16 JULY 1998

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INQUEST INJTO TH£

THE DEATH OF

NATHAN THOMAS JAMES \\fRENCH

REASONS FOR FINDI1N6S

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INQUEST INTO THE DEATH OF NATHAN THOMAS JAMES WRENCH

FINDINGS:

In accordance with Sections 13(l)(e)(i) and 52(1) of the Coroners Act 1997 I FIND:

I. THAT Nathan Thomas James Wrench died at The Canberra Hospital, Garran, in the Australian Capital Territory, on 16th October, 1996.

2. THAT the cause of death was multi-organ failure, resulting from septicaemia, following a surgical procedure carried out at the same Hospital on 15th October 1996 to reduce intussusception of the bowel.

RECOMMENDATIONS:

I recommend, under Section 57(3) of the Coroners Act 1997 that the A.C.T. Attorney-General and Minister for Justice draw to the attention of the New South Wales Minister for Health the facts of this case, as set out in the Reasons for Findings herewith, with a view to suggesting that that Minister:

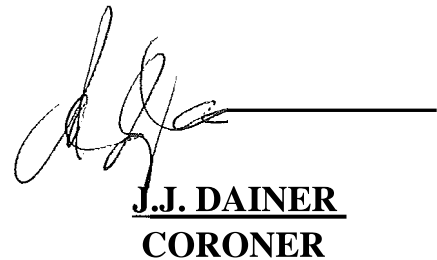
1. Give consideration to the appointment of resident medical staff at the Queanbeyan Hospital;

2. Re-examine, in the meantime, the requirement that local general practitioners accept responsibility for the care of patients at Queanbeyan Hospital on a 24-hour basis each 10 days;

3. Consider promulgating firm guidelines for the transfer of patients from Queanbeyan Hospital to The Canberra Hospital;

4. Consider directing that all paediatric patients presenting to Queanbeyan Hospital be referred forthwith to the specialist paediatric unit at The Canberra Hospital;

5. Consider whether the evidence regarding the part played in the events leading up to the deceased child's death by Dr Peter Lawrence Renshaw, of Queanbeyan, warrants a referral of the matter to the appropriate New South Wales authorities.



J.J. DAINER
CORONER

INQUEST INTO THE DEATH OF
NATHAN THOMAS JAMES WRENCH

REASONS FOR FINDINGS

INTRODUCTION

Nathan Thomas James Wrench, born on [redacted] 1996, died at The Canberra Hospital, Garran, in the Australian Capital Territory, at about 9.45 p.m. on 16th October, 1996.

His death was caused by multi-organ failure from septicaemia, following a surgical procedure to reduce intussusception (a form of obstruction) of the bowel. The procedure had been carried out by Dr E.T. Simpson, paediatric surgeon, at the Hospital, at about 12.00 noon the previous day.

The death was reported to the Coroner under Section 13(l)(e)(i) of the Coroners Act 1997, which provides for the mandatory holding of an Inquest. In addition, the family of the deceased baby expressed concerns to the Coroner regarding certain alleged aspects of his treatment at Queanbeyan Hospital prior to his removal to The Canberra Hospital, and these concerns will be dealt with later in these reasons for findings.

There were some delays in arranging the preparation of a brief by the investigating Police for the Coroner, the reasons for which have been taken up separately, and need not be pursued in this judgement. The usual problems associated with witnesses' difficulties in recalling events at some distance did, however, consequently occur during the course of the Inquest.

Following finalisation of the brief, the Inquest commenced on 2nd December 1997, and continued on 14th and 15th January 1998, and 7th and 8th April 1998.

Mrs M. Doogan, of the Director of Public Prosecutions Office, assisted the Coroner. From 14th January, the family of the deceased baby was represented by Mr S. Pilkinton. A.C.T. Health was represented by Mr R. Bayliss. Dr M. Cross, the baby's General Practitioner, was represented by Mr A. Took. Although Mr E. Pike originally stated that he represented Drs Renshaw, Pahn, Ferguson and Simpson, he ultimately represented only Dr Renshaw. Ms J. Lonergan represented Queanbeyan Hospital.

Fifteen witnesses gave evidence, and thirty-six exhibits were tendered. The latter included records from both Queanbeyan and Canberra Hospitals, as well as statements from medical and nursing staff who were involved in Nathan's care.

At the conclusion of evidence on 8th April 1998, I invited counsel who desired to make submissions to do so in writing. I requested that such submissions be supplied to the Coroner's Secretary by 10.00 a.m. on 23rd April. I asked that counsel exchange their submissions with their colleagues, and that any responses thereto be supplied to the Coroner's Secretary by 10.00 a.m. on 30th April.

I also requested counsel to consider making submissions as to whether or not Section 55 of the Coroners Act 1997 should be invoked, and, if so, in relation to whom.

That Section provides as follows:

> 55. (1) A Coroner shall not include in a finding or report under this Act (including an annual report) a comment adverse to a person identifiable from the finding or report unless he or she has, prior to the making of the finding or report, taken all reasonable steps to give to the person a copy of the proposed comment and a written notice advising the person that, within a specified period (being not more than 28 days and not less that 14 days after the date of the notice), the person may-

(a) make a submission to the Coroner in relation to the proposed comment; or
(b) give to the Coroner a written statement in relation to it.

(2) The Coroner may extend, by not more than 28 days, the period of time specified in a notice under subsection (1).

(3) Where a person so requests, the Coroner shall include in the report the statement given under paragraph (1)(b) or a fair summary ofit.

I advised counsel that I had in contemplation proceeding under the Section, but welcomed their submissions in any event. It was my expressed intention, if I still considered it appropriate to do so, to proceed under the Section by 10.00 a.m. on 25th May.

Following those advices to counsel, Mr Pike sought an extension of time within which to make submissions, pointing out that a full transcript of the proceedings would first be required before such submissions could properly be prepared. As there seemed to be agreement among other counsel to this effect, I agreed that the timetable earlier set should be put back for an appropriate period after the transcript had been supplied.

The result was that, by agreement, submissions were received from counsel by 20th May. The only response to other counsels' submissions came from Mr Pike, on behalf of Dr Renshaw, under date of 26th May.

After considering the submissions and the evidence, on 12th June I caused a notice under Section 55 of the Coroners Act 1997 to be forwarded to Dr Renshaw, care of Mr Pike. I requested a response by 5.00 p.m. on 29th June, and this was received under date of 23rd June, 1998. A supplementary submission was received under date of 24th June 1998. For ease of referral, I attach copies of the Section 55 notice, and, (although no request was made for their inclusion, under Section 55(3))

Dr Renshaw's responses, as annexures to these reasons for findings. I will deal with the Section 55 matter later.

CHRONOLOGY OF NATHAN'S ILLNESS
11th - 14th October 1996

Nathan's mother, Kimberley Arthur, and his grandmother, Donna Arthur, gave evidence that his birth and subsequent progress were generally normal, and he was a healthy baby. This was supported by his general practitioner, Dr Cross, of Bungendore, New South Wales, where the family also resided.

However, on 11th October 1996, when Nathan was eleven weeks old, he commenced vomiting. His mother consulted Dr Cross at about 8.00 p.m. on that date, after the vomiting had been continuing for some five hours.

Dr Cross recommended that the baby be given gastrolyte, and that he be reviewed the following morning.

At about 8.45 a.m. on 12th October, Dr Cross rang Ms Arthur, who told her that the vomiting had continued throughout the night. At midday the same day, Dr Cross examined Nathan. He had still been vomiting. She noted that his nappy was dry but "there was a spot of blood in it at the level of the penis and a smudge of faeces". His temperature was 38 degrees, there were no localising signs and his abdomen was tender. She placed a urine bag on him.

She told Ms Arthur that "because we had no diagnosis .. he should be admitted to hospital". She wrote a referral note to the doctor on duty at the Accident and Emergency Department at Queanbeyan Hospital outlining the history of the case. Nathan arrived at the Hospital with his parents at about 1.45 p.m. and was seen by Dr W. Pahn, the duty Visiting Medical Officer, at about 2.00 p.m. Dr Pahn noted the history given by Dr Cross and the family, and examined the baby. He observed that, generally speaking, there were no abnormalities. However, the results of a dipstick

examination of the urine were "strongly suggestive of a urinary tract infection" and he therefore believed "we had found a cause for this febrile illness".

A first dose of the antibiotic Septrin 2.5 ml and a first dose of Panadol were administered, and "were tolerated well". The diagnosis was explained to the parents, and instructions given for Septrin to be given twice daily and Panadol every four hours. They were told to contact the Hospital "anytime if the baby's condition worsened or failed to improve", otherwise Dr Cross was to follow up; a copy of the final report of the urine test would be forwarded to her. The baby was discharged at about 3.00 p.m. that day after attachment of a bag for collection of urine.

During the evening of 12th October, Nathan was "lethargic and restless", and continued to vomit. Ms Arthur continued to give him small amounts of fluid, which he always regurgitated a short time later.

During the early hours of the following morning, this situation continued. At one stage, Nathan woke up screaming. He was given about 20 millilitres of milk, which he vomited up almost immediately.

After daybreak, Ms Arthur gave Nathan 15 millilitres of water mixed with gastrolyte, which he regurgitated. She noted that his vomitus "appeared to be a bright yellow bile, similar colour to sunflowers".

Later that morning, Ms Arthur took the urine bag to the Hospital. During the day, Nathan remained "lethargic and restless, crying occasionally, which was extremely out of character". Ms Arthur continued to administer the medications and fluids prescribed, but the baby was unable to keep them down, vomiting a short time after each ingestion. She rang Dr Cross that evening and told her what had occurred at the Hospital and since then. Dr Cross suggested that the antibiotics be withheld overnight, and the baby be reviewed the next morning.

At about 3.00 a.m. on the morning of Monday, 14th October, Ms Arthur said Nathan woke up "grizzly and distressed". She gave him a small amount of water and gastrolyte, after which he vomited a "green coloured , bile like substance, which smelled like faeces". She became "extremely distressed and .. was very scared for Nathan's well-being".

At about 8.30 a.m. that morning, she telephoned Dr Cross and told her what had occurred overnight (Dr Cross's recollection was that Ms Arthur told her that the baby was vomiting "yellow fluid", not "green bile").

Ms Arthur said Dr Cross told her that she "suspected a bowel obstruction and (the baby) may require immediate surgery". As to that, Dr Cross, in a signed statement to investigating Police of 4th February 1997 (Exhibit 8), said she told Ms Arthur that there "must be an obstruction", and to take the baby straight to Hospital. However, in her evidence, she said the word "must" was incorrect, and that she meant to say "could". She requested that her written statement be amended accordingly. She did not recall saying anything about the possibility of immediate surgery, agreeing with Mr Pike, during cross-examination, that she would not have referred the baby to Queanbeyan Hospital if that course had been contemplated by her.

Dr Cross said she faxed a copy of her referral note to Queanbeyan Hospital (part of Exhibit 9), at about 10.10 a.m. on 14th October, agreeing that there was no mention of a possible bowel obstruction therein.

At about midday on the same day, Dr Cross received a fax from Queanbeyan Hospital regarding the urine test of the previous day, which indicated a "mixed bacterial growth". She took the view that as the baby was going to the hospital for admission for "further investigations", that "this information would go to the treating doctor as well".

On the 15th October, Dr Cross said she received a call from the Queanbeyan Hospital saying that the fax of her referral of 14th October could not be read. She inquired as to why the matter had not been raised "by return phone call", and was told that the child had already been admitted on 14th. She felt this was appropriate, and had no further involvement with Nathan's treatment.

OUEANBEYAN HOSPITAL
- 14th October 1996

Following the discussion with Dr Cross on 14th October, Ms Arthur, her mother and the child's father, Bruce Wrench, took Nathan to the Accident and Emergency Department of the Queanbeyan Hospital, where Nurse Cassidy, (who had also seen the child on 12th October), was on duty. Nurse Cassidy has been a Clinical Nurse Specialist in Paediatrics since 1991.

There was some difference of recollection between Nurse Cassidy, on the one hand, and Ms Arthur and her mother, on the other, regarding the time they arrived at the Hospital, and of the events which occurred thereafter. I should add that the baby's father did not give evidence. Nurse Cassidy said the family arrived about I 0.45 a.m. The mother and grandmother believed it was about 9.15 a.m., and that they were told to wait for the duty doctor (Dr Renshaw) who, they said, did not arrive until 1.45 p.m.

In the meantime, they said, nothing was done for Nathan except for the provision of a blanket at their request at about 11.30 a.m. On their inquiring, on several occasions, regarding the attendance of the doctor, they were told, they said, that he "had to complete his rounds and would have lunch prior to attending".

On the other hand, Nurse Cassidy said she commenced "nursing triage and assessment" of Nathan on his arrival, noting the history given by Ms Arthur. She said she was not told of the fax being sent by Dr Cross, nor was there any mention by Ms Arthur of bowel obstruction. She said Ms Arthur told her that Nathan had been

vomiting "greenish" material, that his bowel motions had mucus and "pink stuff' in them, and that he was "still passing urine on a regular basis".

Nurse Cassidy said she noted that Nathan was "alert, his skin colour was good, his mucous membranes were moist".

She recorded her observations in the Accident and Emergency Department case notes of the Hospital record. She said she then rang Dr Renshaw, and told him that this was the second presentation for "query dehydration", and of the concerns of the mother and grandmother. She also told him, she said, of her observations and assessment. She said Dr Renshaw stated "that the child should be admitted and that he would attend shortly". That conversation took place, she said, between 11.00 a.m. and 11.15 a.m.

Nurse Cassidy said that prior to Dr Renshaw's arrival, she continued to observe Nathan. She noted that "he cried intermittently, but quietly, and was positting small amounts of fluid". She also noted that he "continued to look around, was moving his arms and legs and smiling at his parents". She recalled giving the grandmother a blanket at the latter's request. She did not recall saying that Dr Renshaw would attend after having had lunch.

Nurse Cassidy said that, on Dr Renshaw's arrival, sometime between 12.15 p.m. and 12.30 p.m., she handed over her nursing assessment to him. She was not present when he carried out his medical assessment.

Subsequently, Nurse Cassidy said, Dr Renshaw returned to the nursing station. There was a discussion regarding the urinalysis of 12th October, the results of which she showed Dr Renshaw. She said that Dr Renshaw "made the decision to admit Nathan to the paediatric ward", and the baby was transferred there at about 1.00 p.m. She later noted in the record: "Admission for investigation", confirming that decision.

Nurse Cassidy said that there were no medications prescribed or other therapies instituted while Nathan was in the Accident and Emergency Department. After he was transferred to the paediatric ward, she had no further involvement with him.

Apart from the inconsistencies between the evidence of Nurse Cassidy and Nathan's mother and grandmother, there were further differences between the latters' evidence and that of Dr Renshaw, and of the nurses involved with Nathan's case later, to which I shall now refer.

As stated earlier, Ms Arthur and her mother said that Dr Renshaw arrived at the hospital at about 1.45 p.m. They said he checked Nathan's eyes and tongue and heart rate. He was told, they said, of the history of the past two days, and that Dr Cross had said that she "believed he had a bowel obstruction and required immediate surgery or intervention to correct the blockage".

Dr Renshaw, they said, was unreceptive to their advice, and said words to the effect of "I assure you he has not got a bowel obstruction; he has a virus, and you can deal with this, just take him home and let him work his way through it".

Ms Arthur, senior, said she mentioned her own experience of children with discomfort, after raising four children. She said that Dr Renshaw "patted (her) on the shoulder, and said 'My dear, after 30 years experience and seeing up to fifty children a week with these symptoms, you get a feel for this sort of thing"'. She said she responded that he should carry out an ultrasound (which had been mentioned earlier as a diagnostic tool for bowel obstruction), which he declined to do, repeating that Nathan had a virus and should be kept on antibiotics and water over the next twenty-four hours. I should add that Dr Renshaw disagreed in evidence (transcript p.45, 8.4.98) that Ms Arthur, senior, had asked for an ultrasound, saying that the discussions "had been taken out of context". I do, however, accept that Ms Arthur, senior, made that request.

Both women said they continued to insist that Nathan be admitted, as he was not well enough to go home. They said that Dr Renshaw left them for about ten minutes, and, at about 3.00 p.m., Nathan was admitted to the paediatric ward. They were told, they said, that he would be kept under observation.

Regarding this passage of evidence, Dr Renshaw's recollection of events was quite different.

He said that, on the 14th October, he was a General Practitioner rostered as the duty Visiting Medical Officer for Queanbeyan Hospital. His tour of duty was for 24 hours, from 8.00 a.m. to 8.00 a.m.

While attending to patients in his private surgery, he received a phone call from Nurse Cassidy sometime after 10.45 a.m. regarding Nathan. She told him that the baby had been seen several times by Dr Cross since 11th October, and that, on 12th October, Dr Pahn had diagnosed a possible urinary tract infection, suggesting that he be treated at home, but returned to the Hospital if necessary. She said the baby had been vomiting for some length of time. He said he told her that Nathan should be admitted for observation, and that she should continue to observe him.

Dr Renshaw said the last patient booked in to his surgery was for an 11.50 a.m. consultation. He planned to attend at the Hospital immediately after that, as there was no suggestion of urgency on the part of Nurse Cassidy.

Between 12.15 p.m. and 12.30 p.m., Dr Renshaw said he attended at the Hospital and discussed Nathan's condition with his mother and grandmother. They told him that Nathan had been "unwell with vomiting", that Dr Cross had seen him, and that they had taken him to the Hospital to see Dr Pahn, who thought he may have a urinary tract infection. They said Dr Pahn had prescribed an antibiotic and wanted urine collected. They described how Nathan continued to vomit, and how they had requested a further assessment from Dr Cross. There was no mention, he said, of bile being vomited, but they said he vomited up whatever he was given.

Dr Renshaw said he was not told that Nathan had been experiencing severe abdominal pain. Nor, he said, was there any mention of incessant or periodic crying that might have indicated this condition. He considered that the nature of the vomiting, as described to him, suggested that "he had quite marked reflux". On physical examination, which lasted some 20-25 minutes, he detected no abnormalities, or signs of overt infection.

Dr Renshaw said he was not clear as to what Nathan's exact diagnosis was. The child seemed happy and normal. There was a possibility of "an exacerbation of reflux, a hidden infection such as a urinary tract infection, or there was a remote possibility of a sub-acute hypertrophic pyloric stenosis". He felt that there was a need for further observation.

Dr Renshaw said he next checked the micro-urine test carried out by Dr Pahn, but considered that a more accurate evaluation was required following a second test, which he later ordered. He agreed that there had been some reference by Nathan's grandmother to Dr Cross's belief that "there might be the possibility of a bowel obstruction". He could not recall what he had responded to that, but said in evidence that he was "a bit perplexed", because if Dr Cross "seriously thought that, she would have sent Nathan to a paediatric unit" rather than sending him "to another GP in a district hospital". He was unaware at that time, he said, of Dr Cross's fax to the hospital. He said he told Nathan's mother and grandmother that he had never seen a child of Nathan's age with a bowel obstruction, and that he could find no evidence to support a finding that such condition existed. He was not given, he said, a history of Nathan vomiting green fluid. Dr Renshaw said that the other evidence given by Nathan's grandmother regarding the question of a possible bowel obstruction was incorrect, because she seemed "to have misunderstood or misinterpreted everything I've said to her". He denied having made any reference, as alleged, to "the number of children that he (saw) every day so that (he) got a feel for it".

Dr Renshaw said that his final diagnosis was that Nathan "probably had a viral infection". He said he stopped his antibiotics, repeated his urine tests, and when he later passed loose bowel motions, ordered a specimen for pathology. In the meantime, gastrolyte was administered, and Nathan was admitted for observation. He asked the nursing staff to let him know if there were any problems.

The events which occurred later on 14th October were also subject to differences of recollection between those involved, i.e., the family, the nursing staff and Dr Renshaw.

Nathan's grandmother said that she stayed with Nathan and his mother until she left at 5.30 p.m. on the 14th. She said that no action was taken during that time by the staff, and she or Nathan's mother were not advised as to what was occurring. She said she returned with Nathan's father at about 6.15 p.m., and alleged that "no action had been taken to administer fluids (or) any other measure to improve his health". Inquiries by her of nursing staff, she said were "met with a hostile response". Eventually, she said, she was told that Nathan was being taken off antibiotics and that staff ''were only monitoring his hydration levels". She returned home after about an hour.

Nathan's mother gave evidence along similar lines, adding that she "was scared for Nathan's well being". She said that, for a few hours after Nathan's admission, staff checked him on two or three occasions, but left her to monitor when and how much fluid he passed and to record these details in a folder.

At about 9.00 p.m., Ms Arthur said, she was sitting in Nathan's room in the paediatric ward, nursing him in her arms, when Dr Renshaw opened the door to the room. She said he was about three metres from her. She said he did not examine Nathan, but said he "looked fine", that she should keep the fluids up to him and that he would be back in the morning. At about 11.45 p.m., Ms Arthur said, a nurse performing night duties offered to take Nathan from her "as he was restless and stirring" and she was extremely tired. She let the nurse take the baby, and went to sleep.

As stated, the recollections of nursing staff who were on duty over the period from Nathan's admission to midnight on 14th October and those of Dr Renshaw differed in several respects from those of Nathan's mother and grandmother.

Nurse Michelle Reid first saw Nathan, she said, at about 1.25 p.m. when he was admitted to the paediatric ward. It should be stated at this point that although Nurse Reid made a statement, which became Exhibit 35, she was not called as a witness, as she had given birth in Darwin the evening before she was due to give evidence by telephone hook-up. There was general agreement that it would be undesirable in the circumstances to call her.

In her statement, Nurse Reid said that between 1.30 p.m. and 2.00 p.m., she made observations of Nathan's temperature, respirations, and pulse, and a general review of his condition, and recorded them in the Hospital record. She observed Nathan's mother feed him approximately 20 mls of gastrolyte, which he immediately vomited up. She said there were no peristaltic waves, and the vomit was not projectile and was clear in colour.

Nurse Reid said she asked Nathan's mother was he sick every time he was fed, and she replied "Yes, every time I feed him, he's sick".

Nurse Drumgold, who was assisting Nurse Reid, bathed and weighed Nathan, and applied a urine bag. Both nurses noted that the baby had passed a "dark green mucousy bowel motion", and Nurse Reid said Nurse Drumgold told her she saw a streak of blood in it. (During her evidence, Nurse Drumgold did not recall this later observation). They attempted, unsuccessfully, to contact Dr Renshaw, and ultimately arranged for a specimen of the motion to be forwarded to Pathology. It should here be mentioned that the result of that test, as recorded in Exhibit 5, showed, on microscopic examination, "a few blood cells". Nurse Reid, who finished duty at 3.00 p.m., noted her observations and relayed them to the afternoon nurse, Nurse Roberts, at about 2.30 p.m.

Nurse Drumgold said her principal role regarding Nathan was to assist Nurse Reid. She did not read the notes relating to Nathan, nor did she take a history. She recorded the amount of gastrolyte (50 mls) administered to him.

When she was preparing to cease duty, Nurse Drumgold said that she was approached by Nathan's mother, who told her that Nathan had vomited about 30 mls. She told Ms Arthur that she would notify the afternoon shift of this, and did so before ceasing duty.

As to her general observations of Nathan, Nurse Drumgold said that, on one occasion, she said to his mother "that he was a beautiful, contented, healthy looking baby". She said Ms Arthur did not respond, although she (Nurse Drumgold) was "almost waiting for her to say that this is not his normal behaviour or something but she did not elaborate".

Nurse Dianne Roberts, a qualified paediatric nurse, said that, about 4.00 p.m., she saw Nathan and his mother in the paediatric ward. She took a history, and examined the baby, noting that he appeared to be lethargic, but had his eyes open, and was looking around. She noted his charted observations. She saw him drinking from a bottle of gastrolyte, and, as she was leaving, saw that he "vomited or more like positted some of the fluid up".

On commencing to record her observations, Nurse Roberts said she was called back to the ward, and noted that Nathan had had diarrhoea, which was "brown, very fluid and offensive and had soaked through the nappy onto his bed sheets". She helped Ms Arthur clean him up, and recorded the bowel action on the fluid balance chart.

Nurse Roberts said she went outside and told the other nurses what had occurred. She "also said to them that if keeps this up he will need an IV as 'he doesn't have much in reserve'". She was then shown his urinalysis, which showed ketones, and said Dr Renshaw was informed of this. It appears that Nurse Winchester showed her the urinalysis and told Dr Renshaw of it. She said she also asked the evening staff to

check with the doctor when he reviewed Nathan later to check whether antibiotics should be recommended as "children with urinary tract infections can become very ill". She ceased duty at 5.00 p.m.

Nurse Winchester came on duty at 2.30 p.m. She first saw Nathan between 3.00 p.m. and 4.00 p.m. He was lying on a bed with his mother, and had a urine bag in situ. His colour was normal. He had a small bowel action which was "loose green and mucousy"; the mucous was clear and there was no evidence of blood. She noted that the urinalysis showed ketones, with a trace of blood, and that the urine was "cloudy and offensive". She noted the results and transferred them to the fluid balance chart. She later showed the results to Nurse Roberts and Dr Renshaw between 4.00 p.m. and 4.10 p.m. Dr Renshaw did not advise any further treatment.

During her shift, which concluded at 11.00 p.m., Nurse Winchester said she had a number of conversations with Nathan's mother regarding his condition.

Between 6.00 p.m. and 7.30 p.m. Ms Arthur asked for Panadol to settle the baby. At that time, Nurse Winchester said she took the baby from his mother, as the latter looked very tired, telling her to go to bed and that she (Nurse Winchester) would look after the baby. Ms Arthur then went back to bed. Nurse Winchester said that she checked Ms Arthur on about four occasions during her shift to give her an update on Nathan's condition, but "she was sound asleep on all occasions and did not stir on the opening of the door to the room". Nurse Winchester said that she looked after Nathan for the remainder of her shift, and took and recorded her observations of him. She noted that he would sleep for short periods, then wake up and whimper, and occasionally draw his knees up to his stomach "like a baby does with colic". He would settle quickly. He seemed "quite well", and smiled at other staff when she took him for a walk. She gave him small, frequent amounts of gastrolyte, and he vomited up small amounts, which she recorded. He was alert on waking, but was pale, although not flaccid, towards the end of the shift.

Nurse Winchester recalled that, during the shift, Dr Renshaw made a general inquiry of the nursing staff as to whether they were concerned about Nathan's condition. Her recollection of the general response was "Yes, and no; yes because of the baby's age, and no, because the baby seemed settled". She handed over to the night shift at about 11.00 p.m.

Nurse Murray-Wilcox, who was on the evening shift with Nurse Winchester, said she first saw Nathan at about 4.00 p.m., lying on a bed with his mother. He had a urine bag in situ. At about 6.00 p.m. she said she changed his nappy. She noted a small motion, "green, loose with mucous, no evidence of visible blood", and charted this on the fluid balance chart.

At about 8.00 p.m., she said Dr Renshaw approached the nursing staff, and asked whether they were concerned about Nathan. She recalled the same response as that noted by Nurse Winchester.

At about that time, Nurse Murray-Wilcox said Nathan's mother asked for a Panadol for him, but she said Nurse Brophy said it may well make him vomit again, and he may not require it. Shortly after this, Nathan's mother went to bed and "was asleep very quickly".

About 30-45 minutes later, Nurse Murray-Wilcox said that Nathan's grandmother came into the ward, and spoke to Nurse Brophy. She did not know what was said. Later, the grandmother had a discussion about social matters with her. During her shift Nurse Murray-Wilcox said she attended to Nathan's observations at 6.00 p.m. and 10.00 p.m., and charted them on the general observations chart. She also charted the administration of 50 mls of gastrolyte and a small vomit of approximately 20 mls on the fluid balance chart. After Nathan's mother went to bed, he was looked after by Nurse Winchester, and remained in the ward desk area. Nurse Murray-Wilcox finished duty at 11.00 p.m.

Nurse Brophy was also on duty from 2.30 p.m. to 11.00 p.m. She was in charge of Nathan's ward. She said she saw Nathan regularly during her shift, but could not recall the number of times. At 4.30 p.m. she made a note that Ms Roberts had requested that Nathan be given antibiotics as he had been on them before admission, but Dr Renshaw said these were unnecessary.

Nurse Brophy said that Nathan was, generally speaking, "resting ... which would mean he was peaceful", but she did make an entry in the notes at about 8.15 p.m. that he was "unsettled". By this she meant, she said, that the baby was "crying, unless held, moving around a lot and basically upset as opposed to being completely quiet". She did not recall being given any orders by Dr Renshaw during the shift, but she informed him that the result of the urinalysis showed "positive for ketones +++" which indicated "the patient was dry (and she) thought the patient may require intravenous fluids". She also told him that the specific gravity result was 1030. She believed this occurred at about 8.15 p.m.

At the same time, Nurse Brophy said that Dr Renshaw reviewed the baby. She could not recall whether he went into the baby's room, and she did not enter it at that time.

There was, however, a discussion between Dr Renshaw and herself and Nurse Winchester at about that time, during which he asked whether they had any concerns regarding Nathan. She recalled she replied "No".

At some time during her shift, Nurse Brophy said, Nathan's grandmother had a discussion with her regarding transferring him to Canberra Hospital; she said there was some concern expressed by the grandmother regarding the cost of an ambulance. Nurse Brophy said she told the grandmother that Dr Renshaw had reviewed Nathan, and that the nursing staff were continuing to observe him.

Nurse Brophy went off duty at 11.00 p.m.

Nurse Janine Turnbull came on duty at 10.45 p.m. on 14th October. On hand-over from Nurse Brophy she was made aware that Nathan had been admitted that morning for observation, and that he had been observed at four-hourly intervals. His condition, she recalled, was within normal limits, and he was taking small amounts of gastrolyte. It was noted that his bowel motions were loose, and that his mother would be staying overnight and attending him.

Nurse Turnbull said she had a conversation with Nathan's mother, who told her she was very tired, and would like a good night's sleep. Nurse Turnbull took over the physical care of Nathan, holding him in her arms, to enable the mother to sleep.

Returning to Dr Renshaw's recollection of the events of the afternoon and evening of 14th October, he said he left the Hospital between 2.15 p.m. and 2.30 p.m., after seeing three or four patients in the Accident and Emergency Department, and then returned to his own room to see other patients. He intended to return to the Hospital after he had finished his normal practice that evening to re-assess Nathan, but proposed to go earlier if called upon by nursing staff. On returning to the Hospital at about 6.00 p.m., he said there were several patients in the Accident and Emergency Department to attend to, including a violent patient who required restraint. While attending to this latter patient, with the help of other staff, at about 7.30 p.m., he was approached by Sister Brophy, who showed him a micro-urine result relating to Nathan.

Dr Renshaw said he believed that result was of the test he had ordered that day; in fact the result was of a test carried out the previous day, and was significantly more normal than the test which had been done at the request of Dr Pahn on 12th October. Dr Renshaw said this confirmed to him that antibiotics were unnecessary.

Dr Renshaw denied that he had been told by any of the nursing staff that a urinalysis which had been done was positive for ketones "+++", or that it showed a specific gravity of 1030. Had he been aware of those results, which would have indicated dehydration, he said, he would have had Nathan transferred to The Canberra Hospital for intravenous hydration.

Dr Renshaw agreed that Nurse Brophy had told him that Nathan had passed two loose bowel motions, leading him to suspect that the child could have gastroenteritis. The three days or so of vomiting was consistent with this condition, and confirmed his decision not to administer antibiotics.

On inquiring of Nurse Brophy as to Nathan's general condition, he said he was reassured that he was not particularly sick. Dr Renshaw said he then returned to the Accident and Emergency Department, where he saw another ten or so patients that evening. At about 8.15 p.m., when things had quietened down, he returned to the Paediatric Ward, where she spoke to Nurse Brophy and other nursing staff. He said, in his evidence, that they had told him that they were concerned because Nathan was a small baby, but were not really concerned about his condition because he seemed better. He said they told him that Nathan's observations were in order, and that he was tolerating everything.

Dr Renshaw agreed in evidence that he did not look at the fluid balance chart, and that, if he had done so, he would have noted that Nathan was receiving insufficient fluids, and was becoming dehydrated. He said he relied on the information from the nursing staff that Nathan was well-looking, happy and normal. He agreed, during cross-examination, that he was "flabbergasted" when he read Nathan's fluid balance chart, when reviewing the notes after the child's death.

He also agreed that he did not read the nursing notes at the time because it would be "too time consuming", but agreed that to do so would be "simple methodology", and would not take "very long". He added that he did not think that was the way that Visiting Medical Officers normally operated. (It should be noted here that VMO

Dr Pahn's evidence (p.19, 14.1.98) was that he "always" or "generally" read the nurses' notes).

Dr Renshaw stressed, in his evidence, that, in a small hospital like Queanbeyan, "the doctor and nursing staff are really much interdependent, they are much more reliant on each other to keep each other informed as to what's going on".

Returning to the events of 14th October, Dr Renshaw said that, after having the discussion with the nursing staff, he went to the Paediatric Ward, opened the door and spoke to Nathan's mother. He told her what the nursing staff had said and asked her how she felt about that. He said Nathan's mother told him that "that was her assessment of what Nathan was doing in terms of keeping his fluids down". Dr Renshaw agreed that he did not examine Nathan, but spoke to his mother from the doorway. He said he then returned to the nursing station and told them to notify him if they had any problems with the baby. He subsequently attended the Accident and Emergency Ward until midnight, and then returned home.

OUEANBEYAN HOSPITAL
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Nurse Turnbull said she took Nathan out to the Nurses' Desk and cared for him overnight while his mother slept, returning him to the ward at about 5.30am. She gave him small amounts of gastrolyte, an average of 20 mls each time, at one half to hourly intervals.

At 2.00 a.m. she noted his temperature at 36.8 underarm, heart rate 126, respiration 30. At 6.30 a.m. temperature was 37 underarm, heart rate 136 and respiration 28. These and other observations, which she said were within normal limits, were noted in Nurse Tumbull's diary, as Nathan's chart was elsewhere at the time. A copy of the relevant entry was attached to her statement, Exhibit 15.

Nurse Turnbull said that she noted "positting, with flecks" at 3.30 a.m., 4.00 a.m. and again at 7.10 a.m. she showed the posits, which she described as a "small dribble" to Nurse Chiffey and asked her what she thought of them. Nurse Chiffey replied that she thought "it could be irritation to the stomach due to the vomiting".

Nurse Turnbull said that entries on the fluid balance chart at 1.30 a.m., 4.45 a.m. and 6.30 a.m. were made, on her directions, by Nurse Linda Colston.

She was aware, she said, of the history of Nathan's vomiting over a period of some four days. When asked if she had "concerns for his welfare and well-being" she replied "I have concerns for every patient, but, yes, I thought this was out of the ordinary".

Nurse Turnbull handed over, at about 7.00 a.m. to Nurse Roberts who had just commenced duty, informing her of the overnight observations, and that they had been "OK". She showed Nurse Roberts the flecks of blood in the posits, and told her Nathan had been taking small amounts of gastrolyte and that there had been a small discharge of urine and green watery stools. She added that Nathan's mother had had a good sleep overnight and was well rested.

Nurse Roberts, it will be recalled, is a trained paediatric nurse and had attended Nathan the previous day.

On arrival she noted that Nathan was in the arms of a night shift nurse, that he was dark under the eyes and the skin on his lips were dry. His eyes were open and he was looking around. The night staff did his observations, including pulse rate of 140, and they looked normal. Nurse Roberts felt his feet and they were warm. The night staff reported that Nathan had taken oral fluid overnight but had vomited it up. He had also vomited a brown coloured fluid, positive for blood, which Nurse Roberts said was on a towel, with a five-cent size brown mark on it.

After looking briefly at other patients, Nurse Roberts returned to Nathan to do his observations at about 7.25 a.m. She undressed him, weighed him and quickly cleaned him. She noted that he was "very lethargic" during this time and offered little resistance. He had lost 260 grams overnight, assuming, she said, he was bare weighed initially. She believed, she said, he was then "very sick". Nurse Roberts said she became very concerned about Nathan and left the room, telling the other staff of her concern, and inquired as to Dr Renshaw's whereabouts, as she wanted to contact him.

At 8.00 a.m., Nurse Roberts spoke to Dr Renshaw on the telephone. She told him Nathan had not tolerated any fluids overnight and continued to have diarrhoea, and was vomiting up brown fluid which was positive for blood. He was dark around the eyes and his mucous membranes were dry. What worried more than anything, she said, was the fact that he was very lethargic. She asked Dr Renshaw to come and review him, to which he responded that he would.

By 8.15 a.m. Nurse Roberts said she was becoming increasingly concerned about the baby's condition. His heart rate had increased, and he was "very tachypnoeic". She again telephoned Dr Renshaw, telling him she was becoming increasingly concerned. He interrupted her, she said, saying "I'm coming. Obviously we are going to transfer him". Believing the conversation was going to end, she said "But his resps (transcribed as "rhythms" in the transcript) are 78". In her evidence, Nurse Roberts said she added this because she wanted Dr Renshaw 'to come straight away and I thought that if I gave him that information... I didn't want him in five or ten minutes time, I wanted him there straight away". She recorded the call in the notes.

Dr Renshaw arrived, according to Nurse Roberts, within five minutes. After examining Nathan, he said "he was obviously sicker now than last night", and requested Nurse Roberts to call an ambulance to transfer him to The Canberra Hospital. Nurse Roberts said she went out to call the ambulance but Dr Renshaw followed her and said he would ring, so she returned to Nathan. He looked, she said, even worse than he had before, so she connected him up to the oxygen and administered it to him.

Immediate resuscitative measures, by way of intraosseous infusion, were then taken by Drs Renshaw and Ross (another VMO) and the nursing staff.

The Canberra Hospital was contacted and Nathan was transferred there by ambulance, Dr Renshaw and Nurse Roberts accompanying him.

The ambulance arrived at the Canberra Hospital at about 9.30 a.m., and Nathan's condition was assessed by Dr K. Sinn, Director of Emergency Paediatrics. Dr Sinn said he was given a history of Nathan's illness by his mother, and told "very briefly" by Dr Renshaw about what had occurred in Queanbeyan Hospital.

Dr Sinn said that his examination disclosed that Nathan was dehydrated and his symptoms indicated that he was suffering from intussusception, a form of bowel obstruction. Urgent arrangements were made for surgery. Dr Simpson, Paediatric Surgeon, performed surgery on Nathan at about 12 noon and found an intussusception, which he reduced.

Nathan survived the operation and was treated post-operatively by Dr Reynolds, Director of the Neonatal Intensive Care Unit, but succumbed the following evening, 16th October, at about 9.45 p.m. of multi-organ failure from septicaemia.

OBSERVATIONS ON THE EVIDENCE

It is clear that there are multiple inconsistencies arising out of the evidence given by the witnesses in this inquest. The recollections of Nathan's mother and grandmother are at variance to a significant degree with those of the nursing staff and of Dr Renshaw. There are also differences between the nursing staff and Dr Renshaw, and, to some extent, between the various members of the nursing staff who were involved in Nathan's care.

The differences between the evidence of Nathan's mother and grandmother, on the one hand, and the nursing staff on the other, were, in the submission of Ms Lonergan, counsel for the Queanbeyan Hospital, explicable because the former witnesses' evidence was "coloured by hindsight, grief and distress". In her submission, the nurses' evidence was given in a professional way and was corroborated by the written notes which they made contemporaneously with the events in which they were involved.

Ms Lonergan also pointed out that the statements of the mother and grandmother were "largely identical" and had been prepared some twelve months after Nathan's death by the investigating officer after "lengthy consultations with both witnesses together".

As to the differences between Nathan's mother and grandmother on the one hand, and Dr Renshaw on the other, Mr Pike for Dr Renshaw submitted that the preparation of the formers' statements at the same time by Constable Lefebvre resulted in them being almost identical and reflected inappropriate practice. He said that not every point in contention was put by him to them in cross-examination because it was "not necessary and in some circumstances, not desirable" to do so. He said this was particularly so when dealing with members of the family of a deceased who are having to deal with the grief and trauma of the death.

As to the differences between the nursing staff and members of Nathan's family, it seems to me, on the balance of probabilities, that, where there is a conflict, the evidence of the former should be accepted. I say this, not because of any deficiencies in the way in which Nathan's mother and grandmother gave their evidence, because I believe they gave their evidence honestly, in a genuine attempt to assist the Inquest, but because the nurses' evidence was supported by the notes they made at the time. Those notes reflect the fact that the nursing staff gave Nathan regular and appropriate attention, in accordance with the instructions given to them by Dr Renshaw.

As to the differences between the family members and Dr Renshaw, I believe, on the balance of probabilities, that Dr Renshaw's evidence is to be accepted, except regarding the conversation about the ultrasound, about which I have already indicated I believe Ms Arthur, senior's, evidence.

As noted, there were several areas of difference between the nursing staff and Dr Renshaw. The critical one, in my view, was the evidence of Nurse Winchester and Nurse Brophy that they informed Dr Renshaw of the ketones and specific gravity readings of the urinalysis on the afternoon and evening of 14th October. Dr Renshaw denied that they had done so, adding that if he had been informed in this regard, he would have believed that the child was dehydrated and would have ordered that he be transferred to The Canberra Hospital for infusion (a process which apparently could not be carried out at Queanbeyan Hospital).

It was his recollection that it was Nurse Brophy who approached him at about 7.30 p.m. to show him the results of the micro-urine test, no mention being made of the urinalysis.

However, Nurse Winchester gave evidence that she conducted a urinalysis between 4.00 p.m. and 4.10 p.m. She said she had written the results on a piece of paper, and later transferred them to the fluid balance chart. She took the piece of paper to Dr Renshaw, who was standing at the desk at Ward B about 4.10 p.m., and showed it to him. He gave no instructions to her. (She later said in evidence that the entry in the nursing notes at 8.15 p.m. that she recorded the results there was incorrect; Nurse Brophy made that note).

Nurse Brophy's evidence (p.8, 15.1.98) was that she informed Dr Renshaw of the results of the urinalysis when he came to review Nathan at about 8.15 p.m., and also informed him of the observations earlier made. She said he told her to continue to observe Nathan.

Dr Renshaw's recollection was that he was in Ward B, helping ancillary staff with an unruly patient who had earlier been treated by him in the Accident and Emergency Ward, and who had been causing "uproar" there.

At about 7.30 p.m., he said, he was there approached by Nurse Brophy, who conveyed to him the results of the micro-urine test which he believed was the one he had ordered that day (but which was in fact one from the previous day). He said nothing was said to him about the urinalysis result, either at that or any earlier time. If there had been, he would have ordered Nathan's transfer to The Canberra Hospital for hydration infusion.

Apart from the inconsistencies arising out of the three different times referred to, i.e., 4.10 p.m., 7.30 p.m., and 8.15 p.m., and the assertion by Nurse Winchester that she had actually show Dr Renshaw the urinalysis results at the first-mentioned time, there is a significant discrepancy between the evidence of Nurse Brophy and Dr Renshaw about the location of, and the circumstances in which she allegedly conveyed the same information to him.

Nurse Brophy said that it was in the Paediatric Ward area, when Dr Renshaw came to review Nathan at about 8.15 p.m., that she had the relevant conversation with him regarding the urinalysis.

As stated, Dr Renshaw's evidence that it was in Ward B, while he was dealing with the obstreperous patient, that Nurse Brophy approached him regarding the micro-urine test, but did not mention the urinalysis. There seemed to be suggested inference that the doctor was distracted by what was occurring with the patient, hence, e.g., the mistake regarding the micro-urine test.

In resolving the conflict of evidence between Nurses Winchester and Brophy, on the one hand, and Dr Renshaw, on the other, I believe the formers' evidence is to be preferred. It was, of course, corroborated to a degree by the entry on the fluid balance

chart. In addition, there was no challenge mounted during cross-examination of either of the nurses as to their evidence in this regard.

The communication break-down which occurred was compounded by Dr Renshaw's admitted failure to read the fluid balance chart at that, or any other relevant time.

He also conceded that his failure to look at the nursmg notes may also have contributed to the, as it transpired, tragic result which ultimately ensued (transcript p.47, 8.4.98). I will refer to Dr Renshaw's reasons for the course he took in these two areas when I deal with the Section 55 notice.

I tum now to an examination of the part played by the medical and nursing witnesses involved in Nathan's treatment.

DR CROSS

Dr Cross was Nathan's general practitioner. The evidence was that she discharged her responsibilities towards Nathan in a caring and competent manner. Faced with a difficult diagnostic problem, she took the appropriate course of referring him to Queanbeyan Hospital for assessment. No blame can be attributed to her for what later occurred.

DRPAHN

Dr Pahn, as the first Queanbeyan Hospital Visiting Medical Officer to examme Nathan, took appropriate steps in the circumstances which he believed to exist when he diagnosed a possible urinary tract infection. The fact that the diagnosis transpired to be invalid cannot be said to be the result of any failure of professional care on his part.

THE CANBERRA HOSPITAL STAFF

Nathan' treatment by The Canberra Hospital nursing and medical staff was exemplary. At the time of his admission, he was at death's door. Dr Sinn made a prompt and correct diagnosis of intussusception. After-care was provided by Dr Reynolds. All three medical practitioners are experienced specialists in areas of paediatric medicine. The nursing staff also performed their duties in a professional and caring manner. Unfortunately, all their efforts were to no avail.

I agree with the submission made by Mr Pilkinton, counsel for Nathan's family, that the staff at The Canberra Hospital did "absolutely everything in their power" to save his life.

QUEANBEYAN HOSPITAL NURSING STAFF

Ms Lonergan, counsel representing Queanbeyan Hospital, submitted that the nursing staff did "their best to closely observe and record Nathan's progress and improve his condition to the extent possible within nursing parameters". Each of the nursing staff involved "observed Nathan carefully and noted their observations on the charts and the notes, attended to urine analysis, (and) arranged for pathology on a faeces sample with a view to checking for blood infection".

The standard of care exercised by the nursing staff, Ms Lonergan submitted, reflected their concern for the child and his mother. For example, to enable Nathan's mother to get some sleep, Nurse Winchester physically held the baby for some three hours until 11.00 p.m. Nurse Turnbull also looked after Nathan by holding him in her hands or on her shoulder or across her lap for most of the night. During this time she observed him, in particular his hydration status, and noted anything of significance in her overnight summary in her diary. She did not find him lethargic nor did she see him drawing his knees up or "screaming in pain". He slept for periods and "sucked his

bottle fine and he looked quite fine ... he was playing, he laughed at our hands ... he smiled".

It is correct, as pointed out by Mrs Doogan, counsel assisting the Coroner, that there are some discrepancies in the nursing notes, e.g., Nurse Reid did not make a notation on the fluid balance chart that Nathan vomited 20 mls of water/gastrolyte at about 1.30pm on 14th October; her notation was "sick +". Nurse Drumgold recorded 50 mis of gastrolyte being administered at 1.30pm on 14th October, but there is no note of the amount of output. There were additional examples referred to by Mrs Doogan.

In my view, the discrepancies in the notes were such as to have no real bearing on what ultimately occurred.

My impression of the evidence given by the nursing staff is that they did their professional best to care for Nathan, having regard to the directions given to them by Dr Renshaw. As Ms Lonergan submitted, the nursing staff cannot make diagnoses, nor can they initiate treatment, e.g., authorise or set up intravenous drips.

In one critical area of Nathan's treatment, i.e., what action should have been taken following the result of the urinalysis, this was, of course, a decision for Dr Renshaw. As stated above, I accept that Nurse Winchester and Nurse Brophy did communicate the urinalysis results regarding the ketones and specific gravity to Dr Renshaw and he failed to take appropriate action by transferring Nathan forthwith to The Canberra Hospital for hydration infusion. In all other respects, it appears to me that the nursing staff followed Dr Renshaw's instructions appropriately, and I do not believe that any Coronial criticism is warranted so far as they are concerned.

DR RENSHAW

Dr Renshaw, at the time of the events covered by this Inquest, had been a general practitioner for some 25 years. He had been a Visiting Medical Officer (VMO) or equivalent at Queanbeyan Hospital for 23 years.

As one of ten visiting VMO's appointed to the Queanbeyan Hospital, he was rostered on each tenth day to be "on call". His shift commenced at 8.00 a.m. and continued for 24 hours. During this time, as well as caring for his own patients in his private practice, he was responsible for all patients attending the hospital.

Dr Renshaw in his evidence said that he believed the (New South Wales) hospital system is "at breaking point... the VMO's are trying to cope with the increased work load that we have in the casualty and to discharge (their) other duties". He added that he "and quite a number of other VMO's have radically changed our work practices in recent times in trying to cope with the stresses and demands on us".

Dr Renshaw said that there were no Resident Medical Officers at Queanbeyan Hospital, nor had there ever been, to his knowledge. He did not claim any specialist paediatric expertise.

The condition which was ultimately diagnosed in Nathan's case, i.e., intussusception, is rare. In Dr Renshaw's experience, and that of his three associates in practice, with a total of "over a hundred years of general practice", he was the only one to have seen such a case. Typically, he said, the condition occurs in infants between the age of six to twelve months. The child presents with episodic pain which is severe, far more severe, repetitive and persistent than that of "infantile colic" or constipation. These symptoms, he said, did not manifest themselves in Nathan's case. In this regard, he was supported by the evidence of Dr Reynolds, who also said that Nathan's "picture" was an unusual one for intussusception.

As mentioned before, Dr Renshaw said in evidence that the local general practitioners who acted as VMO's relied on being kept infonned of patients' progress or otherwise by the nursing staff. That was the principal reason, apart from the question of the shortage of time to do so, which caused him not to refer to notes or charts regarding the patient. This approach, as noted before, was not followed by at least one other general practitioner VMO, Dr Pahn, perfonning duties in the same manner as Dr Renshaw.

As to Nathan's presentation, Dr Renshaw said he took a history from the baby's mother and grandmother. No mention was made, he said, of the baby vomiting bile, nor of any green or yellow vomit. His discussion with Nurse Cassidy over the telephone did not include a history of any vomit of green fluid. Reference by Nathan's mother to a possible bowel obstruction, as thought by Dr Cross, puzzled him, as this should have prompted Dr Cross to refer Nathan to paediatric care at The Canberra Hospital, rather than to another general practitioner at Queanbeyan Hospital. In any event, he could find no evidence of such condition.

The steps taken by Dr Renshaw subsequently have been described earlier. His main action was to order that Nathan be kept under observation. Gastroenteritis was, at one stage, considered.

Because the nursing staff assured him, he said, on the evening of 14th October, that they had no real concerns for Nathan, and that he was well-looking, happy and normal, he decided nothing further needed to be done at that time.

Mr Pike, Dr Renshaw's counsel, submitted that the evidence of Dr Reynolds and Dr Sinn was not helpful in assessing whether Dr Renshaw had acted appropriately in Nathan's case. As he pointed out, they gave their views as paediatric specialists, as to what the appropriate course of action should have been, but they were not, and in Dr Reynolds' case, never had been, general practitioners. Mr Pike stressed that Dr Reynolds conceded that"... it's an easy judgment to make in hindsight", inter alia,

as to when Dr Renshaw should have considered transferring Nathan to The Canberra Hospital.

Apart from that reservation, both Dr Reynolds and Dr Sinn agreed in evidence that Nathan's chances of survival, in their view, would have been increased if he had been transferred to The Canberra Hospital earlier than he was, "even 24 hours earlier", in Dr Reynolds' view (transcript 7.4.98, pp 37 and 65).

On the other hand, both specialists agreed, Mr Pike submitted, that such a decision depended on the clinical picture presented to a general practitioner such as Dr Renshaw, working as a VMO on a 24 hour shift.

As to the reading of nursing notes, Dr Reynolds said it was his common practice to do so; he did not state that such a practice was mandatory or whether he would expect a medical practitioner in Dr Renshaw's position to do so. He did, however, add (p.49 transcript 7.4.98) that "...(nursing notes are) an important part of the clinical record".

It is clear, on the evidence, that, when Nathan's critical condition become apparent on the morning of 15th October, appropriate and urgent action was taken by Dr Renshaw and those assisting him. I accept his evidence that Nathan's appearance caused him to believe that the child "was about to die at any moment" and that he was "devastated... (and) totally shattered".

As to what occurred earlier, one area of concern relates to Dr Renshaw's continued assertion that it was up to the nursing staff to keep him informed verbally of what was occurring, and that it was not necessary for him to inform himself in any more detail than that by reference to nursing notes, or fluid balance charts. As I have already found, in one of the critical areas of disagreement between him and the nursing staff, i.e., regarding the results of the urinalysis, he was given sufficient information to justify Nathan's immediate transfer to The Canberra Hospital. Although he denied being told of the results, I am satisfied that Nurse Winchester and Nurse Brophy's evidence is correct. Dr Renshaw's failure to act accordingly seems to have resulted

from a misapprehension, regarding what Nurse Winchester and Nurse Brophy said, or a complete failure to hear what they said. This becomes more difficult to understand in view of Nurse Winchester's evidence (which was unchallenged in cross-examination) that she showed Dr Renshaw the results of the urinalysis on a piece of paper.

Mr Pike submitted on behalf of Dr Renshaw that he was justified in depending on being kept informed of events by the nursing staff. His submission was:

"As can be expected in a small country hospital which relies entirely on local general practitioners for its medical staff, a very high standard of communication is essential to ensure that proper care is given to the patients. Medical and nursing staff must work perfectly 'in sync'. There is no latitude for, or safety net to cover, errors or breakdowns in communication".

It should be interpolated that, in the discussions regarding the urinalysis involving Nurse Winchester and Nurse Brophy, there was such a patent "breakdown in communication". There was also such a "safety net" to cover this, i.e., the fluid balance chart, to which Dr Renshaw did not refer, for the reason stated by him.

Another reflection of the difficulties arising out of the doctor's failure to read the nursing notes was highlighted during his evidence (p.36, 8.4.98) when he said that he reviewed the notes after Nathan's death, and "was extremely disappointed when he read (them). There was a mention of blood in the faeces there, which I was never informed about". The implication arising is that he would have done something about the situation ifhe had known of it.

Dr Renshaw's insistence that his source of information regarding Nathan was solely the nursing staff, and not their notes, does not seem to accord, as stated earlier, with at least the practice of his fellow VMO Dr Pahn. In my view, the keeping of nursing records and material such as fluid balance charts would seem rather pointless if they

were not intended to be utilised by medical practitioners as well as others responsible for a patient's care.

Dr Renshaw conceded (p.47 8.4.98) that it would be "simple methodology" to read the nursing notes on each occasion he came to examine a patient, that it would "probably not" take very long, and that in Nathan's case "the result may well have been different" if he had done so. He did, however, add, in answer to Mr Pike, that such a practice would be "too time consuming". He did not elaborate on this response.

Here again, to quote the words of Mr Pike, any "breakdown in communication", presumably including an alleged failure by the nursing staff to inform Dr Renshaw of the presence of blood in Nathan's faeces, could have been cured, in my view, by the "safety net" of reference to the nursing notes. As with the fluid balance chart, this did not occur.

THE SECTION 55 NOTICE

A copy of the Section 55 notice is annexed to these "Reasons for Findings".

The first proposed adverse comment referred to therein is, generally speaking, that Dr Renshaw did not "appropriately or adequately" inform himself of Nathan's condition on admission or thereafter.

As to what occurred on admission, Mr Pike's response, on behalf of Dr Renshaw, was that Dr Renshaw had in fact sought a history from Nathan's family and Nurse Cassidy. The latter had noted in the Accident and Emergency notes that Nathan had vomited greenish or bile-like fluid, but admitted in Court that she did not inform Dr Renshaw of this. Dr Renshaw denied that the family told him that that green or yellow fluid or bile had been vomited. They did not mention any severe abdominal pam.

Dr Renshaw's examination of the baby revealed no abnormalities, or signs of overt infection. He was unsure of the exact diagnosis, and, quite properly, in Mr Pike's submission, ordered that Nathan be admitted for observation, not, as alleged later, for investigation.

As to whether Dr Renshaw had properly explored the possibility of a bowel obstruction, as raised by the family following Dr Cross's comments to them, Mr Pike said that Dr Renshaw was puzzled as to why, if that were Dr Cross's opinion, she had referred the child to the Queanbeyan Hospital, for attention by another general practitioner, rather than to specialist paediatric care at The Canberra Hospital.

I should emphasise at this point that there is no criticism regarding Dr Renshaw's failure to diagnose Nathan's condition as intussusception. It was agreed by the specialists that that is a rare condition, and that Nathan's presentation was atypical.

The reference to a possible bowel obstruction is important, in my view, because Dr Cross, after being involved with Nathan's condition for some days, believed that such a condition could exist, and told the family so.

The matter of the fax is irrelevant, because, although she did not refer to this possibility in it, Dr Renshaw was not aware of its contents in any event.

I can understand Dr Renshaw being perplexed as to why, if Dr Cross considered the possibility of an obstruction, she had nonetheless referred the child to Queanbeyan Hospital, where she would know a fellow general practitioner would be involved with his treatment, rather than to specialist paediatric care at The Canberra Hospital.

What I find it difficult to understand, however, is why, knowing as he did that Dr Cross was Nathan's general practitioner, and had been involved in his treatment for some days previously, Dr Renshaw did not communicate with her to ask her why she believed a bowel obstruction could be a possible reason for the child's persistent vomiting.

Dr Renshaw was aware that Nathan had presented on 12th October, at Dr Cross's request, and that Nurse Cassidy had taken a history of further vomiting since then, resulting in Dr Cross's second referral.

It would seem that the obvious way to resolve his perplexity as to Dr Cross's view would be to communicate with her.

She was, after all, in a nearby town, and there was no suggestion that she was not contactable by telephone. It was also not suggested that there was any ethical, or even practical reason, such as lack of time, or pressure of events, for Dr Renshaw not to make an inquiry of Dr Cross, as to why she had considered the possibility of a diagnosis of a bowel obstruction.

As to the proposed criticism that Dr Renshaw did not "appropriately or adequately" inform himself of Nathan's condition after admission, Mr Pike's response was that the doctor relied on being kept informed by the nursing staff of Nathan's condition. They failed to bring to his attention relevant factors, such as the urinalysis, or the presence of blood in the faeces, which could have influenced him in his approach to Nathan's treatment, including transferring him to The Canberra Hospital.

I have already indicated that I accept that Dr Renshaw was informed both by Nurse Winchester and Nurse Brophy of the results of the urinalysis. His failure to take the action which he said in evidence he would have taken had he been aware of the results, i.e., transfer to The Canberra Hospital, had the effect, according to Drs Reynolds and Sinn, of making the tragic result more inevitable.

Dr Renshaw's response to the allegations regarding the urinalysis was a straight denial that he had been informed, not that he was distracted by other events in which he was involved at the relevant time, or that pressure of his other responsibilities (to which will refer later) militated against him being properly responsive to such advice. However, it was not just one, but two Nurses who informed him of the results. In

addition, Nurse Winchester actually showed him the piece of paper on which she had recorded the results. It is not without significance that neither had one question addressed to them in cross-examination challenging their version of the relevant events.

I have referred earlier to Dr Renshaw's concession that he did not refer to the nursing notes, or the fluid balance chart, and to his reasons for not doing so.

It is clear, on the evidence, including that of Dr Renshaw, that Nathan would have been transferred to The Canberra Hospital much earlier than he was if Dr Renshaw had referred to the notes. Apart from his concessions at page 47 of the transcript of 8.4.98, he agreed that it was his duty to read the notes (transcript p.41, 8.4.98) "under certain circumstances" and "when it's drawn to my attention that there is a problem ...". He added (p.42) that he" ... didn't read the notes because I was performing other functions within the hospital. I can't be in two places at once ... I think it's reasonable for me to expect that I can rely on the nursing staff to inform me of those sort of problems".

As stated earlier, the evidence of Dr Pahn, who was similarly placed as a Visiting Medical Officer, that he "always" or "generally" read the nursing notes, supports the view it was not normal practice not to do so, as implied by Dr Renshaw.

Again, the evidence of Dr Reynolds that nursing notes formed an important part of the clinical record of a patient, and that he, himself, referred to them, is relevant in this regard. Mr Pike's submission that Dr Reynolds' evidence should be discounted because he is a specialist, rather than a general practitioner seems, in my view, to be misplaced. I fail to understand why nursing notes should be any less important to medical practitioners such as Dr Pahn or Dr Renshaw than they would be to practitioners such as Dr Reynolds. The first-mentioned also inferentially believed them to be so.

Notwithstanding Dr Renshaw's insistence that it was the sole responsibility of the nursing staff to keep him informed of events relating to Nathan, I believe that he, as the medical practitioner in charge of the child's care, bore the ultimate responsibility for that care. The doctor conceded that this was so during his evidence (transcript p.46, 8.4.98).

In my view, for the reasons advanced above, the proposed comment in paragraph 1 of the Section 55 notice stands.

I tum now to paragraph 2 of the notice, that Dr Renshaw "failed adequately to direct and supervise an appropriate investigation into, and treatment of the deceased child's condition".

There was a dichotomy in the evidence regarding the reason for Nathan's admission. Dr Renshaw said he ordered his admission for "observation", because of the difficulty of making a precise diagnosis, and not for "investigation".

On the other hand, Dr Cross, in her statement of 4th February 1997 (Exhibit 9), referring to the urine test of 13th October 1996, said "I reasoned he was now in hospital for further investigations and that this information would go to the treating doctor as well".

Nurse Cassidy believed that Nathan was being admitted "for investigation", and recorded that phrase in the notes. She did, however, concede that the note was made after Dr Renshaw had assessed Nathan and admitted him.

Dr Renshaw agreed, in evidence, (page 31 Transcript 8.4.98) that "an important function of Queanbeyan Hospital is to provide 24 hour observation and care for patients where a definitive diagnosis has not been made".

It seems, from that evidence, that Dr Renshaw did intend to admit Nathan for observation only, notwithstanding the views formed by Dr Cross and Nurse Cassidy.

To that extent, the proposed comment in paragraph 2 of the Section 55 notice will not be pursued.

As to the allegation that Dr Renshaw failed adequately to direct and supervise appropriate treatment for Nathan, the evidence is that the only appropriate "treatment" for Nathan, given that his condition was due to the intussusception, as ultimately found, was to transfer him to The Canberra Hospital.

Because Dr Renshaw was unaware, for understandable reasons, that this was his condition, he cannot be criticised on that ground alone.

However, apart from stopping his antibiotics, repeating his urine tests, organising pathology for bowel motions, and ordering the administration of gastrolyte, Dr Renshaw's only directions as to "treatment" consisted of requesting the nursing staff to continue to observe the child.

His admitted sole reliance on what he was told by the nursing staff to decide further steps, rather than to refer in addition to the nursing notes and fluid balance chart, in my view, represents a deficiency in his approach to Nathan's "treatment".

Accordingly, that part of the proposed comments in paragraph 2 of the Section 55 notice stands.

The proposed comment in paragraph 3 of the Section 55 notice is that Dr Renshaw failed to arrange timely transfer of the deceased child to The Canberra Hospital before his condition had irretrievably deteriorated.

It is clear, on the evidence, that Nathan's condition, as observed by the nursing staff on the afternoon and evening of 14th October, and overnight on the 15th, was not

such as to alarm them. I have referred to the evidence of the conversation between Dr Renshaw and members of the nursing staff, including Nurses Brophy and Winchester, at about 8.15 p.m. on 14th, in which they told Dr Renshaw that they had no real concerns regarding the child, except for his age.

In addition, Nurse Turnbull, who had the physical care and control of the child for almost the whole of the night of 14th/15th, felt that his observations were within normal limits.

Even when Nurse Roberts returned to duty at about 7.00 a.m. on 15th and first saw Nathan, she was obviously not unduly concerned about him. His observations, she said, were normal, and she felt able to attend to other patients before returning to care for the child. In other words, there was no sense of urgency up until then.

It was on Nurse Roberts' return that she became alarmed, principally because of his lethargy, but also because of the other symptoms which indicated to her that he was then gravely ill. It was at that stage that Dr Renshaw was called.

It seems to me, on that evidence, that Nathan's condition manifested no symptoms such as to cause alarm which were observable by those caring for him during the afternoon and evening of 14th, and overnight on 15th, up until Nurse Roberts' second attendance on him on the morning of 15th.

However, on the evidence of the paediatric specialists, it seems clear that his condition, at the time of Dr Renshaw's urgent response to Nurse Roberts' call, was then irretrievable. As Dr Renshaw said in evidence (Transcript p.23, 8.4.98), Nathan was in "deep shock. I thought he was about to die at any moment".

That there was, however, a good chance of saving the child earlier is borne out by the evidence of Drs Sinn and Reynolds.

Dr Reynolds said (Transcript p.37, 7.4.98) that he "would have been sufficiently concerned that (Nathan) was not responding to the normal treatment of gastroenteritis by the time he was admitted (sic) on 12th October. The clinical notes and observations made during this time, subsequent to that admission (sic), would lead me to believe that he was a pretty sick child at that stage, and not responding, you know, he had clearly not responded to the normal gastrolyte management he'd had. So, I would have been inclined to seek referral for more intensive treatment very early on, effectively on 13th".

In response to a question from Mrs Doogan was to whether Nathan would have had a better prognosis if he had been transferred from Queanbeyan Hospital 24 hours earlier, Dr Reynolds replied" "I think I've made that clear in my statement and my answer to that is yes, if he had been transferred earlier then the vigorous resuscitation that was required on admission to the emergency room would not have been needed ...".

Dr Sinn's evidence was not fully transcribed, owing to a faulty recording. Where there are gaps, I have included my own notes.

Dr Sinn said that, having read the Queanbeyan Hospital notes in November 1997, he believed that "the hospital staff and doctors" had "underestimated the seriousness of (Nathan's) illness" (transcript p.58, 7.4.98).

The urinalysis taken at about 4.10 p.m. on 14th "suggested dehydration", Dr Sinn said; he would "probably change the oral hydration onto intravenous (my note: "hydration, particularly where the") child (has been) vomiting on a number of occasions and being lethargic".

As to the comment by Dr Cross to the family regarding possible bowel obstruction, Dr Sinn said: "I think it depends on examination and history of the patient and each doctor would come up with their own assessment but knowing that another doctor has a suspicion of a bowel obstruction and if I were the treating doctor I would be very

careful to be certain that (my note: "this was explored") either clinically with the history upon an examination or (my note: "consider investigations") such as X-ray(s) or do an ultrasound".

(It will be recalled in this context, that Nathan's grandmother asked Dr Renshaw to conduct an ultrasound, but he declined).

It is apparent from that passage of evidence that Dr Sinn believed that there should have been an examination by Dr Renshaw of the suspicion raised by Dr Cross of a possible bowel obstruction. In addition, given the history of Nathan's condition on 14th, he was of the view that the child should have been transferred to The Canberra Hospital 12 hours sooner than he had been.

Mr Pike suggested that the evidence of Drs Reynolds and Sin should be discounted in view of their standing as paediatric specialists, and their expressions of opinion should be given little weight because they were not in the position in which Dr Renshaw, a general practitioner, found himself on 14th October.

Although it is correct to say that Dr Reynolds had not practised as a general practitioner, Dr Sinn had. In any event, they were aware of the circumstances in which Dr Renshaw made his judgements, and were prepared to express their views notwithstanding those circumstances .

I should accordingly state that I place reliance on their evidence.

It follows from the foregoing, that I am of the view that Dr Renshaw should have arranged for Nathan's transfer to The Canberra Hospital much earlier than he had, and at a time when the child's condition was retrievable. There are several reasons for reaching this view:

1. There was no communication with Dr Cross regarding her suspicion regarding a possible bowel obstruction;

2. There was no effective consideration of an ultrasound to explore such possibility;

3. There was no adequate appraisal of the history of persistent vomiting over some four days;

4. There was no action taken on the results of the urinalysis of 14th October;

5. There would have been a "different conclusion" reached regarding Nathan's condition if he had read the nursing notes (transcript p.42, 8.4.98).

For this reason, the proposed comment in paragraph 3 of the Section 55 notice stands.

CONCLUSION

I should state, at this point, that I express my personal sympathy to Nathan's parents, and to other members of his family. They have been through a very stressful time, both in the events leading up to his death, and thereafter. I must apologise to them for the length of time taken to resolve this Inquest, which must have only added to their grief and distress.

This Inquest, like most, has also been traumatic for those involved in it as witnesses or counsel, particularly as it involved a baby.

I accept that all those involved in Nathan's care at Queanbeyan Hospital, including Dr Renshaw, were devastated by his death. Whilst I have found areas of criticism regarding the part played by Dr Renshaw during Nathan's stay at Queanbeyan Hospital, I believe there are some extenuating circumstances surrounding at least some aspects of those criticisms. I will refer to these shortly.

Apart from commenting on matters inter alia, involving public health, under Section 52(4) of the Coroners Act 1997, a Coroner's responsibilities include recommending measures which may minimise the occurrence of preventable deaths. I believe I should accordingly make appropriate recommendations in this Inquest.

There is, however, a jurisdictional problem, in that all the events which could be regarded as being the subject of recommendations by an Australian Capital Territory Coroner occurred in the State of New South Wales.

Section 57 of the Coroners Act 1997 provides, inter alia, that a Coroner may make recommendations to the Attorney-General and Minister for Justice of the A.C.T. "on any matter ... including matters relating to public health or safety ...".

(I should interpolate here that one counsel in the Inquest made the curious, and inaccurate, submission that the Coroners Act 1997 does not apply to these proceedings. It does.)

Accordingly I intend, at the appropriate stage, to make a recommendation to the A.C.T. Attorney-General and Minister for Justice that he inform the New South Wales Minister for Health of the facts of this Inquest, and of my findings, and convey to the Minister the recommendations which I consider appropriate for his/her information.

Mr Pike, counsel for Dr Renshaw, submitted that the circumstances in which the doctor was required to function as a Visiting Medical Officer resulted in undue pressure being put on him in discharging his duties. In referring to the need for medical and nursing staff to work "in sync", he submitted:

"Although (Nathan's) death was potentially preventable, it did not occur through a lack of care of any of those involved. It occurred because the lack of resources of the practitioners such as Dr Renshaw 'filling in' by being on call for the hospital, resulted in incredible pressure of work. The same lack of resources resulted in the nursing staff of the hospital being left to care for all of the hospital's patients, without any

resident medical staff to fall back on. When comers are constantly cut in this way, it can come as no surprise that sooner or later a tragedy occurs". And further:

"No doubt (the absence of resident medical staff) is a problem attributable at least in part to the under-resourcing of country hospitals. Cost-cutting measures in public health funding may be a political inevitability. Of equal inevitability is that enormous and unrealistic pressure is thereby placed on the individuals trying to keep the health service operating. To focus on the symptoms of the problem, to blame the messenger, is not the answer".

In this regard, as stated earlier, Dr Renshaw was rostered on each tenth day for 24 hours, from 8.00 a.m. to 8.00 a.m., as Visiting Medical Officer at the Queanbeyan Hospital. He was also obliged to care for his own patients in his private practice during this period.

It is obvious, from the evidence, that on the late afternoon and evenmg of 14th October, he was under considerable pressure at the Hospital, particularly in the Accident and Emergency Department. He was involved in the treatment of a violent and drunken patient, who required restraining, and who took considerable expenditure of Hospital resources to control.

During the evening, he also treated some ten other patients in the Accident and Emergency Department, including a woman who was having seizures, and a man with a fractured ankle. This was in addition to attending to other patients in the Hospital, including Nathan, for whom he was responsible.

I believe it is of significance, in this context, to quote part of Dr Renshaw's evidence (Transcript p.36, 8.4.98):

"... and at 6 o'clock I was thinking that if (Nathan) continued to have vomiting and diarrhoea my plan was to transfer him. But I didn't get an opportunity to see him at that time because of the other emergencies that were happening in the Accident and

Emergency Department. And then when I went up to see how he was progressing again over that evening at about 8.15 p.m. At that time I was feeling pretty physically and emotionally exhausted and I still had a long way to go before I finished my shift and I thought the last thing I wanted was to be coping with a sick baby. It was my intention to transfer him. As a result of the conversation that I had with Sister Brophy, I was reassured that there were no particular problems with him, so I asked them to continue to observe him".

The general atmosphere of pressure, and stress under which he laboured, may explain the doctor's complete failure to recall, indeed his denial, that he was informed by Nurse Winchester and Nurse Brophy of the critical urinalysis results, and also his failure to take the time to read the nursing notes and fluid balance chart.

In any event, it does seem that Mr Pike's submission has substance, and that the system in operation at the Queanbeyan Hospital created undue pressure on the Visiting Medical Officers who were required to keep the system functioning, and was conducive to the possibility of mistakes occurring. Mr Pike submitted that I should accordingly recommend that the New South Wales Health Department provide sufficient funding to provide for the employment of full-time resident medical officer staff sufficient to provide 24-hour cover to that Hospital.

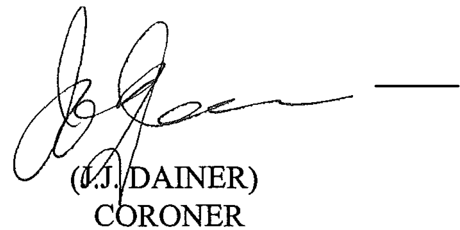
Interestingly, Ms Lonergan, who represented Queanbeyan Hospital, made the same submission. In addition, she submitted that, as Queanbeyan Hospital cannot cope with specialist paediatric care, and "in view of the known risk of paediatric patients deteriorating very rapidly", such patients should be treated in "a major teaching hospital with a large paediatric unit if there is any risk at all of needing surgical attention or rehydration by intravenous therapy".

I should say that I agree with those submissions, and I will incorporate them in the recommendations which I propose making.

In closing, I should refer generally to the submissions made by counsel representing the various parties involved in this Inquest, which I found, in the main, to be of considerable assistance in resolving the issues in this distressing case.

It is obvious that I have not canvassed all the points made in those submissions. This is not because I consider some of the points raised to be invalid or outside the scope of my inquiry, but because I have tried to focus only on those areas of the evidence which enabled me to form the conclusions necessary to discharge my duties as a Coroner.

Finally, and notwithstanding my earlier comment, I would like to express my appreciation of the assistance given to me by counsel during the course of this difficult Inquest, including, in particular, Mrs Doogan, of the DPP's Office.



(J.J. DAINER)
CORONER

16th July, 1998

AUSTRALIAN CAPITAL TERRITORY

OFFICE OF THE CORONER

Magistrates Court Building
Knowles Place
Australian Capital Territory
Canberra City, A.C.T.
G.P.O. Box 370

Telephone: (02) 6217 4231

12th June, 1998

Dr Peter Lawrence Renshaw
cl- Mr Edson Pike
2nd Floor, Wentworth Chambers
180 Phillip Street
SYDNEY NSW 2000

Re: Inquest into the death of Nathan Thomas James WRENCH

I refer to the abovementioned Inquest, in which you gave evidence.

Section 55 of the Coroners Act 1997 of the ACT requires that a Coroner proposing to make a comment adverse to a person involved in an Inquest shall not do so until that person has been given a copy of the proposed comment, and allowed the opportunity of either making a submission, or of giving the Coroner a written statement in relation to it.

I am presently disposed to making comments adverse to you in the following terms:

1. That, as the treating medical practitioner of the deceased child at the Queanbeyan Hospital, you did not appropriately or adequately inform yourself of the condition of the deceased child on admission or thereafter.

2. That you failed adequately to direct and supervise an appropriate investigation into, and treatment of the deceased child's condition.

3. That you failed to arrange timely transfer of the deceased child to The Canberra Hospital before his condition had irretrievably deteriorated.

If you wish to make a submission, or give a written statement, in accordance with Section 55(1)(a) and (b) of the Coroners Act 1997, I hereby nominate 5 p.m. on 29th June 1998, as the time within such submission or statement should be lodged with the Coroner's Secretary, Mrs M. Heidtmann, GPO Box 370, Canberra City, ACT, 2601.

(b:J

Coroner

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23 June 1998

Mr. J.J Dainer
Office of the Canberra Coroner
G.P.O. Box 370
CANBERRA CITY ACT 2601

Dear Mr. Dainer

RE: INQUEST INTO THE DEATH OF NATHAN WRENCH

As counsel for Dr. Renshaw I have ,been asked to make a submission to you in response to your letter of 12 June 1998.

Prior to responding to the pruiicular issues raised by you in your letter, it is appropriate in my submission for some consideration to be given to the nature of proceedings in the Coroner's Court.

Coronial proceedings are essentially fact-finding, and for that reason they are considered to be inquisatorial. The strict rules of evidence are not applied, and the coroner can inform himself of material facts in a manner not open to judges in a court of law. The purpose of those proceedings, ultimately, are to come to a view as to manner and cause of death of the deceased.

Consequently, while coroners are not prohibited from making comments in their decisions which are critical of individuals or agencies (and indeed, some coronial legislation make reference to the making of such comments, as in the ACT), the making of such comments is at its highest at the periphery of the coroner's function.

When should that function be exercised? This question must be answered in the context of the other important role of the coroner in society, namely to assist in the prevention of future similar tragedies. There can be no other scope for coronial criticism. After all, if there are concerns about, for example, the standard of medical care provided to the deceased, other agencies exist with the specific (and often legislative) function of addressing such issues.

If the issue is one of a compensation due to an act of negligence, the appropriate forum is a civii court of law. If the issue is one of protection of the public, and the matter concerns a registered medical practitioner, the body with the statutory obligation to take action is the Medical Board. If the issue is of negligence of such a degree that the criminal law has been infringed, it becomes a matter for the police and the criminal courts.

In all such cases if the target of the allegations is aggrieved by the decision of the tribunal, avenues of appeal exist by which redress may be sought. No such right exists in relation to criticism by the coroner.

We consequently query whether it is an appropriate exercise of the power of the coroner to make critical comments about a medical practitioner which are not directed towards the prevention of future deaths. The coroner does not have the expertise of an expert tribunal such as the Medical Board to make a proper assessment of medical matters. The coroner does not have the capacity or jurisdiction to come to a finding about standards of care, as do the civil courts.

Finally, particularly in a case such as this, regard must be had to the nature of the proceedings and the context in which those proceedings have taken place. As with all hospital-related inquests held in the ACT, this matter has attracted a great deal of media attention. Dr. Renshaw's name, and the allegations made against him, have been front-page news. Regrettably, but typically, the evidence in his favour did not receive commensurate attention. Dr. Renshaw him elf has been devastated by this matt r and it is a matter of note that after he gave his evidence he sought out counsel for the family in order to express personally the deep sadness he has experienced as a result of this tragedy. As Mr. Pilkington will recall, the depth of emotion felt by Dr. Renshaw was plain to see.

It is to be hoped that in considering whether to make the adverse comments you foreshadowed in your letter, you will take these factors into account. The questions you should ask yourself, we respectfully submit, are these:

- What benefit is sought be achieved by the making of critical comment? Is there a matter of prevention of future tragedies which cannot be addressed equally as well by the making ofrecommendations or using measures other than criticism of Dr. Renshaw?

- Given that coronial proceedings are not a trial of an individual, is there some aspect of the conduct of Dr. Renshaw which calls for coronial criticism, particularly given the amount of media attention which would accompany any such statement?

I tum now to the three adverse comments which you if it to in your abovementioned letter.

As I made clear in the submissions previously made on behalf of Dr. Renshaw, unlike in civil proceedings the court in this case does not have the benefit of expert medical

opinion which addresses the standard of care which can reasonably be expected of a general practitioner. Counsel for the family was put clearly on notice that the issue for determination in relation to standard of care was what can be expected of a GP. Despite this, and one can conclude deliberately, counsel for the family did not ask the specialists who gave evidence their view as to this issue.

When the party before the court most adverse to a particular witness fails, after having his attention drawn to the nature of the issue, to ask the relevant questions as to that issue, the court must be very slow to draw inferences in that regard.

Neither Dr. Reynolds nor Dr. Sinn stated in their evidence that the care given by Dr. Renshaw was deficient, when judged by the standards which could reasonably be expected of a general practitioner, in the manner referred to by you in your letter. On that basis, the criticisms should not be made.

It is not clear from your letter why you intend to criticise Dr. Renshaw in relation to his obtaining of a history concerning the patient. Dr. Renshaw initially took a verbal history from Sister Cassidy and then a detailed history from the family. Whilst Sister Cassidy wrote in the Accident and Emergency notes that the patient had vomited bile-like fluid, she admitted in court that she did not inform Dr. Renshaw of this. Throughout the patient's admission at Queanbeyan District Hospital the patient vomited a number of times but there is no record made by the nursing staff that he vomited bile until the time of his collapse. The fax sent by Dr. Cross to the hospital, v:hich \Vas never available to Dr. Renshaw, did not mention bile or the possibility of a bowel obstruction.

During the interview with the patient's family, the family mentioned that Dr. Cross had raised the question of a bowel obstruction. Dr. Renshaw found it impossible to believe that if Dr. Cross was seriously thinking of a bowel obstruction, she would have referred the patient to Queanbeyan District Hospital as it would be impossible for the hospital to deal with such a problem. Nevertheless, when this question was raised it prompted Dr. Renshaw to ask further questions of the family and to examine the patient again. At that time he could find no clinical evidence of an obstruction. What followed with the family was a detailed discussion of the nature and appearance of the patient's vomiting. At no time did the family mention bile.

That is the reason why Dr. Renshaw then explained in detail to the family the nature of hypertrophic pyloric stenosis, a condition in which bile is not vomited. He also discussed with the family other possible diagnoses. He did not discuss the possibility of an intussusception, as at that time there was no evidence to suspect such a condition. The presence of this intussusception, a rare condition in a general practitioner's experience, was entirely atypical. There was no evidence of severe colic (abdominal pain), no evidence of an abdominal mass nor abdominal distension, nor of blood in the motions. The patient was also somewhat younger than the age at which this condition usually presents.

The family was treated respectfully at all times. They account of what Dr. Renshaw is alleged to have said is incorrect. The allegations printed in the Canberra Times as to what he is supposed to have said to the family are simply not true and have caused him tremendous distress.

Under the circumstances it appears to be harsh and unjust to criticise Dr. Renshaw for taking an inadequate history. He did the best he could with a family which was at the time of the consultation agitated and concerned to the point of omitting information they had given other people who had been involved with them and the patient on the presumption that Dr. Renshaw was aware of the information. Even if Dr. Renshaw had read the fax from Dr. Cross it did not contain the information which the family apparently presumed it contained.

The experts both agreed that admitting Nathan to hospital was reasonable, and neither criticised the fact that the plan was for observation, as opposed to intensive investigation, on the basis of the information Dr. Renshaw had been given.

Finally, I note and am aware that you have not indicated to any other party an intention to make adverse comment against them. Presumably this means that you are not troubled by the failure, for example, of Dr. Cross to communicate the nature of the vomiting reported to her nor the possibility which she entertained as to bowel obstruction.

Presumably also you are not troubled by the failure of the nursing staff to comrnur.icate matters of concern to them, or matters which should have been of concern to them, to Dr. Renshaw - despite the fact that the experts were critical of that failure (see, for example, the evidence of Dr. Reynolds at T 7.4.98 p.44.2-4). This aspect of the matter is of fundamental importance to a proper consideration of this case. This was not the only patient requiring Dr. Renshaw' s attention - he had to devote time and thought to all of the patients in the hospital, as well as those of his practice. In those circumstances he must be entitled to rely on the assessments of and communications from the nursing staff. Dr. Renshaw did in fact inquire of the nursing staff as to the patient's condition on several occasions, and was reassured that there were no concerns. Tragically, this reassurance was, as it turned out, false.

The unchallenged evidence of Dr. Renshaw was that the doctors and nurses are a team, and that consequently the medical practitioners in that team are entitled to expect information of concern to be communicated to them. There is no evidence before you, we would respectfully submit, to allow you to downplay that responsibility. Nursing staff are health professionals just as doctors are, and their responsibilities are no less important. No one person "carries the can" for the whole team.

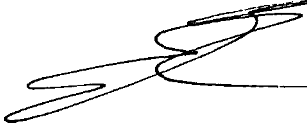
It should be noted that counsel for the hospital has made no criticism of Dr. Renshaw, and did not attempt to dispute the fact that the matters of concern to the nurses should have been communicated to him.

The clear impression left by your letter and your foreshadowed critical comments is that in your view, only Dr. Renshaw bears responsibility in this case. If this were so, it would be clearly unfair and further would not be supportable on a proper reading of the evidence. In our submission if there has been an aspect of this matter which calls for criticism, it arises as a result of the collective efforts of the health-care team. If one is to be criticised, then all must be.

A great advantage possessed by the Coroner's Court is its ability to accept into evidence matters and information which may not be admissible in other courts. The reason for this is that it is in the interests of society for a coroner to be able to fully delve into the circumstances of a death.

While a coroner may use his office in order to criticise, if such criticism is not based on the appropriate evidence, and in particular if in a medical case such criticism is not based on evidence of expert medical practitioners commenting on the relevant standard of care to be expected, the great advantage possessed by the court is misused. In our submission the office of the coroner would be damaged if this were to happen.

Yours sincerely,



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24 June 1998

Mr. J.J Dainer
Office of the Canberra Coroner
G.P.O. Box 370
CANBERRA CITY ACT 2601

Dear Mr. Dainer

RE: INQUEST INTO THE DEATH OF NATHAN WRENCH

I refer to my letter of 23 June 1998. I have realised that there is a matter to which I did not make reference in that letter, and as the time for making a submission has not yet expired, I seek now to remedy my oversight.

The effect of section 55 of the Coroners Act 1997

I referred in my letter of 23 June 1998 to the nature of coronial proceedings and of coronial criticism. No legal authorities were cited in that regard. Indeed, aside from Waller's book to which reference was made in my earlier submissions there is little Australian authority as to the issue of the permissable scope of coronial criticism.

I have unearthed a recent UK Court of Appeal decision, however, which does provide some assistance. In this case *(R v North Humberside Coroner, exparte Jamieson* [1995] 1 QB 1) the Court made reference to the Coroners Rules 1984, which provide, inter alia, as follows:

"42. No verdict shall be framed in such a way as to appear to determine any question of -

(a) criminal liability on the part of a named person, or

(b) civil liability.

43. A coroner who believes that action should be taken to prevent the recurrence of fatalities similar to that in respect of which the inquest is being held may announce at the inquest that he is reporting the matter in writing to the person or authority who may have power to take such action and he may report the matter accordingly."

While equivalent rules have not been promulgated in the ACT (similar provisions do exist in some Australian jurisdictions) it is submitted that these Rules, in any event, merely reflect what would be adopted as law in the ACT were the decision to be determined on appeal in an appropriate case. This submission receives support from the following passage in *North Humberside* (at p. lOOC-D):

> "Our law accords a defendant accused of crime or a party alleged to have committed a civil wrong certain safeguards rightly regarded as essential to the fairness of the proceedings, among them a clear statement in writing of the alleged wrongdoing, a right to call any relevant and admissable evidence and a right to address factual submissions to the tribunal of fact. These rights are not granted ... to a party whose conduct may be impugned by evidence given at an inquest."

This statement of the law applies equally in the ACT, where there is no right of appearance save with leave and where there is no right, prior to the conclusion of the calling of evidence, to be advised of the "allegations".

In our submission, the proposed adverse comments foreshadowed in your letter of 12 June 1998 have the appearance of determining a question of civil liability, namely the standard of care provided by Dr. Renshaw to the deceased. Such a comment, we submit, should not be made.

Yours sincerely,

EDSON PIKE