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CORONIAL COMMUNIQUÉ

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CONTENTS

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FREE SUBSCRIPTION

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EDITORIAL

This issue of the Communiqué describes two cases in detail. The recurring themes of clear and adequate documentation and the need to listen to family concerns are prominent. In both cases, the coronial investigation focussed on the statements requested and provided by the treating doctors. There is a common perception that a request for statements is an allegation that a treating team "is in trouble". Within a coronial setting however, statements are requested to provide practitioners with an opportunity to describe their involvement with patients in the context of issues such as workplace pressures, physical settings and clinical complexities that may not have been evident from the medical records. The process also then enables practitioners to draw attention to any positive changes in individual or systems practices that were reflected upon and implemented as a result of the case.

RESULTS OF THE CORONIAL COMMUNIQUÉ SUBSCRIBER SURVEY

In 2003, the Clinical Liaison Service established the "Coronial Communiqué", a subscriber-based, electronic newsletter published quarterly describing the lessons learnt from deaths investigated by the Coroners' Office. A cross-sectional population study of all currently registered subscribers to the Communiqué was conducted by an electronic survey in 2007. Of 1,325 subscribers invited to participate, 697 (52.6%) complete and valid responses were received. Virtually all subscribers would recommend the Communiqué to colleagues, 98.4% (n=686).

Subscribers agreed or strongly agreed that the Communiqué is:

Reliable	98.3%	(n=685)
Useful	95.1%	(n=663)
Timely	84.1%	(n=586)

Subscribers agreed or strongly agreed that the Communiqué:

Provided ideas for improving patient safety	84.4%	(n=588)
Led them to review their practice	61.5%	(n=429)
Led them to change their practice	41.6%	(n=290)

The results of the survey suggest that communicating lessons for improving patient safety through the Communiqué is effective and prompts a significant proportion of subscribers to initiate changes to clinical practice for patient safety.

A more detailed and comprehensive report is being prepared for publication and we will place this on our website when completed.

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

If referring to this publication, the following citation should be used: Coronial Communiqué [electronic resource]: Clinical Liaison Service, Connecting Clinicians and Community with Coroners. Southbank, Vic. State Coroners Office; Victorian Institute of Forensic Medicine. Available at: **http://www.vifm.org/communique.html**

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**

HARD TO SWALLOW

CASE NUMBER: 2075/06

Case Precis Authors: Carmel Young RN, CLS

CLINICAL SUMMARY

Ms W was a 98 year old independent female who lived in a granny flat behind her grand-daughter's house. She had a past medical history of arthritis, CCF and COAD. She was diagnosed with an oesophageal pouch in 2001 by a private physician and instructed to maintain a soft food diet. In June 2006, Ms W ate a fish fillet which regurgitated after swallowing and she developed a sore throat and a deeper cough than normal. Two days later she was found collapsed at home by her grand-daughter and was taken to a public hospital. She complained of shortness of breath and a productive cough and was diagnosed with left lower lobe pneumonia. A pneumonia pathway was implemented and she was treated with intravenous fluids and antibiotics.

There was no notation in the medical file about her inability to swallow, and no reference made of the previously diagnosed oesophageal pouch in the documentation by the emergency doctor. While in hospital, the nursing notes showed that she vomited after eating and could only tolerate fluid orally. Her swallowing worsened and the ward medical staff referred her to a speech pathologist and a gastroenterologist, and a gastroscopy was planned following consultation with her private physician. Two days later she was transferred to a private hospital for the gastroscopy and ongoing care, and was diagnosed with aspiration pneumonia. Her condition deteriorated rapidly however, and she died the next day.

PATHOLOGY

An autopsy found the cause of death to be bronchopneumonia and pulmonary congestion from an obstructing food bolus within the oesophagus, and cardiac amyloidosis. The forensic pathologist who performed the autopsy commented that the large food bolus within the oesophagus would be expected to lead to significant obstruction to ingestion of food, fluids and medications.

INVESTIGATION

This case was referred to the Clinical Liaison Service by the family who expressed concern that Ms W's inability to swallow had not been taken seriously. They felt that the hospital neglected to obtain a complete past medical history. The grand-daughter reported that she had informed the admitting staff about the oesophageal pouch. The focus of the coronial investigation was to determine whether there had been systems and communication issues that delayed the identification of the previously diagnosed oesophageal pouch. A number of statements were obtained from the treating medical staff.

Hospital staff had no independent memory of such discussions however, and there was no documentation in the medical records of a presenting symptom of dysphagia.

At review it was considered that in the setting of an oesophageal pouch Ms W had a chronic risk of aspiration, however there were other significant medical conditions that contributed to her death.

CORONER'S COMMENTS

The coroner acknowledged that the hospital was able to demonstrate a number of inadequacies in Ms W's management including lack of documentation regarding the dysphagia and of consultant review. Subsequently, changes had been made to a number of relevant systems for managing patients routinely treated by private physicians, who present to a public emergency department with incomplete records of their medical history. These included formalising routine consultant assessments and clinical handovers within the medical units.

AUTHOR'S COMMENTS

This case again highlights the importance of listening to the family when they express concerns and documenting discussions and issues that are raised.

KEY WORDS

Diagnosis, medical, management, statements, oesophageal pouch, dysphagia, bolus obstruction, autopsy, communication, medical records

SUSPECT A CLOT? TO TREAT OR NOT?

CASE NUMBER: 4355/06
Case Precis Authors: Dr Nicola Cunningham FACEM, CLS

CLINICAL SUMMARY

Ms A was a 74 year old female with a history of end stage renal failure requiring peritoneal dialysis, ischaemic heart disease, long-standing abnormal liver function tests and recent episodes of rectal bleeding associated with haemorrhoids. She presented to a metropolitan emergency department early one morning complaining of feeling generally unwell with limb weakness, chest tightness and swollen legs.

The resident medical officer noted an initial oxygen saturation of 87% on room air; however, the nursing observation chart documented consecutive oxygen saturations above 95%. On examination, she had bilateral pitting oedema to the knees with her left leg more swollen than her right.

The possibility of an acute myocardial or neurological event as well as a deep vein thrombosis was considered and over the following 12 hours, the patient received cardiac monitoring, a chest x-ray, arterial gases, a CT brain and peritoneal dialysis, and was referred to the renal team just after 13:00 hours following admission. They requested an urgent Doppler ultrasound of her legs which was performed later that afternoon at 17:50 hours, approximately 15 hours following her presentation to hospital. No prophylactic anticoagulant treatment had been instigated in the interim period.

The ultrasound subsequently demonstrated an extensive thrombus involving the left common femoral vein. During the imaging, Ms A suffered a cardiac arrest and died.

PATHOLOGY

No autopsy was performed as the deceased had not been referred to the coroner at the time of death.

FINDINGS

The cause of death was pulmonary embolism caused by a deep vein thrombosis to her left leg.

INVESTIGATION

The case was reviewed following a family letter which outlined concerns regarding the delay of approximately 15 hours before an ultrasound was performed of her swollen leg and that blood thinners had not been administered when a deep vein thrombosis was considered. Statements from the treating units were requested to clarify the circumstances regarding the apparent delay in anticoagulation therapy to assist in determining whether it may or may not have contributed to the death. Statements received from the Emergency and Renal Physicians outlined the diagnostic and medical complexities of the case. The history of recent rectal bleeding and the greater incidence of spontaneous intracerebral haemorrhage in dialysis patients on clexane were discussed. A copy of the hospital policy on Reportable Deaths was also viewed which states that unexpected deaths are reportable.

CORONER'S COMMENTS

While there is evidence that Ms A was experiencing symptoms consistent with deep vein thrombosis at the time of admission to the emergency department, professional interpretation of these symptoms was complicated by her other clinical co-morbidities including worsening end stage renal failure and ischaemic heart disease. The delay in implementing diagnostic procedures and prophylactic anticoagulation may not have significantly altered the circumstances of her death. The case was therefore closed via a Chambers Finding.

AUTHOR'S COMMENTS

This case highlights the difficulties faced in prioritising management of suspected deep vein thrombosis in patients with multiple medical issues. Practice guidelines do exist for outlining risk stratification and appropriate preventative management for thromboembolic disease in various subsets of patients.[1]

In the clinical scenario of a suspected acute deep vein thrombosis or pulmonary embolus however, there are no such standard recommendations for commencement of treatment prior to radiological confirmation. Thus, a risk-benefit judgement needs to be made in each case, taking into account factors such as the probability of a clot, the time and availability of the test, the impact on the patient of potential side effects, and the urgency of management of any concurrent medical problems. Withholding anticoagulant therapy pending the result of an ultrasound scan would not be an unusual decision to make in the setting of recent rectal bleeding and significant renal and hepatic disease.

Nevertheless, the need to show consideration and documentation of the conflicting issues that have been addressed in that decision-making process is of paramount importance.

KEY WORDS

Metropolitan, diagnosis, management, medical, statements, anticoagulation, deep vein thrombosis, risk stratification

FOOTNOTE

1. Fletcher J, Baker R, MacLellan D, Chong B, Fisher C, Gallus A, Gibbs H, Hannan T, Matthews G, Salam H, Stacey M, Gatt S, van Rij A and Flanagan D. Prevention of venous thromboembolism: best practice guidelines for Australia and New Zealand. Health Education and Management International (ISBN 0 9578909 15), Sydney 2006.

OPEN DAYS

The overwhelming response to our invitation to attend our Open Days has been pleasing. Unfortunately the small capacity means some people will miss out this time.

The first of our two Open Days for this year will take place on Monday June 16th (for Metropolitan attendees), commencing at 13:30 hours. The afternoon will feature information sessions hosted by CLS together with Coronial, Forensic Pathology and Donor Tissue Bank staff.

Please note there is no parking available on-site.

RECENTLY CLOSED CASES

1/06 Ms B was a 45 year old woman who had a history of hypertension, diffuse headaches and an incidental arachnoid cyst. Whilst on holiday at a caravan park, she collapsed and bystanders commenced cardiopulmonary resuscitation. Attempts by paramedics to resuscitate her were unsuccessful. Cause of death was haemorrhage into the arachnoid cyst with associated subdural haemorrhage.

762/06 A 38 year old female with a history of schizoaffective disorder treated with clozapine, borderline personality disorder, and borderline intellectual functioning, presented to hospital with an altered state of consciousness. She was subsequently admitted with suspected acute myocarditis. The day following admission she suffered two tonic-clonic seizures and had a cardiac arrest and died. An autopsy concluded that the cause of death was pulmonary thromboembolism in a setting of probable clozapine-induced myocarditis.

1181/06 A 36 year old female had a history of major depression, back problems and post-traumatic stress disorder following an alleged physical assault while at work. Her psychiatrist and general practitioner had communicated their concerns regarding her use of analgesic medication. She was found deceased at home by her father. Her death was deemed to be an accidental overdose of codeine in the setting of significant coronary artery atherosclerosis.

2217/06 Mr S was a 71 year old male with a past medical history that included hypertension. He presented to a regional hospital with chest pains. A dissecting aortic aneurysm was diagnosed and he was transferred to a metropolitan hospital for surgery. The aneurysm was located at the arch of the aorta; during the surgery it extended leading to severe bleeding and he died.

2418/06 Ms C was a 15 year old female with no relevant past medical or family history who presented to her local doctor with a two day history of abdominal pain, diarrhoea, fever and vomiting. Following a finding of abnormal liver function tests, she was referred to her local hospital with a provisional diagnosis of acute hepatitis. Her condition deteriorated and she was transferred to a metropolitan hospital with liver failure, sepsis, deteriorating renal function and a coagulopathy. She was admitted to ICU for haemofiltration and investigation of her hepatitis, and placed on the National Transplant List. She died intraoperatively and the cause of death following an autopsy was multi-organ failure complicating operative management of fulminant hepatic failure (liver transplant) and Wilson's disease.

3386/06 A 40 year old male with a past medical history that included heavy alcohol consumption and gout presented to hospital with a history of vomiting on a recent background of an increase in his gout medication. He was admitted with dehydration, acute renal failure, thrombocytopaenia, bowel obstruction and toxicity to colchicine and indomethacin. He became septic and required intubation, haemofiltration and triple antibiotic cover for suspected hospital-acquired pneumonia. His condition deteriorated and a CT of his brain revealed an intracerebral haemorrhage. He died shortly afterwards and at autopsy was found to have intracerebral haemorrhage complicating multiple aspergillus cerebral abscesses; angioinvasive pulmonary aspergillosis; and acute renal and bone marrow failure following potential mixed indomethacin and colchicine toxicity.

3932/06 Ms F was a 58 year old female with a past medical history which included anxiety and vertigo. She saw her local doctor for review of her recurrent symptoms of vertigo and tinnitus and the clinical notes suggested an acoustic neuroma as a possible cause. A CT scan of her brain was requested and was reported as normal by the radiologist. Approximately two months later the deceased felt unwell one night and took some analgesia. Her husband checked on her at 05:00 hours and found that she had died. The cause of death following an autopsy was large cell lymphoma of the 3rd ventricle of the brain.

3977/06 Mr T, an 87 year old male was seen by his local doctor at home for a routine scalp check following skin surgery. During the visit he complained of experiencing constipation for a week. His abdomen was noted to be moderately distended and filled with gas. The doctor advised him to use lactulose and planned to review him if the symptoms did not settle. Mr T was later found to have died from peritonitis and sub-acute bowel obstruction.

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.