IN THE CORONERS COURT)
AT CANBERRA IN THE)
AUSTRALIAN CAPITAL TERRITORY) CD 71/06

INQUEST INTO THE DEATH OF MEG MALAIKA

FINDINGS

Delivered on 30 April 2010 by Chief Coroner Burns

Appearances

Ms Margaret Hunter, Counsel Assisting the Chief Coroner
Ms H L Donohue SC, Counsel for the Australian Capital Territory (instructed by the ACT Government Solicitor)
Mr S Whybrow, Counsel for Ms Malaika's family.

1. Former Chief Coroner Cahill commenced the hearing into this death on 15 January 2008. By that time nearly two years had passed since the death of Ms Malaika. The hearing continued, on and off, until July 2009. The former Chief Coroner had not concluded the preparation of his findings in this matter when he retired in November 2009. On behalf of the court I express my sincere regrets for the delay in concluding this matter.

2. On 11 March this year I convened a Directions Hearing in this matter. I was advised by counsel for those parties who had been granted leave to appear at the hearing that they did not propose making any further submissions and that they had no objection to me concluding the hearing and making findings based upon the evidence taken by the former Chief Coroner. To that end I have read the transcript of the hearing conducted by the former Chief Coroner and have given careful consideration to the issues raised by counsel in their submissions.

PART 1 – THE LEGISLATIVE SCHEME

3. By virtue of section 13(1)(e) of the *Coroners Act 1997* (the Act), I am required as the coroner to hold an inquest into the manner and cause of the death of Ms Meg Malaika. Section 13(1)(e) provides that a coroner must hold an inquest into the manner and cause of death of a person who dies after, during or within 72 hours after, or as a result of (i) an operation of a medical, surgical, dental or like nature; or (ii) an invasive medical or diagnostic procedure.

4. The matters on which the Coroner holding an inquest must make findings, if possible, are set out in section 52(1) of the Act as follows:
   "(a) identity of the deceased; and
   (b) when and where the death happened; and
   (c) the manner and cause of death; and
   (d) in the case of the suspected death of a person—that the person has died."

5. Section 57(3) of the Act empowers me to make recommendations to the Attorney-General on "*any matter connected with an inquest ... including matters relating to public health or safety."*

6. As the Full Court of the Supreme Court of the Australian Capital Territory made clear in *The Queen v Doogan; Ex Parte Lucas-Smith & Ors* [2005] ACTSC 74 the *Coroners Act* is generally concerned with the resolution of relatively straightforward questions such as "What was the cause of this death?" It is not the role of the coroner to seek to attribute blame or fault with respect to a death, although the Act anticipates that the coroner may be called upon, from time to time, to make *"adverse"* comments with respect to a person. The role of the coroner is to determine what happened, and then to make the findings required by section 52(1) of the Act. If in the course of that exercise the coroner identifies a matter relevant to public health or safety or the administration of justice, or some other matter connected to the death that the coroner believes should be brought to the attention of the Attorney-General, the coroner may comment on that matter.

7. I will be making recommendations to the Attorney-General with respect to the need for accuracy and verification of entries in patient medication records.

PART 2 - FORMAL FINDINGS UNDER SECTION 52

8. As required by section 52 of the Act, I make the following findings:

   The deceased was Meg Malaika, aged 39 years. She died at midnight on 18 March 2006 in the Canberra Hospital at Garran in the Australian Capital Territory.

   The cause of Ms Malaika's death was heart failure connected to a massive pulmonary embolus as a result of deep vein thrombosis.

PART 3 – FACTUAL FINDINGS

9. Ms Malaika had been unwell for some 10 days prior to admission to the Canberra Hospital on 16 March 2006. She attended her GP Dr Liz

Fraser on 15 March 2006 complaining of persisting nausea and left iliac fossa (LIF) pain and had been off her food for 7-8 days. She was seen by the GP for a urinary tract infection before and was treated with Augmentin for that condition which had apparently settled down.

10. On 16 March 2006, Ms Malaika's partner telephoned the surgery to inform Dr Fraser that she had now developed vomiting. Dr Fraser was unable to see her and recommended that she present herself to the Emergency Department [ED] at the Canberra Hospital.

11. Ms Malaika attended the ED and was seen by Dr Tippett at 10.33 hours. Dr Tippett examined her and ordered several blood tests and an abdominal and pelvic ultrasound, commenced IV fluids and asked the surgical registrar to review Ms Malaika's condition. Dr Tippett formed the view that she could be suffering from either a urinary tract infection, an ovarian cyst, bowel pathology or acute appendicitis.

12. Ms Malaika was reviewed by the surgical registrar Dr Elobadi. He reviewed the blood tests and ultra sounds and then discussed her diagnosis of acute appendicitis with Dr Damian McMahon. Ms Malaika was booked into the operating theatre list to have a laparoscopic appendicectomy.

13. Later that evening, Ms Malaika was to have an appendicectomy but the operation was cancelled and she was admitted to Ward 6B at 02.00 hours on 17 March. It transpired that there was no operating time available. During 16 March Ms Malaika was prescribed Heparin 5000 units by Dr Cheung who also prescribed TED stockings to be applied. On the face of the records there does not appear to be any notation that TED stockings were applied nor is there any notation that she received the Heparin at this time.

14. There is a nursing notation at 16.45 hours by Nurse Vendiola that Ms Malaika had TED stockings in situ. Ms Malaika at that time complained of pain in her left heel and her legs were then placed on a pillow to relieve pressure. It was noted that she was listed for surgery at 19.00 hours.

15. Ms Malaika was finally taken to the operating theatre and a laparoscopic appendicectomy was conducted at 23.34 hours by Dr Usama Majeed, a surgical Registrar, and the operation was completed at 00.30 hours.

16. Ms Malaika was transferred back to Ward 6B and had an unremarkable recovery, her observations were stable and she was encouraged to ambulate.

17. On 18 March at 07.45 hours she was seen by Dr Majeed who explained the operation findings and ordered Ms Malaika to ambulate and noted she was for possible discharge the following day. At 08.30 hours she was seen by Dr Hsu and was told she could have a light diet and to mobilise.

18. At 08.40 hours Ms Malaika became dizzy whilst walking to the shower. She sat down but began to lose consciousness. She was taken back to bed and the Medical Emergency Team [MET] was called. She complained of abdominal pain with a distended abdomen and difficulty in breathing.

19. The team gave various treatments and a provisional diagnosis of either intra abdominal pathology (bleeding or infection) or pulmonary embolism. Ms Malaika was transferred to the ICU at 10.10 hours and subsequently a Trans Oesophageal Echo-Cardiogram [TOE] showed a clot in the pulmonary artery reaching the bifurcation. She also had ultrasound examination of her abdomen to exclude any other problems.

20. Dr Lim reviewed Ms Malaika and examined her. He consulted with Dr Anne Leditschke and agreed that Ms Malaika had an acute pulmonary embolism and discussed treatment option. Dr Lim advised that Ms Malaika should be fully heparinised but due to her having had surgery recently did not consider Thrombolysis (treatment to break down the clot).

21. At 18.00 hours Ms Malaika was seen by Dr Peter Subramanian, a cardiac surgeon, who proposed that she required an urgent pulmonary embolectomy. Ms Malaika was taken to theatre and operated on at 20.29 hours. The embolectomy was performed and a clot removed. Whilst this operation was successful in removing the clot it was noted that her right ventricle was akinetic and causing severe tricuspid regurgitation. Despite all efforts to support Ms Malaika's heart, she succumbed and died at midnight on 18 March 2006.

22. Dr Lavinia Hallam, a Forensic Pathologist, performed an autopsy on 22 March 2006 and concluded that Ms Malaika died from a pulmonary embolism as a result of a deep venous thrombosis. Dr Hallam also suggested that Ms Malaika had certain risk factors including the taking of contraceptive pill and a previous malignant melanoma, although there was no evidence of recurrence.

PART 3 – ISSUES

23. The following issues arose out of the evidence:

    (a) Did the blood clot which ultimately lodged in Ms Malaika's pulmonary artery pre-exist her admission to hospital or did it occur as a consequence of her treatment whilst in hospital?

    (b) If the blood clot was a result of her treatment in hospital, was the development of the clot caused or contributed to by a failure to properly administer Heparin or to apply TED stockings?

(c) Were there any inappropriate delays in the treatment of Ms Malaika at the hospital that contributed to her death?

24. Whilst there was some minor dispute about the degree of Ms Malaika's mobility in the week or so leading up to her hospitalisation, it is clear that she had a number of risk factors for developing deep vein thrombosis such as illness, inflammatory process (appendicitis), using the contraceptive pill and being slightly overweight (although not obese). However on the *venous thromboembolism prophylaxis guidelines* in place at Canberra Hospital she scored on the low to moderate risk of having a pre-existing thrombus.

25. The evidence also suggests that having to wait for the operation for longer than 24 hours, as well as being prescribed a strong narcotic for pain which would have further reduced her mobility, added to her risk factors.

26. There were no clinical signs or symptoms of a developing clot at either her admission or during the pre operative period.

27. I have carefully considered the evidence concerning the development of the blood clot, particularly the medical evidence, and find myself unable to be satisfied that the fatal blood clot was not present in the body of Ms Malaika at the time the deceased entered hospital. It seems to me that much of the evidence on this issue never rose above hypothesis. Objectively, all that can be said about the clot is that it was days rather than weeks old, as described by Dr Hallam following autopsy.

28. Although I cannot say that it is probable that the fatal blood clot was not present when Ms Malaika entered hospital, there are a number of issues revealed by the evidence concerning her treatment at hospital that warrant comment. Those issues broadly address the second and third questions posed in paragraph 23 above.

29. It is not clear from the evidence and the hospital records when Ms Malaika first received prophylactic Heparin. Heparin had been 'written up' by Dr Cheung on 16 March 2006 whilst in ED prior to her laparoscopic surgery. This prescription was on a different chart to that included on the emergency nursing notes chart. On 18 March she received a dose of Heparin at 6am and an intravenous dose at 12.45 hours. This dosage appears on the general medication chart.

30. There is a nursing entry in the Emergency Department Nursing Admission Notes on 16 March at 10.45 hours which states that "medications administered as charted". The medications charted on those notes only refer to Morphine, Maxalon and Ketorolac being given. There appears to be no documentary evidence that Heparin was administered prior to 18 March 2006.

31. If Ms Malaika had developed a clot prior to her admission prophylactic Heparin would not have been effective in either dissolving the clot or preventing it from getting bigger or breaking off. If the clot was not

present when Ms Malaika entered hospital, it is theoretically possible that a failure to administer Heparin before the laparoscopic surgery could have contributed to the development of the clot.

32. Hospital records are not kept for the purpose of allowing coroners or lawyers to pore over them in the course of litigation. The primary purpose of hospital records is to assist in the treatment of the sick and injured. It is axiomatic that in order to achieve that goal the records must be accurate and comprehensive. Insofar as they incorporate directions to hospital staff, they must be acted on. Suffice it to say that the records of administration of Heparin to Ms Malaika prior to 18 March 2006 reveal either a failure by the hospital staff to administer prescribed medication, or a failure to record its administration. Neither is acceptable in terms of patient management. In the instant case the evidence does not definitively support either of those alternative failures being a significant factor in Ms Malaika's death.

33. It is clear that optimally Ms Malaika's laparoscopic surgery should have been conducted within 24 hours of admission. The evidence suggests that Ms Malaika's operation was delayed due to other more urgent cases being given priority. Whilst this was unfortunate and may lead to increased risk factors in relation to the development of a clot, hospitals are frequently called upon to make difficult choices about the use of scarce resources. There is no evidence that the decisions made about the timing of Ms Malaika's laparoscopic surgery were made negligently, or that the delay led to a worse outcome for Ms Malaika.

34. Similarly there was a delay between Ms Malaika's collapse on the morning of 18 March 2006 and the embolectomy performed by Dr Subramanian at about 8pm that day. Whatever may be the position about the desirability of that delay, and I incline to the view that the decisions made by those treating Ms Malaika at this time were not unreasonable, the clear evidence is that the fatal damage to Ms Malaika's heart was occasioned at the time of her collapse, and it is unlikely that anything that occurred thereafter detrimentally affected the course of her illness.

RECOMMENDATIONS

35. I recommend that the Canberra Hospital review its practices with regard to prescribed but not administered, or keeping records of drugs prescribed and administered to patients so as to minimise the possibility that drugs may be administered and not recorded and consider implementing a requirement that two responsible persons must sign the records of the hospital to confirm that prescribed medication has been administered.