



From Death We Learn 2012



Acknowledgements

Mr Alastair Hope, State Coroner, Western Australia (now retired)

Ms Evelyn Vicker, Deputy State Coroner, Western Australia (now Acting State Coroner)

Mr Dominic Mulligan, Mr Barry King and Mr Peter Collins, Coroners, Western Australia

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The Health Services' Safety, Quality and Performance Units

All medical and nursing staff involved in the reporting and review of death

The patients and their families

The Patient Safety Surveillance Unit (PSSU) welcomes suggestions on how this publication series may be improved. Please forward your comments to PSSU@health.wa.gov.au

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From Death We Learn and coronial inquest finding documents identified in this text can be downloaded from the following website:

http://www.safetyandquality.health.wa.gov.au/mortality/coronal_liaison.cfm

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Coroner's foreword

It is commonly said that the most important role of coroners is to speak for the dead to protect the living. It is in this context that coroners make comments or recommendations following inquest hearings into reportable deaths with a view to preventing similar deaths happening in the future. These comments and recommendations in a medical setting often relate to issues bearing on public health and safety and standards of clinical care.

While only a small proportion of deaths investigated by a coroner proceed to a coronial inquest, which is a court hearing, all reportable deaths are investigated.

Families whose loved ones have died unexpectedly following medical treatment often struggle to come to terms with the circumstances surrounding the death. For these families it is often extremely important for them to have an expectation that the death of their loved one will result in changes which could prevent similar deaths occurring in the future.

When it appears that medical treatment could have been better or issues have been identified which, if addressed, could prevent similar deaths from occurring in future, it is important to ensure that the information is communicated to those who can use the information.

In this context the Patient Safety Surveillance Unit has taken the very positive step of providing short clinical summaries of inquest findings and de-identified summaries of other cases. These summaries highlight the clinical messages and lessons learned, allowing hospital and health professionals to benefit from the information which has been obtained.

All hospitals and health services are encouraged to use these summaries to raise awareness of important messages which have come from the investigation of these deaths so that lessons learned from investigating the circumstances of death can protect the living.

Mr Alastair Hope
WA State Coroner¹

¹ Alastair Hope was State Coroner for the duration of 2012; however, retired as State Coroner prior to publication of this document in 2013.

Editorial

This is the seventh edition of *From Death We Learn*. The cases included highlight a range of issues which have the potential to impact on the daily practice of many health practitioners. We encourage all practitioners, hospitals and health services to use these case summaries as educational tools in order to share the lessons learned and avoid similar issues arising again. We should all continue to strive towards providing the highest quality, safest care we can for our patients.

A number of the cases in this edition occurred in regional and rural settings. The provision of health care in rural areas of WA remains challenging. Rural clinicians provide an essential service to a growing number and wide range of patients, often with limited resources and without access to local specialist support. They are also increasingly required to consider cost and logistical factors in managing their patients. It is vital that appropriate advice and support is made readily available to rural practitioners, and imperative that the difficulties they face are recognised and understood by specialist colleagues in tertiary centres.

Another recurring theme arising from this year's cases is that of clinical documentation. Maintaining clear and accurate medical records is an essential component of good clinical practice, particularly in hospital settings where multiple clinicians are often involved in patient care. Clear documentation facilitates continuity of safe care for the patient and avoids delays, errors and unnecessary duplication. The requirements of good clinical documentation are outlined by the Medical Board of Australia (MBA) in their publication *Good Medical Practice: A Code of Conduct for Doctors in Australia*.² This document is available online at the MBA website and all practitioners should be aware of their obligations in this area.

The Coronial Liaison Unit would also like to take this opportunity to acknowledge the hard work and achievements of our outgoing State Coroner, Mr Alastair Hope. Mr Hope was WA's first State Coroner and has filled the role since the enactment of the *Coroners Act 1996 (WA)*. During this time he has presided over almost 500 inquests and has overseen the implementation of major changes in our state coronial processes. His insights and leadership have been invaluable in establishing a firm basis from which our current processes can continue to develop. We thank Mr Hope for his 17 years of dedicated service and wish him all the very best for his retirement.

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² Medical Board of Australia. *Good Medical Practice: A Code of Conduct for Doctors in Australia* [internet]. 2010. Medical Board of Australia. [cited 2013 October 17]. Available from: <http://www.medicalboard.gov.au/Codes-Guidelines-Policies>.

Introduction to the Coronial Liaison Unit

The Coronial Liaison Unit (CLU) is situated within the Patient Safety Surveillance Unit, Performance Activity and Quality Division, at the WA Department of Health. Currently the CLU consists of Clinical Advisors (two Consultants and a Senior Registrar) and a Senior Policy Officer. It was established in 2005 as a health initiative to improve communication between WA Health and the Office of the State Coroner. The CLU facilitates the allocation of health related findings from coronial inquests for implementation in hospitals and health services.

The CLU reviews all public inquests that have a health care aspect to them and places the recommendations via the Chief Medical Officer with the appropriate area within WA Health. Expert advice and comment on the recommendations and actions taken to improve patient safety in response to the inquest findings are fed back to the State Coroner in a biannual report.

The CLU also receives non-inquested³ case reports from the Office of the State Coroner's Medical Advisors for the purpose of quality improvement. If there are aspects to these cases which are of concern, the CLU raises these issues with the appropriate clinical director from the relevant health service and seeks assurance that the death has been reviewed in a quality improvement environment.

For the purpose of quality improvement, the Coroner's Ethics Committee allows the CLU access to post mortem reports to assist clinicians to undertake mortality reviews. Where clinicians require post mortem findings to effectively review a death, an application for the preliminary results can be made via the CLU.

The CLU continues to work with the Office of the State Coroner to share lessons learned from mortality review to improve future patient care.

³ Deaths which are reportable to the Coroner, that do not require a public inquest, but may have an aspect which needs investigation or review by the health system.

Introduction to inquested cases

Under the *Coroners Act 1996* every regional magistrate is contemporaneously a coroner. However, in practice the majority of Western Australian inquests in 2012 were conducted by: the State Coroner Mr Alistair Hope; Deputy State Coroner Ms Evelyn Vicker; and Coroners Mr Dominic Mulligan, Mr Barry King, and Mr Peter Collins.

Approximately 1,900 deaths are reported to the Office of the State Coroner each year. Of these, approximately 760 deaths are subsequently dealt with by the treating doctor by issuing a death certificate recording a cause of death. The remainder are accepted as coronial cases for further investigation and approximately 100 cases each year are subject to public inquest.⁴

Public inquests are legal cases conducted in open courtrooms, and the coroner has a similar role to that of a judge of the Supreme Court. The objective of an inquest is to establish the facts surrounding the death of the person in question; it is not to determine any question of liability.

After hearing an inquest, a coroner must find, if possible:

- the identity of the deceased
- how the death occurred
- the cause of death, and
- the particulars needed to register the death under the *Births, Deaths and Marriages Registration Act 1998 (WA)*.

They are then able to make comments and recommendations regarding any matter connected with the death, including the provision of healthcare or the actions of other public sector agencies.

WA Health notes all coronial recommendations pertaining to healthcare, and provides regular reports to the Office of the State Coroner outlining the responses to each. These responses have been included in this report where the time-frame has allowed a response to be formulated prior to publication.

⁴ Office of the State Coroner. Annual Report: 2011-2012 [internet]. 2012. Government of Western Australia. [cited 2013 October 7]. Available from: http://www.coronerscourt.wa.gov.au/_files/Coroners_Court_Annual_report_12.pdf.

Unrecognised neonatal sepsis

Key messages:

- Abnormal observations must be recognised, monitored and acted on.
- The limited resources available in rural centres must be recognised, and access to expert advice and assistance should be readily accessible wherever necessary.
- Medical records must be a true contemporaneous record; addendums should be clearly identified, timed and dated.

A newborn baby died after being born prematurely at 35 weeks gestation at a small rural hospital. Her mother had presented to the hospital in labour at approximately 12:30am. The hospital does not have any maternity services and attempts were made to arrange transfer to the nearest obstetric service at a larger regional hospital for delivery. The obstetrician was unavailable however, and the regional hospital advised that they were therefore unable to assist. A retrieval service was then contacted to arrange urgent transfer to a tertiary centre, but it soon became clear that labour was progressing rapidly and preparations were made for an emergency delivery. The baby was delivered at 2:40am and appeared healthy. There were no apparent complications with the delivery of either the baby or the placenta.

The tertiary centre subsequently advised that they were unable to accept the transfer due to constraints on bed availability. It was then decided to send both mother and baby to the maternity unit at the regional hospital. Minimal advice appears to have been offered from the tertiary centre in terms of management or transfer arrangements.

A single set of observations was taken on the baby in the 10 hours from the time of her birth until she was transferred to the regional hospital. These observations were taken three hours after delivery and noted an elevated heart rate and a temperature of 38°C which were attributed to the baby being under a heater following a bath. A plan was recorded to remeasure the temperature later, but this was not followed through. There was no protocol or guideline available for the nurses to follow regarding the frequency or type of observations required for newborn premature babies. The doctor did not give explicit instructions and the nurses did not attempt to obtain any advice regarding this issue.

At 7:00am care of the baby was handed over to day staff who made arrangements for a non-urgent ambulance transfer of both the mother and baby to the regional hospital. No further observations were recorded, but it was noted that the baby appeared lethargic when being transferred into the ambulance at 12:15pm.

The transfer was performed by a volunteer ambulance driver without a nurse or doctor escort, which meant that no monitoring of the baby or mother could be performed in transit. The neonatal retrieval service (then known as the WA Neonatal Transport Service; now known as the Newborn Emergency Transport Service) was not contacted as neither the doctor nor nurses were aware of the existence of the service.

On arrival at the regional hospital the baby was found to be extremely unwell and staff commenced urgent treatment. In spite of their best efforts, the baby deteriorated and died that afternoon.

Inquest findings

It was the State Coroner's finding that the rural hospital was well resourced to undertake regular observations of the baby but that the baby's deteriorating condition was not monitored adequately. Had observations been acted upon, the baby would have had a realistic chance of survival.

The State Coroner also found that the ambulance transfer was undertaken in circumstances which were far from optimal.

Conflicting information was identified between the patient notes retained by the first hospital and those sent with the deceased in the ambulance and faxed to the second hospital. On review of the hospital records it was found that additions had been made to the patient notes in retrospect, including nursing instructions and comments on the condition of the baby. This was a matter of concern to the State Coroner as was the fact that they purport to record different events.

The baby died as a result of perinatal pneumonia in association with untreated meconium aspiration. The State Coroner found that death arose by way of misadventure.

State Coroner's recommendations

1. WA Country Health Service put in place a system whereby the taking of observations by nursing staff in appropriate cases is audited.
2. WA Country Health Service put in place a system whereby note taking of staff is audited on a regular basis.
3. All medical staff in regional areas of Western Australia be informed about the existence and function of NETS (Newborn Emergency Transport Service) AND that this information be included in the orientation provided to visiting medical practitioners.
4. WA Department of Health review the process of induction for visiting medical officers from overseas with a view to ensuring that those practitioners are better equipped to deal with emergencies which may occur in country hospitals.
5. WA Department of Health put in place a system whereby visiting medical officers have improved access to advice and assistance from suitably qualified medical experts in a supportive environment.

WA Health action:

- Health services have confirmed that clinical documentation audits occur on a regular basis, and are evaluated as part of the broader *Recognising and Responding to Clinical Deterioration* program across WA Health.
- The WA Country Health Service has developed an *Interhospital Patient Transfer of the Neonate Policy* which is provided to all visiting medical practitioners during orientation.
- The induction processes for medical practitioners new to the WA Country Health Service have been revised and orientation resources have been developed which highlight both clinical escalation protocols and support services available in emergencies.

Reference: [LITTLE Inquest⁵](#)

⁵ www.safetyandquality.health.wa.gov.au/docs/mortality_review/inquest_finding/Little_finding.pdf

The risks of co-sleeping

Key messages:

- Education is still required on the risk factors of co-sleeping, second-hand smoke and warm environments in increasing the risk of infant death.

A six-month-old baby girl died after she was found unresponsive in bed whilst co-sleeping with her father.

She was the first-born of twin girls who were born prematurely at 33 weeks gestation. During their time in hospital the twins remained well; however concerns were repeatedly raised regarding the mental health of their mother who was known to have schizophrenia. Ultimately the mother's condition deteriorated such that she required involuntary admission to stabilise her mental health.

The twins were discharged home from hospital into the care of their father, but were cared for temporarily by a family member whilst their father was taken into police custody and their mother remained in hospital. The Department for Child Protection (DCP) was involved in assisting family members to decide who would provide care for the children.

After a period of three weeks, following the mother's subsequent discharge from hospital and the father's release from prison, the children returned to live in their family home. No ongoing concerns were raised, no support was provided and no welfare visits were conducted to the home.

In the early hours of the morning of her death her father had placed the baby in her parents' bed as she had been unsettled overnight, and had fallen asleep next to her. It was a cold night and the heating was on so that the bedroom was very warm. The baby was placed on her back to sleep and was covered with a small blanket. Her father later awoke to find the baby lying on her stomach and noted that she was floppy and unresponsive. He drove with the baby directly to the nearest regional hospital where staff attempted to resuscitate her. Their efforts were unsuccessful however, and she was pronounced dead at the hospital.

A post mortem examination was performed. Initial conclusions that the death was consistent with Sudden Infant Death Syndrome were revised at the inquest due to improvements in knowledge surrounding the issue of sudden infant deaths. It was therefore no longer appropriate to categorise the death in those terms.

Inquest findings

It was acknowledged that the deceased had a number of risk factors for sudden unexpected infant death:

- Premature birth
- Co-sleeping with an adult at the time of her death
- Parental history of smoking, especially during pregnancy
- History of maternal illicit drug and alcohol use
- Over-heated environment.

Note was made of a lack of education regarding safe sleeping arrangements provided to the baby's parents: The baby's mother was suffering severe mental illness and it was unlikely that she had the capacity to understand or retain any relevant information that she was provided with during the course of her pregnancy or post-partum period relating to relevant risk factors. Her father received no information relating to sudden infant deaths particularly relating to the issue of co-sleeping.

Coroner's conclusion

The cause of death was unascertainable, and the Coroner made an open finding in relation to the manner of the baby's death.

Coroner's recommendations

1. The DCP offer the Best Beginnings Program (or any subsequent and similar program) to all new parents with whom the DCP has dealings so that the program draws the widest participation from the broadest range of the population, particularly those parents whose circumstances are challenging.
2. WA Health work with other stakeholders (Community Health Nurses, the DCP, Aboriginal medical health providers, SIDS and Kids, and other interested groups) to work towards developing and transmitting a coherent message relating to the known risks that can cause unexpected infant mortality. In providing that information to Aboriginal parents it should be developed and delivered in a culturally appropriate and relevant way.
3. The Department of Health develop a tab in its All About Me child health record book (also known as the Purple Book), (or subsequent iteration), that gives parents advice about the fact of sudden infant deaths, the factors that are reasonably thought to be associated with those deaths and practical advice as to how to reduce risks to a child. For example, parents should be provided with appropriate information about their child's safe sleeping arrangements, the risks associated with a child being exposed to second-hand smoke and a child being kept in an environment that is too warm.

WA Health action:

- WA Health has convened a Safe Sleeping Working Party which includes a multidisciplinary team comprising stakeholders from health services, government agencies, community care agencies, advocacy groups and special interest groups. The group's purpose is to review all consumer resources to ensure that it is consistent, accurate and culturally appropriate. The working party is developing a Safe Sleeping Policy Framework document.
- WA Health has reviewed the information provided in the Purple Book and compared it against best practice. Information is being strengthened to include pictorial representations of the six safe sleeping recommendations, a reminder for child health nurses to provide education to parents at set intervals, and questions for parents.

Reference: [BENFIELD Inquest⁶](#)

⁶ www.safetyandquality.health.wa.gov.au/docs/mortality_review/inquest_finding/BENFIELD_finding.pdf

Fatal flu

Key messages:

- Doctors and nurses should recognise their level of competence and operate only within the appropriate scope of practice for their experience and ability.
- All doctors and nurses should make their patients their first concern and never be too proud or afraid to ask for help.
- Appropriate orientation, training and supervision are essential for safe practice and allowances for these should be built into each roster where required.
- Documentation should be made contemporaneously wherever possible, and should reflect a true and accurate account of events. Where documents are written in retrospect this must be made clear.

A 16-year-old male died as a result of pneumonia secondary to influenza A (H1N1 or “Swine Flu”) infection.

The teenager began to develop symptoms of viral illness six days prior to his death, beginning with a cough, tiredness, and lethargy. Initially his symptoms were attributed to a cold, but they progressed over the next five days to include headaches, fever, nausea, vomiting and diarrhoea. The day prior to his death, he was not able to tolerate any food or fluids and was weak and unsteady on his feet. He had developed wheezing in addition to his cough. His mother was unable to obtain a GP appointment and was advised to take him to the nearest regional hospital for assessment.

On arrival at the regional hospital, the deceased was seen at triage by a registered nurse who took a brief history and recorded a fever of 39.4°C before diagnosing gastroenteritis, recommending oral rehydration solution and advising his mother to take him home. The patient was not seen by, or discussed with, the doctor on duty. No notes were made at the time and no observations were taken other than temperature.

The patient returned home with his mother and went straight to bed. The following morning his mother found him cold and unresponsive, having died overnight.

A post mortem examination confirmed the presence of both viral infection with influenza A virus and a secondary bacterial infection with pneumonia and septicaemia (bacteria within the bloodstream).

Inquest findings

The Deputy State Coroner noted that the registered nurse was a junior nurse who had never triaged alone before working at the regional hospital, and commented on orientation and supervision. A preceptor had been allocated to support the registered nurse in obtaining additional experience; however the need for direct supervision at triage was not specifically communicated to either the registered nurse or his designated preceptor.

It was noted that all documentation relating to the deceased's presentation at the hospital had been completed retrospectively, and that the documentation did not reflect a true account of events. The Deputy State Coroner found the registered nurse's recollection of events to be unreliable; citing inconsistencies with CCTV footage and other evidence. It was noted that prior to the commencement of the inquest, the registered nurse involved had been referred to Australian Health Practitioner Regulation Agency (AHPRA) with respect to this incident.

The Deputy State Coroner acknowledged that both the WA Country Health Service and the regional hospital had responded promptly to the incident and have developed clear guidelines for triage in their Emergency Departments (ED), and Competency Assessments which require completion prior to allowing staff to undertake a triage role alone.

The Deputy State Coroner accepted that it was impossible to say whether the deceased would have survived had he received full and appropriate medical intervention upon presentation to the ED; but found that he was deprived of the opportunity to access proper medical care.

The deceased died from severe Staphylococcus sepsis as a complication of H1N1 influenza A infection. The Deputy State Coroner found that death arose by way of natural causes.

Deputy State Coroner's recommendations

1. WA Country Health Service develop a standardised online e-learning package for preceptors.
2. Nursing rosters make it plain who is a preceptor on any given shift.
3. Introduction of a requirement that all new nursing staff sign to acknowledge receipt of orientation documentation and that the document they sign contains an index of the documents they receive.
4. Mandatory provision of verbal and written advice to all new nursing staff detailing the differences between working in a tertiary hospital in the metropolitan area and a regional hospital.
5. Mandatory provision of verbal and written advice to all new nursing staff detailing the role of preceptors and the area/s in which it is believed the new nurse requires support over and above that of adapting to a new regime/facility.
6. Mandatory completion of the MR1 form (or equivalent) including patient name and basic observations at/for every presentation to triage unless impossible due to the patient's state of consciousness and/or required immediacy of treatment.
7. The Department of Health continue the roll-out of the new patient administration system to ensure improved access to clinical information to country hospitals and real time access to patient information.
8. Provision of on-site educational workshops to assist in competency compliance in key areas which must include triage.

WA Health action:

- An online clinical supervision program for preceptors in the WA Country Health Service is in development.
- The Department of Health has conducted 'The Art of Clinical Supervision' workshops across regional Western Australia.
- A number of existing strategies have been identified by health services that communicate who the preceptor is on any given shift and record acknowledgement of orientation requirements. These strategies have been reviewed in light of the coroner's recommendations, and further strategies have been implemented where appropriate.
- All health services reported compliance with the requirement to complete an MR1 (or equivalent) at point of triage. WA Country Health Service conducts regular audits of triage practice, which includes reviewing the completion of the MR1.
- Implementation of the new Patient Administration System (WebPAS) commenced in 2011 and is undergoing a staged implementation; it is scheduled to be installed in all public hospitals within the next four years.

Reference: [ALLAN Inquest](#)⁷

⁷ http://www.safetyandquality.health.wa.gov.au/docs/mortality_review/inquest_finding/Allan_finding.pdf

Patient sedation – a risky business

Key messages:

- Emergency departments are not optimal environments for agitated or psychiatrically unwell patients. The high levels of external stimulation increases agitation and the risk to patients, staff and visitors. Often this results in a need for physical and/or chemical restraint. Anticipation of potential complications and close monitoring is required when repeatedly or continuously sedating a patient in any environment.
- Documentation of events and the rationale for underlying decisions about patient management should be made clearly and contemporaneously in order to facilitate the continuity of safe patient care.

A 37-year-old male died in a regional hospital whilst awaiting retrieval and transfer to a tertiary centre. At the time of his death he was involuntarily detained under the *Mental Health Act 1996 (WA)*, and as such, the provisions of the *Coroners Act 1996* requires there be an inquest into the circumstances of his death.

The deceased had a long history of mental illness and suffered from schizophrenia. He was variably compliant with medication and had taken to misusing alcohol in an attempt to control his symptoms. On the afternoon before his death, he had been taken to hospital by the police after an alleged altercation with his neighbours. He had been drinking and his neighbours had expressed concerns that he had become mentally unwell. The deceased had willingly left his home with the police officers but had become very agitated en route and required several oral sedation medications prior to exiting the police vehicle at the hospital.

The deceased settled down after the oral medications and became cooperative enough that he was able to exit the police vehicle and walk into the ED. Once inside, a cannula was inserted and further sedation was administered intravenously. Shortly after receiving the intravenous medication he became obtunded and required ventilatory support. The doctors in the ED were unable to gain adequate control of his airway so an anaesthetist was called who inserted an oropharyngeal airway (Guedel airway) and instructed that the patient be nursed on his side to minimise the risk of aspiration whilst the sedation wore off.

Care of the patient was then handed over to another doctor in the ED, but there was minimal documentation of the events since his arrival at the hospital. It was unclear as to what state the patient had arrived in, or exactly what medication he received and the doctor responsible for ongoing care was under the impression that the patient required heavy sedation as he had been violent and posed a threat to both himself and to hospital staff.

The deceased received ongoing sedation over the ensuing ten hour period whilst awaiting retrieval from the hospital. During this time he remained heavily sedated with Glasgow Coma Scale (GCS) scores between three and eight, the oropharyngeal airway remained in situ, and a number of discussions were had regarding the possibility of intubating the patient in order to protect his airway and support his breathing. The decision not to intubate was made on the basis that there were insufficient staff in the hospital to manage an intubated patient for any extended period of time.

In the early hours of the morning the deceased became agitated, sat up in bed and removed the nasopharyngeal airway. He was given further IV sedation and within ten minutes became apnoeic and cyanosed. Multiple attempts to support and secure his airway were unsuccessful and he subsequently suffered a cardiac arrest. Further resuscitation attempts were unsuccessful.

Inquest findings

The Coroner noted that the legal status of an involuntary patient, and the basis of their incapacity to make decisions, needs to be determined and recorded in his/her medical notes. Furthermore, although security issues were recognised, the Coroner was of the view that alternative strategies to sedation should be employed to ensure the safety of staff and patients.

The cause of death was found to be consistent with respiratory arrest in association with medication drug affect and alcohol intoxication, and the Coroner concluded that death arose by way of misadventure.

Coroner's recommendations

1. The WA Country Health Service should take immediate steps to employ permanent and/or ad hoc security staff to help medical staff care for and treat agitated mental health patients, so as to minimise the need for prolonged and deep sedation.
2. The WA Country Health Service should take immediate steps to ensure that when a patient is cared for or treated, without informed consent first having been obtained, then the treating doctor should contemporaneously, or as soon as practicable thereafter, record the fact that the treatment or care has been given without consent and explain the basis upon which the treatment or care was provided.
3. The WA Country Health Service should take immediate steps to ensure that in the case of a patient who is unable to provide informed consent and who needs to be sedated or restrained:
 - The most limited form of sedation/restraint should be applied
 - Any period where a person is sedated/restrained is limited to the shortest possible period of time.
4. The WA Country Health Service and the Department of Health should consider providing greater funding for the Royal Flying Doctor Service, so that transfer times for severely mentally ill patients can be minimised.

WA Health action:

- The employment of private security staff was deemed not feasible and inconsistent with the *'Review of the Admission or Referral to and the Discharge and Transfer Practices of Public Mental Health Facilities/Services in Western Australia* (the Stokes Review). However, the Pilbara region of the WA Country Health Service has developed the *Assessment and Care Plan for Agitated Patients and the Management of the Agitated Patient Flowchart*.
- The *Emergency Psychiatric Treatment and Issues of Consent Operational Directive* (OD 0244/09) sets out the required standard of documentation to record the rationale of providing emergency psychiatric treatment.

Reference: [LEE Inquest](#)⁸

⁸ www.safetyandquality.health.wa.gov.au/docs/mortality_review/inquest_finding/LEE_finding.pdf

Custodial medicine

Key messages:

- Patients have the right to make decisions regarding their medical care, including refusal of medical treatment. These decisions should be respected in all cases unless the patient has been deemed not competent to make such decisions.
- Managing end-of-life care is complex, and may be very complicated in unusual or difficult circumstances.

A 52-year-old man died from complications of Human Immunodeficiency Virus (HIV) in a tertiary metropolitan hospital. At the time of his death he was a prisoner detained indefinitely under the *Dangerous Sexual Offenders Act 2006 (WA)* and as such, the provisions of the *Coroners Act 1996* requires there be an inquest into the circumstances of his death.

His medical history included HIV which he repeatedly declined to have treated, chronic low mood and antisocial personality disorder. He had developed a number of skin lesions over his back and face which had been shown to be basal cell carcinomata (skin cancers) but despite the increasing size and ulceration of these lesions and the associated pain he continued to refuse involvement with specialist medical care, only allowing dressings, and at times, treatment with antibiotics.

A psychiatric assessment had been conducted and it was determined that the deceased was competent to give, and also to refuse, informed consent for medical treatments.

Approximately 12 months prior to his death, the deceased agreed to be seen in a plastic surgery unit at a tertiary hospital where an extensive infiltrating skin cancer extending into the right parotid gland was diagnosed. It was explained that further delay in treatment would complicate the surgery needed to remove the lesion as well as greatly reduce his chances of survival, and the deceased consented to further biopsy which confirmed recurrent basal cell carcinoma. However he subsequently refused two admissions for surgery, preferring to receive only symptomatic treatment with analgesia and dressings.

The cancer continued to grow such that it eroded into the facial and jaw bones and was causing difficulties with eating and speaking. Eventually, profuse bleeding developed from his mouth and the deceased was transferred to the tertiary hospital where it was found that the tumour had eroded into a blood vessel and was most likely incurable. The bleeding was able to be controlled, but a percutaneous endoscopic gastrostomy (PEG) feeding tube and a tracheostomy were required as the upper airways and oesophagus were grossly distorted by the tumour.

The deceased wished to return to prison after his surgery but was unable to be cared for there with a tracheostomy in place. He remained in hospital, receiving palliative care until his death.

Inquest findings

Overall, it was felt that the supervision, treatment and care of the deceased was reasonable, but that efforts to provide medical care were hampered by his constant refusal of interventions.

It was recognised that the Department of Corrective Services (DCS) is faced with an aging prison population, a number of whom will need care in facilities which can accommodate for both their medical and detention requirements.

The Deputy State Coroner found that the death arose by way of natural causes.

Deputy State Coroner's recommendations

1. The DCS Health Services develop "Not for Resuscitation" protocols, consistent with those used by Health Department, for use in a custodial setting.
2. DCS Health Services explore procedures to facilitate easy access to patients for observations and care while placed in the prison infirmary at the end stage of their illness.
3. DCS Health Services obtain or facilitate the consent of prisoner/patients for appropriate placement at the end stage of their illness, including their expressed wish to die in a prison setting.
4. DCS Health Services develop appropriate protocols to ensure the timely and relevant flow of medical information between agencies in relation to prisoner/patients.
5. DCS Health Services develop appropriate protocols around removal of restraints consistent with relevant considerations.
6. DCS Health Services develop relevant legislative change if necessary for early or urgent review in exceptional circumstances.
7. The Department of Health engage in this process to assist DCS in achieving an outcome consistent with current medical practices.

WA Health action:

- The CLU has engaged with the Department of Corrective Services to offer assistance with the implementation of recommendations one to six.

Reference: [GARRETT Inquest](#)⁹

⁹ www.safetyandquality.health.wa.gov.au/docs/mortality_review/inquest_finding/GARRETT_finding.pdf

Suicide shortly after discharge

Key messages:

- Labile and impulsive patients can remain at chronic risk of self-harm or suicide.
- Suicide risk assessment identifies risk factors to aid in minimising suicide risk; it is not a validated suicide prevention tool.

A 62-year-old woman committed suicide several hours after she was discharged from a regional hospital.

The deceased had a history of depression and intermittent violent behaviour and on the day of her death had been involved in a heated domestic dispute with her housemate. The police and ambulance service were called to the house and the deceased was taken to the nearest regional hospital where she was seen in the ED by a GP to whom she expressed suicidal ideation. She remained irritable and aggressive and it was felt that she required a formal mental health assessment. A Form 1 for Psychiatric Assessment under the *Mental Health Act 1996* was completed.

The mental health ward was full at the time of the deceased's presentation to the hospital, and according to hospital policy she effectively could not be assessed by a psychiatrist unless she was admitted to the mental health ward. As a result, the deceased did not receive a psychiatric review that day. She was instead reviewed later by the GP and found to have calmed down significantly. She denied ongoing suicidal intent. It was felt that she no longer needed to be held under the *Mental Health Act* so the Form 1 was rescinded and she was discharged to attend an appointment that afternoon with her psychologist.

The deceased did attend the appointment with her psychologist where the day's events were discussed. Again it was felt that she was quite stable without any suicidal ideation. She left with a plan to return home and avoid escalating the situation with her housemate. On returning home however, a further argument with her housemate ensued, this time deteriorating into physical violence. After the altercation the deceased shouted that she was going to kill herself, got into her car and drove away. The police were notified immediately.

The deceased drove to a seaside cliff outside of the town site. Her arrival was witnessed by several tourists and her body was subsequently found by police on the rocks at the bottom of the cliff. In her car she had left a note indicating disposition of her property.

Inquest findings

The Deputy State Coroner expressed concern that in the particular circumstances of this case the technicalities of the interaction of the provisions of the *Mental Health Act* were used to avoid the object and intent of that Act. The blending of the concepts of 'receipt', and 'admission', to an 'authorised facility', and the 'delegation' of the responsibility to find appropriate psychiatric assessment back onto the ED did not serve the community well.

In the event one of the psychiatrists had assessed the deceased it was accepted that they may have come to the same conclusion as the GP, albeit for different reasons, however, it was felt that this was not a decision that the GP should have been forced to make in lieu of the proper psychiatric assessment that was requested on behalf of the deceased.

As a result of the circumstances of her discharge none of the normal discharge planning that was routinely in place in the mental health unit was applied to the discharge of the deceased. The lack of support to ED by way of liaison and protocols for the discharge and for transfer of patients already on a Form 1 was considered a serious flaw in hospital policy.

It was appreciated that the situation in the hospital had changed significantly since the presentation of the deceased. It was felt that the amended protocols and policies, and the clarification of the liaison services to ED from the Mental Health Services demonstrated a willingness to address issues which would protect the system from the severe miscommunication which occurred in this case.

The Deputy State Coroner found that death arose by way of suicide, and that the cause of death was multiple injuries.

Deputy State Coroner's recommendations

1. If, after assistance from a Mental Health Liaison Nurse (MHLN) in person, and a psychiatrist by phone, a plan cannot be agreed between the treating doctor and psychiatrist in respect of the patient, a psychiatrist (if requested to do so) must attend the patient to provide psychiatric review and assistance. This attendance will be at the earliest possible opportunity, allowing for periods when there is no psychiatrist rostered after hours.
2. The psychiatry service should provide written protocols to the ED for the discharge of patients from ED who have required psychiatric input, whether it be by MHLN or a psychiatrist, to ensure known concerns surrounding discharge have been addressed and minimised.

WA Health action:

- WA Health is progressing the development of guidelines for the discharge of patients with psychiatric concerns from the ED.
- In addition, a new Mental Health Unit has been established at the regional hospital with these recommendations being key considerations in its development.

Reference: [STONE Inquest¹⁰](#)

¹⁰ www.safetyandquality.health.wa.gov.au/docs/mortality_review/inquest_finding/Stone_finding.pdf

Intermittent shunt blockage

Key messages:

- It remains highly important that the concerns of family members and carers are listened to and addressed.
- Clear communication of all the facts is necessary to obtain fully informed consent and refusal for aspects of patient care.
- Maintaining clear, accurate and legible medical records that report relevant details of clinical history, clinical findings, investigations, information given to patients, medication and other management is essential for the ongoing safe and high quality care of patients.
- Medical practitioners (and, by extension, Health Services) are obligated under the *Coroners Act 1996* to provide medical records to the Coroner. The Coroner does have the power to issue a warrant for seizure of medical records which are not provided on request.

A 15-year-old boy died in hospital from complications of a ventricular-peritoneal shunt. He had been born with cerebral palsy and brain malformations resulting in obstructive hydrocephalus (a build-up of fluid surrounding the brain) requiring a ventriculo-peritoneal (VP) shunt (to drain the accumulated fluid). He also had deformities of his feet and a severe intellectual impairment, but was able to walk and could communicate in a limited way with his family.

Five days prior to his death the deceased appeared to complain of pain, was arching his neck backwards and had an episode of vomiting at home. He was not able to describe his pain but as this behaviour was unusual, his parents took him to a tertiary hospital where he was admitted under the care of a paediatrician for observation. Over the course of a two-day admission, the deceased was assessed by a consultant paediatrician on several occasions. The VP shunt was examined and the reservoir was noted to be tense but compressible. The x-rays of his neck were performed but did not reveal any cause for concern. He was noted to have several further episodes of arching of his neck; however his vomiting resolved and he remained stable. He was discharged on the second morning with a diagnosis of probable viral gastroenteritis.

Later that evening the deceased suffered a seizure, the first for some years, and unlike his previous seizures. He was taken to a second hospital where his parents requested a CT scan to assess the VP shunt. He was seen by doctors in the ED and at this time the shunt reservoir examined normally. His case was discussed with his neurologist and the ED Consultant and a plan was made to again admit him for observation overnight with a view to obtaining a CT scan under general anaesthetic in the morning. His parents were advised of the plan to admit the deceased overnight for observation, but not that a CT scan was to be arranged the following morning. They declined this admission.

The deceased re-presented to the first hospital with further pain and vomiting the next evening. He was given 2mg Midazolam IM, then 1mg Morphine IV in the ED for pain-relief and subsequently stopped breathing, requiring intubation and ventilatory support. He underwent a CT scan whilst intubated and was then transferred to the paediatric intensive care unit (PICU). The CT scan was reported by a radiology registrar, noting the presence of the VP shunt and the known brain malformations, but not demonstrating any new pathology. A paediatric radiologist and a consultant neurosurgeon reviewed the CT scan and also felt that there was no indication of raised intracranial pressure.

The deceased deteriorated overnight and his pupils became fixed and dilated. The VP shunt was aspirated and increased pressure was detected suggesting obstruction. The deceased was taken urgently to the operating theatre where the distal shunt was found to be blocked. Despite efforts made to alleviate the intracranial pressure, his condition was such that it was not survivable. Life support was withdrawn and he died in the intensive care unit.

The deceased's CT report was subsequently revised by a specialist in paediatric neuroradiology, and corrected to read 'appearances indicate shunt blockage and failure'. The specialist worked only sessionally in the public hospital system and the report correction occurred after the death.

Inquest findings

The Coroner believed that several opportunities to diagnose an intermittently blocked shunt had been missed.

The Coroner identified several inadequacies in communication both between senior and junior medical staff, and between medical staff and the deceased's family at his second presentation. This resulted in the correct diagnosis being missed and the deceased's parents making a poorly informed decision to take him home from hospital.

The Coroner noted poor documentation standards from the second hospital and identified discrepancies between what was documented in the notes and evidence given during the inquest.

The Coroner also expressed concern that the court was not provided with all of the relevant documents at the outset of the inquest. The medical file provided by the second hospital did not contain the pertinent documents relating to the deceased's attendance at the ED, and relevant documentation was only provided during the course of the inquest.

The Coroner agreed with the cause of death noted on the death certificate: that the death was the result of cerebral ischaemia in a young man with a blocked VP shunt and obstructive hydrocephalus. The Coroner found that death arose by way of misadventure.

The Coroner also intended to exercise the power granted by section 50 of the *Coroners Act 1996*, to refer two medical practitioners to the Australian Health Practitioner Regulation Agency.

Coroners recommendations

1. The Director General of Health consider creating a single clinical guideline relating to VP shunts, common to all state hospitals where paediatric patients are accepted, or that he invites all state hospital clinical review panels, where paediatric patients are accepted, to develop and adopt a single clinical guideline relating to VP shunts. The clinical guideline should include:
 - a. Advice to physicians that VP shunt failure can occur as a consequence of a variety of factors: blockage, intermittent blockage, the disconnection of its constituent parts and infection, and the latest known symptoms associated with VP shunt failure (including hyperextension of the neck, if that is thought to be clinically appropriate). Emphasis should be given to the fact that a patient's symptoms will reflect the extent of the VP shunt failure and that a nuanced approach is required in order to properly identify symptoms related to a disconnected or intermittently blocked VP shunt.

- b. The appropriate clinical and technical means of identifying the fact of VP shunt failure, the need to discuss/or refer a patient with/to a paediatric neurosurgeon at the earliest stage. It should be emphasised that Princess Margaret Hospital has a paediatric neurosurgeon available on call at all times.
2. The clinical review panel at Princess Margaret Hospital consider publishing material that can be given to the parents or carers of children with VP shunts. That material should contain information about hydrocephalus, the operation to insert a VP shunt, complications relating to VP shunts, important symptoms for parents to be aware of, and where to go in order to get help or advice if it is suspected that their child has suffered a VP shunt complication.
3. The Director General of Health consider implementing a process whereby a cranial CT scan is performed and retained after the insertion or revision of a VP shunt. The CT scan should be stored in a manner in which it can be readily accessed by physicians in state hospitals which accept paediatric patients.
4. The Director General of Health consider implementing a policy in which hospitals dealing with paediatric patients ensure that cranial CT scans of patients with VP shunts are reviewed in a timely manner, whether by an expert employed within the hospital or by an expert who is located elsewhere.
5. The Director General of Health circulate to all physicians employed in state hospitals likely to have exposure to children with VP shunts, a brief summary of the relevant clinical facts of this case, together with an invitation to those physicians to exercise extreme caution when treating a paediatric patient with a VP shunt, where its failure cannot be ruled out as the cause of the presenting symptoms.

WA Health action:

- A single clinical guideline based on that of the Great Ormond Street Hospital protocol has been developed. The guideline stresses the importance of early consultation and referral to paediatric neurosurgeons.
- A patient/carer information pamphlet is being developed and will be disseminated to patients with VP shunts and their parents/carers.
- Since 2008, all children undergoing a VP shunt insertion or revision have a CT scan prior to discharge or an MRI within three months to provide a baseline status for further investigation.

Reference: [RASMUSSEN Inquest](#)¹¹

¹¹ http://www.safetyandquality.health.wa.gov.au/docs/mortality_review/inquest_finding/Rasmussen_vaughn_finding.pdf

Viral illness in a young woman

Key messages:

- Rare complications can be fatal.

A 17-year-old girl died as a result of complications arising from a viral infection.

The deceased first attended a metropolitan hospital two weeks before her death with a headache and respiratory symptoms. She was diagnosed with a viral upper respiratory tract infection and treated for mild dehydration before being discharged home feeling well. She was subsequently prescribed antibiotics by her GP.

She re-presented to the same hospital four days prior to her death with a severe headache of several days duration and a fever. After an overnight stay in the ED with repeated assessments and a number of investigations including lumbar puncture, a diagnosis of likely viral meningitis was made. Due to her recent use of antibiotics however, partially treated bacterial meningitis could not be excluded and she was admitted to the hospital for ongoing treatment with intravenous antibiotics and analgesia.

She remained as an inpatient on a medical ward for two days receiving ongoing monitoring and treatment. During this time she remained stable but continued to complain of a severe headache and required frequent doses of analgesia.

She was discharged home two days prior to her death, still with a severe headache requiring regular analgesia, but otherwise stable. Her discharge diagnosis was viral meningitis; a typically self-limiting disease associated with a headache, and which is usually treated only with oral analgesia.

She was found by her mother, unresponsive, not breathing and without a pulse, the day after her discharge. Resuscitation was commenced at the scene and continued until cardiac output was regained at the hospital's ED. Despite resuscitation, she sustained a significant hypoxic brain injury and died the following day at a tertiary hospital.

A post mortem examination confirmed the presence of both viral meningitis and viral myocarditis. It has been postulated that the myocarditis precipitated cardiac failure and a lethal cardiac arrhythmia resulting in her death.

Inquest findings

Initially, there was concern that the lumbar puncture had been performed prematurely. The difficulty was the lack of reasonable documentation of the clinical steps taken to ensure the lumbar puncture was not contraindicated without CT scan. Evidence presented at the inquest showed that an appropriate clinical workup had been undertaken prior to performing the lumbar puncture.

An ECG performed on the deceased during her hospital admission was normal, however all clinicians involved in the inquest agreed that an ECG may be normal in the presence of myocarditis. It was recognised that the deceased was showing no clinical signs of myocarditis and it is quite feasible it was not diagnosable at the time she was discharged from hospital.

Tragically the deceased was not misdiagnosed. The clinicians involved in her care all diagnosed the deceased as suffering from viral meningitis, which they expected to be self-limiting. They expected her to suffer severe headache, however no-one expected a fatal outcome from viral meningitis. It is not unheard of, but it is extremely rare.

Death arose by way of natural causes as a result of acute lymphocytic meningitis and focal myocarditis.

Deputy State Coroner's recommendations

1. Clinicians dealing with difficult differential diagnoses, such as the difference between bacterial/viral meningitis, or some other inflammatory process, ensure they accurately document the clinic decision-making process, especially where a significant procedure such as lumbar puncture is used as part of the diagnostic process.
2. Clinicians discharging patients with viral meningitis are mindful there are rare cases of concurrent inflammatory processes which can have an unexpected and fatal outcome.

WA Health action:

- These inquest findings were disseminated to all health services within WA Health which have identified a number of quality improvement initiatives occurring that target clinical documentation and clinical handover.
- Health services have committed to disseminating the findings to health practitioners within their respective services to facilitate learning and development.

Reference: [DAWKINS Inquest](#)¹²

¹² http://www.safetyandquality.health.wa.gov.au/docs/mortality_review/inquest_finding/dawkins_finding.pdf

Death from pulmonary embolism

Key messages:

- The risks and benefits of anti-coagulation need to be considered, documented and communicated clearly. Specialist haematology input should be sought in complex cases.
- To enable appropriate management decisions to be made, full documentation of a patient's past history, including relevant investigation findings, should be obtained wherever possible.
- Clear communication between healthcare teams and between different health services or facilities is required for continuity of safe care.

A 38-year-old woman died at a tertiary hospital as a result of pulmonary embolism (PE).

The deceased had a complex medical history including steroid dependent glomerulosclerosis and nephrotic syndrome. She had also been recently commenced on warfarin as treatment for a suspected deep vein thrombosis (DVT) and PE during an admission at a regional hospital. No definite DVT or PE was found on investigation, however anti-thrombin III deficiency, an underlying pro-thrombotic disorder, had been identified. Her treating teams at the tertiary hospital were not aware of these results.

Prior to her death she had been hospitalised for almost two months following surgery to remove a pancreatic tumour. She had developed a localised intra-abdominal infection following the initial surgery and had required a number of additional procedures to address this.

During her stay in hospital, the deceased's anticoagulation was managed by her treating surgical team. Due to the recurrent procedures, her medication had been changed from warfarin to heparin and at times had been withheld due to the risks of bleeding with surgical interventions. At one point, a recommendation to increase the dose of heparin was documented in the medical record but was not transcribed onto the anticoagulation chart. It was not clear whether this was an oversight or a decision made in light of her increased bleeding risk with the higher dose.

Following her recovery from her surgical interventions, the deceased was transferred to a rehabilitation unit. The discharge documentation did not outline a specific plan for ongoing anticoagulation, however twice daily doses of heparin were continued.

The deceased's observations remained stable in the days prior to her death and there is no documentation of any complaints of chest pain or breathlessness.

On day five of her stay in the rehabilitation unit, the deceased was found collapsed in bed and unresponsive. CPR was commenced and she was transferred to another tertiary hospital, where, unfortunately, resuscitation was not successful.

Bilateral PE was found on post mortem examination.

Inquest findings

The inquest identified a lack of communication between the regional hospital and the tertiary hospital regarding the deceased's previous admission, investigation findings and management. The treating team instead relied on information provided by the deceased and proceeded on the basis that she had previously had a pulmonary embolus. The Coroner stated however, that there was no evidence to indicate that the failure to obtain the deceased's diagnostic reports had adversely impacted on the quality of the clinical care provided during her admission at the tertiary hospital. Similarly, it could not be concluded that the failure to increase the deceased's dose of heparin during her admission adversely impacted on the deceased's care, especially given the complex clinical situation which prevailed at that time.

It was recognised that the deceased had a difficult and complicated surgical problem as well as a number of conditions and factors predisposing to thrombosis. It was felt that consultation with a haematologist, perhaps at an early stage in the deceased's tertiary admission, would have provided an opportunity to improve the management of the deceased's anticoagulation therapy and provide specialist input into the risk factors flowing from the deceased's pro-thrombotic disposition. However, the Coroner was satisfied that the management of the deceased's anticoagulation therapy was satisfactory in all circumstances. It was accepted that had the deceased been fully anticoagulated there would still have been a risk of her developing a PE.

The Coroner noted that in busy public hospitals there are countless different medical and nursing staff involved in the care of a patient from day to day, and that this makes clear and concise written notes all the more important. If appropriate notes are not made, then other staff are left in the dark when things do not happen as expected.

The Coroner found that the death arose by way of natural causes as a result of pulmonary thromboembolism.

Coroners recommendations

1. The hospital creates a separate tab in patient medical files, entitled 'Orders', which records instructions and orders by consultant surgical teams and treating medical practitioners, including all decisions to change patient medications and decisions made not to institute particular medications.
2. The hospital consider developing guidelines or protocols for obtaining advice and guidance from consultant haematologists in relation to the management of patients at higher levels of risk of developing a DVT or a PE.
3. Discharge summaries prepared by the hospital (including those prepared for the hospital's rehabilitation unit) be amended to include a section for the surgical consultant discharging the patient to write current orders and directions about the patient, giving short reasons, and contact details for consultation.
4. The hospital considers developing a Thrombosis Management Service to provide specialist advice in relation to patients with increased risk of DVT and PE.

WA Health action:

- Public health services have considered the inclusion of a separate tab entitled 'Orders' in patient medical files; however, they have determined that implementing such a system would present a greater risk to patient safety.
- Public health services have identified existing units or services that provide specialist advice in relation to patients at increased risk of DVT or PE.

Reference: [KEOGH Inquest](#)¹³

¹³ http://www.safetyandquality.health.wa.gov.au/docs/mortality_review/inquest_finding/Keogh_finding.pdf

Communicate, communicate, communicate

Key messages:

- Important information can be lost on patient transfer; both the referring and receiving clinicians need to ensure that all pertinent details are conveyed during the handover process.
- It is incumbent on all doctors who are aware of information regarding a reportable death to ensure that this is communicated appropriately, either directly to the Coroner or to the reporting doctor, so that an informed decision regarding reportability can be made by the Office of the State Coroner.
- Although an out-of-hours doctor may confirm death, it may be more appropriate for the patient's treating team to complete death certification as they should be aware of all aspects of the patient's care.

The deceased was an elderly farmer with a history of chronic obstructive pulmonary disease, who had seen his GP for lower back pain and been prescribed a course of panadeine forte and ibuprofen. He then presented over the weekend to his local rural hospital as the pain was not improving. He was diagnosed with musculo-skeletal pain, the ibuprofen stopped due to his age and he was discharged with oxycodone.

He collapsed a day later and was brought in as a priority and resuscitated; a CT scan showed a large abdominal aortic aneurysm. He was transferred to a metropolitan hospital and went straight to theatre. This was complicated by an intra operative arrest but he survived to go to the ICU.

The ICU consultant met with the family, who were upset and expressed concern about his previous doctors' visits.

He had a complicated post-operative course in ICU and eventually died of pneumonia and respiratory failure.

The night resident medical officer (RMO) contacted the Office of the State Coroner to discuss this case. The transfer letter that the RMO referred to did not mention either of the previous presentations. She did not read the notes from the ICU consultant. The Coroner's officer was satisfied that the death was an inevitable consequence of complications subsequent to his aneurysm, that care had been appropriate and consequently asked the RMO to certify his death.

The patient's ICU consultant attended the departmental Morbidity and Mortality meeting, where this case was discussed. It was debated as to whether the misdiagnosis altered his ultimate outcome however, as his family had expressed concerns about the medical treatment, the decision was made to contact the Office of the State Coroner to discuss the case again.

The Office of the State Coroner subsequently contacted the family and started an investigation into the deceased's medical treatment leading up to his death. They requested reports from deceased's GP and the rural hospital.

Nota bene

In determining whether a death is reportable to the coroner, question 10 of the 'Death in Hospital' form asks health practitioners *"To your knowledge has any one expressed any concerns regarding the cause of the deceased person's death or medical treatment?"* In answering this question, consideration should be given to any concerns that the family has expressed about the patient's care.

Part three (Reporting of deaths) of the *Coroners Act* states that "if more than one doctor is present at or soon after the death and one of them reports it to a coroner, the other doctors need not report the death but must give to the coroner investigating the death any information which may help the investigation" (s.17.4).

Reference: see also [RASMUSSEN Inquest](#)

Near miss – missed opportunity

Key messages:

- Prevention is better than cure.

The deceased was an 83-year-old who resided in a nursing home. She had a history of dementia, and her behaviour had become increasingly difficult for the nursing home to manage. She was known to be quite agile and had frequently escaped from the nursing home to try to return to her old home. On the day of admission to hospital, the deceased had engaged in an altercation with a fellow resident that resulted in her falling and sustaining a laceration to her head. She was subsequently sent by ambulance to a tertiary hospital for treatment. Her laceration was treated and she was admitted to the general medical ward for further observation pending placement in a dementia specific nursing home.

She was seen by the physiotherapist and occupational therapist and a falls risk assessment was completed. Aside from her cognitive impairment she did not have any other risk factors for falls and was compliant with her assessment. Her medical team reviewed her and found no acute delirium or reversible cause. Her medications were reviewed by the ward pharmacist in conjunction with her Geriatrician to rationalise her medication. She was commenced on risperidone for agitation as needed throughout the night.

That evening she was restless and wanted to leave to go home. She seemed to settle with the risperidone. However one of the night nurses was called to assist another patient walk to the bathroom. As they returned to the bay the deceased had woken and was attempting to climb over her bed rails. The nurse assisted her to the bathroom, but had difficulty getting her to return to bed as she wanted to leave and attempted to wander out of the ward. She eventually was persuaded to go back to bed and fell asleep. This was documented in the notes but the falls management plan was not altered, nor was this handed over.

The next night a loud thump was heard from that bay, where the deceased was found beside the bed on the floor with a shortened and externally rotated right leg. She went to theatre the next day but unfortunately had an intra-operative cardiac arrest and could not be resuscitated.

Near miss events provide opportunities for practice to be reviewed and potentially reformed. This can be significant for the patient themselves as in this circumstance but can also be an opportunity to change practice to avoid an adverse incident for another patient.

Notes:

Notes:

This document can be made available
in alternative formats on request for
a person with a disability.