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# CORONIAL COMMUNIQUÉ

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## PUBLICATION TEAM

**Editor in Chief:** Adam O'Brien  
**Consultant Editor:** Joe Ibrahim  
**Managing Editor:** Zoë Davies  
**Designer:** Caroline Rosenberg

**Address:** Clinical Liaison Service  
Coronial Services Centre  
57-83 Kavanagh St  
Southbank 3006  
**Telephone:** +61 3 9684 4364

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## EDITORIAL

Welcome to our 13th issue of the Coronial Communiqué. In this edition, our authors have summarised cases that have a number of lessons for us all.

The first case study, 'Fatal Chinese Whispers', highlights the consequences of poor communication at various levels and the importance of adhering to hospital protocols. The second case, 'Head Injuries in the Anticoagulated Elderly' summarises a common coronial issue in which the complications of anticoagulation therapy are not fully appreciated. A discussion paper that highlights the difficulties associated with prescribing warfarin can be accessed by following the links provided with this article. The third case, 'Constipation Can be Deadly', discusses a fatal complication of a commonly used medication, as well as the importance of having appropriate systems that ensure timely review by a senior clinician.

### Evaluation of the Coronial Communiqué

All of our readers were recently invited to respond to an evaluative survey about the Coronial Communiqué. The response rate was amazing and provided us with positive and constructive feedback. We were pleased to learn that a significant number of our readers have used Coronial Communiqué articles to instigate clinical changes at various levels. To harness these lessons, we have plans to develop a forum to discuss the clinical changes and how they can be appropriately disseminated.

Amongst the many valuable observations provided during our recent Coronial Communiqué survey was one that commented that "...*Many of the cases seem to trigger "what would I do to prevent this happening again" type of thoughts. It would be interesting to hear from readers at the "coal face" (nurses, doctors, pharmacists, etc) as to what steps they would take to prevent a problem recurring. It would be interesting to compare these steps to the Coroner's recommendations, or to the response of the institution in question. One way you could do this, without making the Coronial Communiqué too large, is by presenting the case in one issue & the responses from coroners, institutions & readers in the next issue...*" The Coronial Communiqué editorial team thinks this is a fantastic suggestion and encourages our subscribers to comment about cases, with the hope that important lessons and practice changes can be circulated to others.

### Complaints Handling

The Clinical Liaison Service is pleased to announce that as part of our work towards achieving quality accreditation, we have published our complaints handling procedure on our website. If you would like to view our policy, or make a complaint about the service please click on the following link: <http://www.vifm.org/n961.html>

## 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](mailto:cls@vifm.org)

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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>

## FATAL 'CHINESE WHISPERS'

**CASE NUMBER:** 3291/03

**Case Precis Author:** Professor Peter Ebeling, Chair, Victorian State Committee, RACP

### CLINICAL SUMMARY

A 63yo female was being investigated as an outpatient for falls. She had a past history of vertigo, ataxia and hypertension. She was taken to a metropolitan hospital emergency department (ED) following a collapse.

Less than two hours later her Glasgow Coma Score (GCS) was 10/15. A brain CT was interpreted for the radiology registrar by the on-call radiologist two hours after the fall stating that he was unable to make the diagnosis of a possible sagittal sinus thrombosis and recommended a second brain CT with contrast. The radiology registrar then informed the ED staff there was a possible sagittal sinus thrombosis.

Two hours later the second brain CT was performed. The radiologist believed sagittal sinus thrombosis was one of several differential diagnoses, so a third brain CT was recommended. The ED doctor told the on-call neurology registrar that the diagnosis of sagittal sinus thrombosis was certain. Five hours after the fall a loading dose of phenytoin was administered and two hours later a loading dose and infusion of unfractionated heparin were given

Two hours after the patient was admitted to a ward a clotting profile was ordered on the blood samples taken on admission, however, the samples were not appropriate. At this time there was a rapid deterioration with the GCS decreasing to 7/15. A third CT scan then showed a 1cm subdural haematoma with midline shift. Heparin was ceased and the patient was intubated and transferred to a major teaching hospital. The patient died three weeks later despite evacuation of the haematoma.

### PATHOLOGY

The deceased's family objected to an autopsy. The pathologist on reviewing the medical records gave the cause of death as acute subdural haemorrhage.

### CORONIAL INVESTIGATION

The focus of the Coroner's investigation was to determine the reason for the administration of heparin and the miscommunications between medical

staff that resulted in the patient's death from acute subdural haematoma. The patient's treatment was against the hospital's guidelines for administration of anticoagulants in patients with recent cerebral infarcts. In particular, no blood was taken for a clotting profile before commencement of heparin, which should have only been administered after consultation with the neurologist on call. This was not done. In addition, a bolus of heparin was given which was also against the guidelines.

Another critical problem was the uncertainty regarding the original diagnosis. The beginning of the chain of miscommunication appeared to begin with the misinterpretation of the radiologist's verbal reports by the radiology registrar. This then flowed on to the ED staff and neurology registrar. Because of this uncertain original diagnosis, the Coroner could not assess to what degree the heparin administration contributed to the patient's death.

### RECOMMENDATIONS

The Coroner recommended that all patients presenting with an acute deterioration in conscious state should have access to an immediate CT scan and that specialty unit referrals be expedited in patients with critical illnesses.

### HOSPITAL RESPONSE

The hospital introduced new guidelines defining the duties and responsibilities of specialty registrars between 10pm and 8am. In cases of unstable medical illnesses they must attend within 15 minutes of notification by the ED doctor and within two hours for other less urgent opinions.

### AUTHOR'S COMMENTS

The system problem that contributed to the death of this patient arose from a misinterpretation of a verbal specialist radiology report by the radiology registrar. An incorrect diagnosis was promulgated to both the ED staff and specialty registrar, which resulted in an incorrect treatment being administered. This treatment was also administered without adhering to local clinical treatment guidelines. There should be a low tolerance for referring critically ill patients to specialty registrars and specialists on call. All specialists would prefer to know of difficult cases at the time rather than after the event.

## HEAD INJURIES IN THE ANTICOAGULATED ELDERLY

**CASE NUMBER:** 1890/03

**Case Precis Authors:** G Broomhall  
RFD MBBS DRCOG MRACGP, J Sweet  
BPharm AACPA, AJ O'Brien FACEM

**Comments:** M Cole-Sinclair, Clinical Haematologist

### CLINICAL SUMMARY

An 84 year old female had a history of falls. She was taken to the emergency department (ED) of a regional hospital following a fall at her home after she had overbalanced and hit her head on a chair when attempting to retrieve her walking frame.

The ambulance staff who transported her to the hospital noted a past history of a pacemaker, acute myocardial infarction, transient ischaemic attacks and falls. She was taking multiple medications including warfarin.

The deceased was treated at the hospital for a laceration to her head and was observed to be alert with a GCS of 15/15. There was no loss of consciousness following the fall and baseline observations of temperature, pulse and blood pressure were reported as being normal. There were no complaints of headaches nor were there any change

in the patient's condition. She remained in the ED for just under three hours and was discharged from hospital by taxi at 23:30 hours after expressing her wish to go home.

The deceased's condition deteriorated the following night, approximately 24 hours after being discharged. She was returned to the hospital the following morning and a CT scan of her brain revealed the presence of a subdural haematoma. She died later that day as a result of her injuries.

### PATHOLOGY

An autopsy found that the cause of death was from a subdural haematoma following a fall.

### Coronial Comments

It was noted that the Director of Emergency Medicine stated that following this case there was a new practice where "patients over the age of 60 years with even minor head injury are now routinely CT scanned." Furthermore, information provided by the hospital to its clinicians stated that "patients with risk factors for bleeding or more severe injury (age >60 years, use of anticoagulants or extended period of loss of consciousness (LOC)) require immediate CT scanning."

### RECOMMENDATION

Consideration should be given to the Admission and Discharge protocol for Emergency Medicine (requirement for a CT scan) adopted by the hospital in this case in becoming a standard practice for managing patients over 60 who are admitted to hospital with apparently minor head injuries.

### AUTHOR'S COMMENT

Assessment for dangerous or cryptic bleeding complications of warfarin therapy (eg. subdural & retroperitoneal haematomas) is often done in ED's by junior staff who may not consult or have the relevant experience. As such events are likely to present to ED's, systems ensuring adequate supervision need to be in place.

An informative discussion about the usage, complications and risk stratification for warfarin can be found at <http://www.vifm.org/communique.html>

## RECENTLY CLOSED CASES

**4085/05:** An 82yo nursing home resident who fractured her humerus in unwitnessed circumstances developed a pressure sore due to the plaster back-slab. This wound became infected with MRSA necessitating treatment in hospital for more than one month. She died soon after transfer back to her facility.

**3601/05:** An 81yo female fell at home and sustained spinal cord oedema. Soon after being admitted to hospital she developed pneumonia and was treated palliatively until she died approximately two weeks later.

**792/06:** A 37yo male psychiatric patient with depression and bipolar & schizoaffective disorders, and who had a history of poly-substance abuse & alcohol abuse, committed suicide by

hanging. He had recently been released from a CTO as he appeared to have made a significant improvement.

**3124/05:** An 86yo male with multiple medical problems was admitted to a major public hospital for treatment of intractable diarrhoea. He died three and a half weeks later due to his multiple medical problems.

**2582/04:** The parents of a four week old baby boy took their baby to the ED with a three day history of lethargy and poor feeding approximately one week post discharge from hospital. The baby was resuscitated and transferred to the special care nursery. The child was found to have extensive hypoxic cerebral ischaemic changes on CT and subsequently died. His condition was a known side effect of the drug atenolol which the mother was taking to prevent life threatening ventricular arrhythmias.

**2163/05:** A 73yo woman was admitted to a supported accommodation facility following discharge from hospital for cardiac failure and a chest infection. Her condition deteriorated over the next four days and she collapsed and died.

**849/05:** An 84yo male who had been admitted to an aged care mental health facility with dementia choked on a sandwich he was given late at night. He collapsed and died despite extensive resuscitation attempts by paramedics. The staff member was unaware that the patient was on a special diet and not allowed to eat sandwiches.

**101/05:** A 72yo aged care resident developed a urinary tract infection (UTI). There was a delay in the treatment of the UTI and a lack of identification of the severity of the patient's condition which resulted in the delayed transfer to a hospital. The

## CONSTIPATION CAN BE DEADLY

**CASE NUMBER:** 390/04

Case Precis Author: Carmel Young RN

### CLINICAL SUMMARY

Mr H was a 20 year old male who had been investigated at the Royal Children's Hospital for constipation for which there was no cause found. He presented to a regional hospital feeling unwell and not having had his bowels opened for four days. On reviewing Mr H's abdominal x-ray the radiologist reported that it was "the worst constipation he had ever seen."

He was admitted to the ward with a bowel obstruction secondary to constipation and was to be managed with serial enemas. Mr H's bowel chart documented that he was "incontinent of loose faecal matter". Both he and his mother were insistent that enemas never worked and Mr H often refused to have them.

Three days after his admission he developed a fever and tachycardia. His clinical status was discussed with a colorectal surgeon at a tertiary hospital in Melbourne for advice and possible transfer. There were no signs of peritonism at this stage. It was decided to add oral Picoprep to his medication regimen after which it was noted that he

deteriorated. Transfer to Melbourne was being organised when he deteriorated further. An emergency laparotomy found necrotic and perforated bowel with peritonitis. He was admitted to ICU where he died a few days later.

### PATHOLOGY

An autopsy found the cause of death to be sepsis from faecal peritonitis resulting from a ruptured megacolon due to an underlying colonic motility disorder.

### INVESTIGATION

The inquest heard evidence from three expert witnesses who all agreed that up until the administration of Picoprep, clinical management was reasonable. It was heard that the use of Picoprep increased the chances of bowel perforation. However, not all the experts agreed that it was wrong to administer the Picoprep. One considered that a half dose would have been more appropriate. Another considered that decompression of the bowel was urgent and in the circumstances where the patient was refusing enemas a full amount of Picoprep needed to be given.

### CORONER'S COMMENTS

"What caused Mr H's death was 'sepsis from faecal peritonitis resulting from a ruptured megacolon', with the weight of evidence satisfying me that the Picoprep was the causal link to the perforation.

The evidence highlights the complex nature of Mr H's presentation and the differences between practitioners as to their preferred regimes".

The coroner found that the registrar was senior enough to manage the patient, but thought that due to the complexity of his presentation he should have been transferred to Melbourne earlier. The doctor who ordered the Picoprep believed he was advised to do so by the doctor in Melbourne. However that doctor denied he would have given such advice.

### RECOMMENDATIONS

There were a number of recommendations made by the coroner including:

- Consideration be given to developing peer review standards as to when a new patient is to be assessed by a senior clinician;
- Regional hospitals review their processes to ensure clear, comprehensive and accurate communication between the regional and the specialist hospital; and
- Clinicians should be reminded about the importance of listening to family concerns.

## RECENTLY CLOSED CASES CONTINUED...

patient died due to overwhelming urinary sepsis (and multiple medical problems).

**3283/04:** A 65yo male with a history of renal and cardiac failure on warfarin for atrial fibrillation, was taken to hospital with severe hypovolaemic

shock secondary to gastrointestinal bleeding. He died soon after and his INR was found to be 10.

**4586/05:** A 37yo female presented to a large public hospital ED with abdominal pain and diarrhoea and was treated for gastroenteritis with IV fluids, morphine and was sent home with Buscopan. She received further treatment with IM Buscopan the next

day from a Locum GP. The following morning she was found unresponsive and attempts by paramedics to resuscitate her were unsuccessful.

### Would you like the full Coroner's Finding?

If you have read one of our Coronial Communiqué summaries you may wish to obtain and read the complete original coroner's finding. If you do, please send an email to [cls@vifm.org](mailto:cls@vifm.org) with details of the case you require.

*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.*