurred as a result of an emergency - therefore with no opportunity of pre-operative work up; and

• The injury is a result of an impact (i.e. as a result of some considerable force causing damage to surrounding blood vessels).

It was noted that none of the orthopaedic clinicians involved in the management of the deceased were aware of the hospital's guidelines for the management of DVT. Although nothing turned on this issue, the apparent lack of communication of the guidelines could potentially have consequences in other circumstances. This issue needs to be drawn to the attention of all Medical Directors of Hospitals.

Recommendations

1 The Victorian Quality Council and the relevant Colleges consider the issues raised by the deceased's family (and the Coroner) with a view to identifying practical improvements in the identification of risks and the management of the group of patients who are thought to be at low risk of developing DVT;

2 That the hospital incorporates into their 'Operation Report' form a provision for specific orders for DVT prophylaxis so that instructions are unambiguous.

Reviewable Death Law in Victoria

Author: Natalie Morgan, Paediatric Liaison Coordinator & Helen McKelvie, Medico-Legal Officer

The Victorian Government has introduced a new system for dealing with multiple child deaths in one family. The changes were recommended by the 2003 "Report into the System for Dealing with Multiple Child Deaths" which was commissioned by the Premier, the Hon. Steve Bracks, after the deaths of four children from one Victorian family. The *Death Notification Legislation (Amendment) Act 2004* implemented the recommendations of this report and came into operation on 1 January 2005. The intention of the legislation is to ensure that Victorian systems and processes for handling deaths are capable of dealing effectively and humanely with all cases of multiple child deaths within a family. In doing so, the legislation seeks to balance the rights of grieving families with the public interest in ensuring that living children are protected in cases where intervention is necessary.

The obligation to report a "reviewable death"

The legislation provides that where there has been a second or subsequent death of a child in a family, this death is termed a "reviewable death" and must be reported to the State Coroner. As of 1 January 2005 a doctor who is present at or after the death of a child must, where that death is a reviewable death, report the death to the State Coroner as soon as possible. Reporting is mandatory and must be done regardless of the circumstances surrounding the death, including where the cause of death has been established."

Investigation of the "reviewable death" by the State Coroner

The legislation empowers the State Coroner to investigate a reviewable death to determine the identity of the deceased, how the death occurred and the cause of death. The State Coroner has the same investigative powers in relation to a reviewable death as he has in relation to a reportable death (i.e. a death that is unexpected, unnatural or violent or has resulted from accident or injury).

Investigation of needs of the family by the Victorian Institute of Forensic Medicine

The State Coroner may refer a reviewable death case to the Victorian Institute of Forensic Medicine ("VIFM") for investigation. The primary focus of the investigation is the health and safety of living siblings and the health of their parents. Treating health professionals are invited to take part in this process. The investigation can result in referral of a family to specialist medical services, notification being made to the Victorian Child Protection Service and/or a recommendation being made to the State Coroner that further investigation of the reviewable death is warranted.

VIFM has appointed Ms Natalie Morgan as Paediatric Liaison Coordinator to carry out these investigations. She is empowered by the legislation to collect, use and disclose personal and health information in relation to a reviewable death investigation. She may contact you for information regarding the deceased child, living siblings or parents. The legislation authorises a person to whom such a request is made to provide the information requested.

Further Information

You may find further information about the reviewable deaths process on the VIFM website at www.vifm.org. If you wish to enquire about VIFM's role in reviewable deaths investigation please contact:

Ms Natalie Morgan
Paediatric Liaison Coordinator
Victorian Institute of Forensic Medicine
57 – 83 Kavanagh Street, Southbank, Victoria 3006

Recently Closed Cases

3249/97: A middle aged patient died by hanging herself on a coat hook on the back of a door in an inpatient psychiatric facility. Prior to this time clinical staff considered that there had been an improvement in her condition.

1015/00: A patient with chronic pain died following an accidental overdose. Discussion centred on actively encouraging patients to participate in their pain treatment and to routinely ensure clinical monitoring.

1518/01: A patient admitted to a Drug & Alcohol unit to undergo opiate detoxification using Buprenorphine died of hypoxic encephalopathy due to combined drug toxicity. Patients self administering medications and caution in use of Buprenorphine were discussed.

3630/98: A middle aged patient died of renal complications 15 months post delayed diagnosis of a "saddle embolus". The need for supervision of junior staff, after hours management and listening to concerns of relatives were discussed.

3351/00: A newborn baby died of multi-organ failure and sepsis due to a subaponeurotic haemorrhage following Ventouse extraction. Obstetric professionals should be mindful of this rare complication so it can be identified and treated early.

2381/01: A young patient died in hospital from lobar pneumonia and septicaemia. The use of the Thoracic Society Severity Score to assist in the assessment of pneumonia and the need for earlier transfer to ICU were discussed.

Recently Closed Cases Continued....

2720/01: An elderly patient died of septicaemia after failure to monitor TPN administration. The use of enteral versus parenteral feeds in a functioning gut and listening to concerns of relatives were discussed.

154/02: A patient on haemodialysis died from severe blood loss from punctures in her AV fistula. The need to provide and document clear and explicit instructions to patients was discussed.

605/02: An angioplasty performed ten days after a myocardial infarction was complicated by coronary artery dissection requiring transfer to a tertiary hospital for emergency bypass surgery. The patient became unstable and died post-operatively. It was found that performing the angioplasty at an institution where cardiac surgery was available would have shortened the time to theatre. However, the risks associated with delays in transferring for emergency surgery were explicitly stated in consent forms.

689/02: A male with schizophrenia and depression killed himself on a railway track while an involuntary patient. How involuntary patients could be better contained in psychiatric units was discussed with recommendations made.

801/02: An elderly male was in a private hospital with increasing falls. Following a fall from bed his mental state deteriorated secondary to a subdural haematoma. Recommendations included the development of 'falls' prevention policies.

4386/03: An elderly male at a rural ED with ventricular tachycardia was prescribed a large dose of lignocaine that caused asystole and death. It was recommended that hospital protocols be followed by clinicians. A copy of the finding was sent to the Medical Practitioners Board (Victoria).

127/04: An elderly male died in hospital from Staphylococcal endocarditis of a prosthetic valve. Critical investigations were not clearly documented in the medical record and it was recommended that legible documentation with the date and time should be a minimum standard.

506/04: A young male with depression hanged himself after absconding from a metropolitan ED. A new system for dealing with mental health patients in EDs requiring psychiatric admission was discussed. It was recommended that other hospitals should consider adopting a similar system.

617/04: An elderly female had a routine insertion of a pulmonary artery catheter for post-operative cardiac surgery management. She died from a lacerated pulmonary artery sustained during insertion. Despite the healthcare institution maintaining that the death was unavoidable and that there was no need to change practice, a recommendation was made for the healthcare institution to review practices and procedures for cardiac surgery patients, commenting that "there is no place for 'routine' medical practices in the absence of individual patient risk analysis".

857/04: A premature female neonate died from Group B Streptococcal septicaemia despite negative ante-natal cultures and prophylactic antibiotics.

1040/04: An elderly female died in a hostel from a myocardial infarction. Despite family concerns about the over prescribing of morphine it was found that the amount of analgesia was reasonable.

1112/04: A young male with depression hanged himself with his pyjama top over a door despite being in an intensive care psychiatric ward. Changes to procedures included more rigorous observations and changes to the doors.

1125/04: An elderly male died from lung trauma that occurred during the insertion of an intercostal catheter. The registrar performing the procedure had had significant experience without prior complications. Recommendations included the development of a formalised training program for such procedures and the development of a database to document experience and complications.

1205/04: A middle aged female with long-standing chronic pain and mental health problems died from morphine toxicity whilst on a CTO. She had been reviewed regularly at home and was considered to be a low suicide risk.

1659/04: An elderly frail male with profound intellectual disability died in a residential facility from bronchopneumonia. The management of falls and timely referral to aged care services were discussed.

3524/04: An elderly female with lymphoma was admitted for symptoms related to a pleural effusion. Following a pleural tap she became increasingly dyspnoeic and died from bleeding from her intercostal vessels causing a haemothorax.

The Clinical Liaison Service would like to wish you a Happy & Safe Holiday Season