CORONERS COURT OF THE AUSTRALIAN CAPITAL TERRITORY

Case Title: **AN INQUEST INTO THE DEATH OF JOSEPH YATRAS**

Citation: **[2018] ACTCD 12**

Date of Findings: 28 June 2018

Before: Coroner B. C. Boss

Decision:

1. Joseph Yatras died on 26 June 2014 at The Canberra Hospital, 1 Dann Close, Garran, in the Australian Capital Territory;
2. The manner and cause of death of Mr Yatras are sufficiently disclosed and a hearing is unnecessary;
3. The manner and cause of Mr Yatras's death is left chest cavity and abdominal cavity haemorrhage due to multiple rib fractures and splenic injury due to involvement in a motor vehicle accident, with cirrhosis of the liver with portal hypertension being a significant condition which contributed to his death but was not related to the direct cause of death; and
4. Pursuant to s 52(4)(a)(i) of the *Coroners Act 1997*, a matter of public safety is not found to arise in connection with this inquest.

File Number: CD 136 of 2014

1. Joseph Yatras, a 52 year old man, was involved in a single vehicle accident on Shingle Hill Way, Gundaroo, NSW, at about 3pm on 22 June 2014. He was riding his motorcycle when he lost control of the vehicle on a sweeping left hand corner while travelling at about 40 km/hr. Mr Yatras was discovered some time later by passers by lying on his back on the grass verge. He reported having no memory of the incident.
2. Mr Yatras was transported by road ambulance to The Canberra Hospital (TCH) and was admitted initially to the Intensive Care Unit (ICU). He was diagnosed with fractured ribs on his left side, a lacerated spleen, and an aneurysm in a splenic artery. Doctors intended to operate on the aneurysm but were waiting for Mr Yatras to recover from his previous injuries so he would be in a better condition to recuperate post-surgery.

3. Initially Mr Yatras appeared to be recovering appropriately with bed rest and pain management, and he was transferred onto a general ward. However on the evening of 24 June 2014 his condition worsened, and this was believed to be related to the lacerated spleen. The next day ICU doctors attended to review Mr Yatras for consideration of return to ICU, and he was given a blood transfusion and placed under close observation.

4. At about 12:10am on 26 June 2014, Mr Yatras went into cardiac arrest. Despite lengthy attempts at resuscitation, Mr Yatras was unable to be revived.

5. A post mortem examination of Mr Yatras undertaken at my direction identified the direct cause of his death as left chest cavity and abdominal cavity haemorrhage due to multiple rib fractures and splenic injury, with cirrhosis of the liver with portal hypertension being a significant condition which contributed to his death but was not related to the direct cause of death. I make formal findings accordingly.

6. Of note, a sample of Mr Yatras's blood taken on arrival at TCH identified the presence of tetrahydrocannabinol (TCH), the psychoactive substance in cannabis, in his system at a level reported in other persons to be toxic and/or lethal, and to indicate recent ingestion of the substance. I infer that Mr Yatras was intoxicated to some degree that I am unable to quantify accurately while in control of his motorcycle.

Concurrent Jurisdiction

7. As Mr Yatras was ordinarily resident in NSW at the time of his death, and may have been (depending on the facts of the case) last at some place in NSW before the circumstances of his death arose, the NSW Coroner also potentially had concurrent jurisdiction under the NSW *Coroners Act 2009* to enquire into Mr Yatras's death.

8. I caused the Goulburn Coroner to be notified of the circumstances of Mr Yatras's death shortly after I had been notified. I was advised that the Goulburn Coroner did not wish to exercise concurrent jurisdiction and was content for me to retain carriage of the investigation; further, that NSW Police had determined that there were no suspicious circumstances in relation to Mr Yatras's death and that no person would be charged.

Matter of Public Safety

9. The pathologist who conducted the post mortem examination of Mr Yatras noted in respect of the injuries which caused Mr Yatras' death:

> I note that the injuries had been diagnosed clinically, but a decision was made to treat these injuries conservatively (ie. without surgical intervention). The extent and severity of bleeding appears to have been underestimated in this patient, to the extent that death appears to have been unexpected. I therefore recommend that review of the clinical management and autopsy findings by a qualified expert in the treatment of such patients be considered.

10. Initially I requested whether a physician from TCH would be available to conduct such a review. I did so because I am generally aware that hospitals conduct internal reviews of all adverse incidents such as deaths, and it seemed efficient that the two reviews be conducted concurrently. I was first told that TCH would consider my request, but

ultimately some months later I was told that TCH would not conduct a review of Mr Yatras's treatment on my behalf.

11. I then caused the post mortem report relating to Mr Yatras to be forwarded to TCH and requested they comment on this issue. I received no response from TCH.

12. I then issued a subpoena to the TCH Clinical Review Committee (CRC) requesting a copy of its report of the internal review it had conducted into the treatment of Mr Yatras and the circumstances of his death. I note that I did so based on advice the Court received from TCH about the way in which this document could be accessed. I then received back a letter from the ACT Government Solicitor acting for the Territory (and therefore TCH) which included the following:

> The Clinical Review Committee is an approved quality assurance committee established under the *Health Act 1993* (the Act). Section 43 of the Act states that a quality assurance committee may give protected information to the Coroner's Court if the committee is satisfied that giving the information would be likely to facilitate the improvement of health services provided in the ACT.
>
> The Clinical Review Committee Executive (the Committee) met to consider your request, noting that the report into the death of Mr Yatras contains protected information. The Committee formed the view that the release of the full report would be unlikely to facilitate the improvement of health services in the ACT, however, have agreed to release the suggestions for improvement arising from the review. …

13. The suggestions for improvement were as follows:

> 1. A process be developed and implemented to facilitate communication between treating consultants and consultation radiologists when a diagnosis is unclear.
>
> 2. Consideration be given to the installation of the PACS system for on-call review at home by consultation radiologists.

14. I infer therefore that the TCH review identified an issue in relation to diagnosis of the extent of Mr Yatras's bleeding. In my view, which is fortified by the suggestions for improvement set out above, this constitutes a matter of public safety.

15. I did however still wish to gain insight as to what had or had not been considered by the review, so I caused a letter to be sent to TCH requesting the Clinical Governance Executive Report, which my staff had been informed might be a "non-privileged version" or version for publication (indeed, possibly the version published internally to all TCH staff) of the CRC Report. I was informed by letter again that this report too fell to be considered under section 43 of the *Health Act 1993* and again the Committee formed the view that the release of the full report would be unlikely to facilitate the improvement of health services in the ACT.

16. The matter has been on foot for a considerable period of time and Mr Yatras's family are entitled to closure and findings. In respect of the matter of public safety I have found to arise, I will refer the circumstances of Mr Yatras's death to the Australian Health Practitioners Regulatory Agency for their investigation from a disciplinary perspective. I will also make a referral to the ACT Health Services Commissioner in

relation to the process and systems issues identified by the TCH CRC, and to ascertain whether the suggestions for improvement have been implemented by this time.

17. I wish to express my considerable concern with the course of action taken by TCH and specifically the CRC in this case. I accept the rationale behind protection of information given to Quality Assurance Committees such as the CRC – that confidentiality and qualified protection from liability will ensure practitioners are forthcoming and fulsome, and that this drives better health protection outcomes – and indeed the law recognises similar principles for example in relation to taxation information. However, I consider this principle needs to be qualified in circumstances where the CRC and the Coroner have a unity of purpose, which is to identify potential issues of public safety and take steps / make recommendations to mitigate against repeated incidents that could be preventable. I note also that any information released by the CRC under section 43 would still remain sensitive and subject to the protections afforded by the *Health Act 1993* whilst in the possession of the Coroner, and could not be admitted in evidence before a Court in any case (see section 47). For the CRC to take the view that release of information about the death of a patient that the Coroner is also investigating would not "facilitate the protection of health services in the ACT" is disappointing. If the CRC takes the view that section 43 acts as a barrier to information release to the Coroner's Court then I strongly suggest that it be reformed. I formally note that I have been frustrated in the conduct of my investigation by the conduct identified above. There may be an issue of public safety but the decision made to withhold information from me means that I cannot make any determination on that question.

Recommendation

18. I recommend that the ACT Government amendment section 43 of the *Health Act 1993* to avoid a repetition of this conduct.

Hearing

19. In all the circumstances as detailed above, and in light of the referrals I intend to make, in my view there is no utility in holding a public hearing in relation to Mr Yatras's death. There is no issue about which I would be empowered to hold a public hearing and which in and of itself warrants that course being taken given the state of the evidence.

20. I will publish my findings and reasons on the ACT Coroners Court website, together with any response I might receive from Ministers or Government. I will also forward a copy of this document to the Attorney-General and the Health Minister for their information and consideration.

21. I extend my condolences to Mr Yatras's family and friends.

I certify that the preceding twentyone [21] numbered paragraphs are a true copy of the Findings of Coroner B. C. Boss

Associate:

Date: 28 June 2018