Form 17
Coroners Act 2009, Sections 81 & 82

FINDINGS AND RECOMMENDATIONS

COURT DETAILS

Court	Coroner's Court of NSW
Case number	235/07

PROCEEDINGS

Inquest into the death of	**Joan DENNISON**
Hearing dates	17th - 19th November 2010
Date of findings	21st December 2010
Place of findings	Court House, Market St, Wollongong
Findings of	His Honour Magistrate Ian Guy, Deputy State Coroner

FINDINGS

I find that Mrs Joan Dennison died on 18 November 2007 at Shellharbour Hospital, Shellharbour, New South Wales, from sepsis and aspiration with metabolic dysfunction as a result of a mechanical small bowel obstruction.

RECOMMENDATIONS

To The Minister

New South Wales Department of Health

1. That the Southern Hospitals Network gives specific consideration to the inclusion of graded assertiveness training as part of the establishment of the Simulation Centre at Wollongong Hospital.
2. That the ISBAR principles continue to be emphasized in the training of all medical staff in the Southern Hospitals Network.
3. That the superseded telephone consultation check list for medical officers (appearing at page 277 of the brief of evidence) be incorporated into the training of medical officers in the Southern Hospitals Network as part of the ISBAR program.
4. That the principle that responsibility and authority for the transfer of patients from one hospital to another remains with the referring clinician in the sending hospital be emphasized to all medical staff and those staff involved in the patient transfer process in the Southern Hospitals Network.

REASONS FOR FINDINGS

1. Mrs Joan Dennison aged 78 years was a resident of South Australia. In October 2007 she arrived in the Illawarra area to visit friends. On 16 November 2007,at the insistence of a friend, she went to Shellharbour Hospital emergency department, complaining of anorexia, shortness of breath, nausea and vomiting.

2. She was seen by a medical officer who examined her and arranged for amongst other things, an x-ray of her abdomen. Concerned as to the possibility that Mrs Dennison was suffering from a bowel obstruction, the medical officer sought an opinion by telephone from the on-call surgical registrar at Wollongong Hospital. The surgical registrar expressed the provisional diagnosis of constipation with a recommendation for an enema, antiemetics and discharge.

3. The diagnosis of constipation was incorrect. Mrs Dennison had an obstruction of her small bowel. She should not have been discharged.

4. Mrs Dennison was discharged on the afternoon of 16 November 2007 and returned to her friend's home where she continued to experience diarrhoea over many hours. She collapsed at her friend's home in the early hours on 18 November 2007 and was taken back to Shellharbour Hospital emergency department. Efforts to re-hydrate and stabilise Mrs Dennison were unsuccessful. She suffered ultimately a cardiac arrest and died.

5. Mrs Dennison's death was directly related to the bowel obstruction and the complications from that condition.

Nature of an Inquest

6. Before turning to the issues, it is important to briefly outline the nature of an inquest.

7. It should be noted that the role of a Coroner is limited by statute, in particular under section 81 of the Coroners Act 2009, to return a finding, where there exists sufficient evidence, as to the identity of the deceased, the date, place, manner and cause of death. An inquest is not adversarial in nature. It is neither a criminal nor civil proceeding.

8. Section 82 allows for recommendations to be made by the Coroner as are considered necessary or desirable in relation to any matter connected with the death with which the inquest is concerned. Such recommendations are more often seen in cases involving public health and safety.

9. Apart from the statutory functions and power to make recommendations, an inquest may serve the important function for family members to understand the circumstances surrounding the death of a loved one.

10. The main focus of this inquest has been the manner of Mrs Dennison's death. A volume of evidence has been presented in an effort to clarify the circumstances of the death and the actions of the Hospital and staff.

11. It should be noted that it is not the function of the Coroner to make formal findings of negligent behaviour on the part of any particular medical staff involved in the care of Mrs Dennison. Nor is the Coroner's role to sit as a type of medical misconduct tribunal. Where specific or systemic failings of an individual or of the Hospital are identified as contributing to the death, any commentary or findings are done so in the context of determining manner and cause of death.

Issues arising in the Inquest

12. The inquest has concentrated upon the circumstances surrounding or manner of Mrs Dennison' death. The medical cause of death is clear from the post mortem report. It records the direct cause of death as sepsis and aspiration with metabolic dysfunction. The antecedent causes are mechanical small bowel obstruction due to fibrous adhesion of small bowel in pelvis from previous abdominal-pelvic surgery.

13. The issues that principally arose in evidence at the inquest to which reference will be made in these findings can be conveniently listed as follows—

    1. The actions of Dr Tsia at Shellharbour Hospital.
    2. The actions of Dr Koshman at Wollongong Hospital.
    3. The level of communication between the 2 doctors and generally within Hospitals.
    4. The communication between the doctors by telephone.
    5. The transfer of patients to Wollongong Hospital.
    6. The introduction of morbidity and mortality meetings.

Issue 1 –The actions of Dr Tsia on 16 November 2007

14. Dr Tsia saw Mrs Dennison at about 2 pm. She had previously been seen by a nurse and the clinical records indicate she had been given some maxalon to assist with nausea.

15. Dr Tsia was at that time, a medical officer with several years experience working on a casual basis in the emergency department of Bulli and Shellharbour Hospital.

16. His observations of his examination and patient history are not contained in the hospital clinical notes but rather in a discharge letter dated 16 November 2007 addressed to the emergency department of Shellharbour Hospital, a copy of which was given to Mrs Dennison.

17. The letter records Ms Dennison presenting to the hospital with nausea and anorexia. It states--

    > "The diagnosis was hyper emesis"

18. As noted by Dr Truskett, Consultant Surgeon, who gave evidence at the inquest, this means vomiting and is not in fact a diagnosis.

19. The letter records the medical background and current medications, stating –

    > '.. vomiting and nausea past few days. Had similar episode last week spontaneously resolved and felt it was due to some food poisoning. No diarrhoea, chest pain, SOB, URTI, cough. No fevers, sweats, rigors. Looked at itself in mirror and concerned about significant weight loss. No abdominal pains."

20. The discharge letter then notes the following --

    > "On examination, pleasant not distressed. A febrile and haemodynamically stable. Heart sounds dual. Chest tight. Nil crackles audible. Abdo bloated with gaseous distension and mildly sore on the deep palpation generally. Nil rebound or guarding."

21. According to Dr Tsia, he examined Mrs Dennison approximately 4 occasions during her time in the emergency department. Each time the result was that her

abdomen was soft, somewhat bloated and distended and mildly sore on deep palpation with no rebound or guarding.

22. Dr Tsia ordered basic blood tests (which came back normal) and abdominal x-rays. He said he interpreted the results as showing lots of gas and faeces in the descending colon and a few air fluid levels in the small bowel.

23. Dr Tsia says he was not entirely certain whether it was constipation or bowel obstruction as the faecal loading was consistent with constipation, but the air fluid levels indicated a possible bowel obstruction. He was concerned enough about the possibility of a bowel obstruction to contact the on call surgical registrar at Wollongong Hospital.

24. The reason he contacted Wollongong was that Shellharbour Hospital did not have 24-hour on-site surgical registrar coverage. A surgical registrar is rostered on duty from 8 a.m. to 4:30 p.m. Monday to Friday. There is an on-call consultant surgeon available from 6 a.m. to 6 p.m. Surgery does not occur at Shellharbour on Fridays. It appears that a surgical registrar may attend on Friday ward rounds at Shellharbour and then return to Wollongong Hospital. The date of Mrs Dennison's first admission was in fact a Friday.

25. Shellharbour has a low risk elective surgery services. Patients presenting to Shellharbour deemed to require admission or surgery are routinely transferred to Wollongong and are not admitted to Shellharbour.

26. As there was no surgical registrar readily at hand, Dr Tsia rang the on-call registrar at Wollongong, Dr Koshman.

27. The account of Dr Tsia's conversation with Dr Koshman includes --

> "Her abdomen is soft and she has no abdominal pain. She is a bit bloated but there is no rebound or guarding. I have given her some anti-emetics and since then she has not vomited further. Her bloods are normal. X-rays show faecal loading of the descending colon and a few air fluid levels and dilated loops of bowel. My impression is a bowel obstruction. What would you like me to do with her?"

28. According to Dr Tsia, he gave the registrar the medical registration number (MRN) of Mrs Dennison over the phone; there was a pause in conversation at which time he assumed Dr Koshman was looking at the x-ray films on the computer at Wollongong hospital. Dr Koshman told him to give Mrs Dennison an enema and anti-emetics before discharging her with advice to return to Wollongong Hospital should her condition worsen.

29. Consistent with the advice, an enema and anti- emetics were given with what the doctor described as a good result. He again examined her prior to discharge.

30. Dr Tsia generated a second letter dated 16 November 2007, again addressed to the emergency department at Shellharbour Hospital. The letter has the heading as follows –

> Imp--Nausea due to sub acute obstruction/ileus

31. The letter states --

> "Discussed with surgical registrar and has advised fleet enema and anti emetics and for discharge home with a view to presenting to Wollongong ED if nausea and vomiting worsens occurs or becomes symptomatically unwell with. Advised regular laxatives."

32. The letter then went on to deal with issues about weight loss and mental and medication.

33. When viewing the x-ray, Dr Tsia used the Hospital's picture archiving communications system (PACS). It is a film less x-ray system. High-resolution monitors are installed throughout the area hospital network. Access to images is instant from any terminal in the network. Relevantly, the network includes Wollongong Hospital. Hardcopy x-rays are not produced through this system.

34. It is clear that Mrs. Dennison had her abdominal x-ray at 2:37 p.m. The procedure was completed at 2:48 p.m. The computer image of the x-ray became available about that time both at Shellharbour and Wollongong.

35. A radiologist reviewed the x-ray. An audio file of his report was available on the system at 4.27pm on 16 November 2007.

36. The report said --

> "There are gas filled dilated loops of small bowel consistent with a small bowel obstruction. Clips are seen from previous surgery."

37. Mrs Dennison was discharged from Hospital at 4.50 pm.

38. Dr Tsia did not listen to the audio format x-ray report before Mrs Dennison's discharge.

The diagnosis of sub acute bowel obstruction / ileus

39. There was according to Dr Truskett, no basis for a diagnosis of ileus. There was according to Dr Truskett a very strong case for bowel obstruction rather than sub-acute.

The interpretation of the x-ray

40. The effect of the evidence from Dr Leslie, Medical Director of the emergency department of Shellharbour Hospital and Dr Truskett is that although some x-rays may show subtle signs of a possible diagnosis, this was not such a case.

41. As Dr Leslie said, he had no doubt this was a surgical case, that is, a bowel obstruction, and every doubt that it was constipation case. Among a number of signs of a bowel obstruction was the significant weight loss that suggests an inability to absorb food due to the blockage.

42. Dr Tsia was in fact correct in having a concern that the symptoms displayed by Mrs Dennison were consistent with a bowel obstruction. The x-ray request form completed by Dr Tsia has a comment directed to the radiologist querying bowel obstruction.

43. The analysis of the x-ray by Dr Tsia and the information that was subsequently conveyed to Dr Koshman was however seriously flawed.

44. The evidence from Dr Leslie and of Dr Truskett was that contrary to the opinion of Dr Tsia expressed in his discharge letter, the x-ray did not in fact show lots of gas nor did it show lots of the faecal matter.

45. Moreover, both Dr Leslie and Dr Truskett identified 2 significant features of the x-ray that were not properly considered or considered at all by Dr Tsia. They were the existence of multiple air fluid levels and dilated loops of bowel.

a. Multiple air fluid levels

46. Although there are several air fluid levels within the abdomen as a matter of course, where there are a number of air fluid levels beyond approximately 2 to 3, (the figure varying slightly as between expert opinion), it is a significant clinical indicator of bowel obstruction. Here, the x-ray revealed at least 6 to 7 additional air fluid levels.

47. Dr Tsia recorded in his discharge letter "a few" air fluid levels. This imprecise term was conveyed to Dr Koshman in the telephone call.

b. Dilated loops of bowel

48. Dr Leslie explained that where there is a bowel of obstruction, and a person continues to eat, the bowel becomes distended or dilated. The existence of dilated loops of bowel is a particularly significant indicator of bowel obstruction.

49. When this feature was pointed out on the x-ray during the inquest, the appearance of the dilated loops of bowel, even to a layperson, was of striking appearance.

50. The discharge summary letter prepared by Dr Tsia makes no reference to dilated loops of bowel as having been seen by him. If Dr Tsia did in fact recognize this feature, did he convey this important piece of information to Dr Koshman?

51. Although Dr Tsia records in his statement that he did tell Dr Koshman of the existence of dilated loops of bowel, he fairly conceded in his evidence that his recollection at the time of making his statement may very well have been influenced by his review of the x-ray report which contains these words. I am satisfied on the evidence that Dr Tsia did not convey this information to Dr Koshman.

Dr Tsia's understanding of the appropriate treatment

52. Dr Leslie and Dr Truskett indicate that an enema is for treatment of constipation. Although it may produce some faeces, it would have no effect on a small bowel blockage.

53. It is clear that a small bowel blockage diagnosis or differential diagnosis should ordinarily mean the patient is admitted for observation and further examination to determine the nature and extent of the obstruction.

54. On the state of the evidence, it is difficult to determine what Dr Tsia understood to be the rationale for the plan to administer an enema to Mrs Dennison.

55. There are 2 likely scenarios. The first is that Dr Tsia considered the possibility that Mrs Dennison had a small bowel obstruction but was ultimately swayed by the opinion of a more senior doctor to administer treatment inconsistent with bowel obstruction and consistent with treatment of constipation. If this scenario is correct then the decision to accept treatment for constipation demonstrated a lack of assertiveness by Dr Tsia and a lack of patient advocacy on behalf of Mrs Dennison.

56. This issue of communication with another doctor will be discussed further in issue 3 below.

57. The second and potentially more troubling scenario comes from the evidence given by Dr Tsia at the inquest. Dr Tsia said in evidence that the treatment plan of an enema as recommended by Dr Koshman was not of concern to him. He explained that about a week before 16 November 2007, he dealt with a patient at Bulli Hospital with a similar presentation and x-ray result. A telephone call to a surgical registrar produced the recommendation of an enema. He said it appeared to be successful treatment and he therefore assumed as a result of the Bulli Hospital event that giving an enema was in fact the latest treatment plan for a bowel obstruction.

58. This apparent belief was reinforced when dealing with Dr Koshman. When the advice of an enema was again given, he believed this represented the latest treatment plan.

59. If this is account is accepted, it represents on any view an extraordinary departure from the standard practice and training in dealing with a small bowel obstruction. Dr Tsia has apparently accepted this new course of treatment without question. It is reasonable to assume that such a radical plan of treatment would excite some interest as to why there has been such a change and how it is that an enema placed in the rectum can have an effect on a blockage in the small bowel. Dr Tsia was perhaps understandably unable to offer an opinion as to how such a treatment would work. There is nothing in the statement Dr Tsia provided to the inquest that supports the contention that he understood that an enema represented new treatment for bowel obstruction.

60. This apparent belief of a new treatment is in fact inconsistent with paragraph 32 of Dr Tsia's statement, in which he outlines his understanding that where small bowel obstruction is diagnosed, the patient is admitted, a nasal- gastric tube inserted, nil by mouth and an investigation of the cause of the obstruction often by C. T. scan. He said he did not institute those measures because of the advice given by the surgical registrar (Dr Koshman). Pressed as to why the statement records his understanding of a practice that is inconsistent with an enema being the latest bowel obstruction treatment, he said the statement represented his understanding prior to the Bulli hospital event and Mrs Dennison's case and now represents his correct understanding of the procedure to follow.

61. It is fair to say that I found the explanation as to his understanding of an enema as the latest treatment unconvincing. If this did represent his belief at the time, it follows that Dr Tsia would have acted no differently and proceeded to discharge Mrs Dennison even if he had accessed the x-ray report in oral format that confirmed a bowel obstruction. It also raises very serious concerns as to Dr Tsia's clinical skills.

Conclusion as to issue 1

62. The possibility of bowel obstruction was correct. Thereafter there were a disturbing number of serious clinical errors made as to the x-ray findings, their communication to Dr Koshman and the ultimate treatment given and decision to discharge Mrs Dennison.

Issue 2 – The actions of Dr Koshman

63. Dr Koshman is an experienced medical practitioner. An Urologist for some 13 years in Ukraine before arriving in Australia in 1994,he worked for about 6 years from 2001 as a surgical registrar, advanced trainee in general surgery at Prince of Wales Hospital. In 2007, he was undertaking a six-month secondment to Wollongong Hospital.

64. On the day Mrs Dennison attended Shellharbour Hospital, he was the surgical registrar at Wollongong Hospital rostered to have the pager for the surgical team. He described that pages concerning a surgical matter can occur from a number of sources including calls from doctors in the emergency department at Wollongong Hospital, calls from other hospitals such as Bulli and Shellharbour and from the various wards within Wollongong Hospital.

65. He says that at the time he received the page, he was scrubbing in the operating theatre at Wollongong Hospital. He took the call and then returned to the procedure he was to undertake.

66. According to Dr Koshman, he was told over the phone that there was a 79-year-old patient who had presented with nausea, loss of appetite and abdominal discomfort. He was advised the abdominal examination was largely unremarkable and blood tests normal. He was told that the plain abdominal x-

rays showed faecal loading of the large bowel and a few air fluid levels on erect views.

67. According to Dr Koshman, on the basis of the clinical information provided and the description of the x-ray given by the medical officer he formed the view the most likely diagnosis was constipation with a differential diagnosis of early sub acute small bowel obstruction. He stated the appearance of faecal loading of the large bowel and the apparent lack of acute abdominal symptoms made constipation the most likely diagnosis and that ordinarily where there is a small bowel obstruction he would have expected significant abdominal pain and distension, no flatus or stools, dehydration and violent non-stop vomiting.

68. A further factor leading him to the provisional diagnosis was that he was told there were a few air fluid levels on the erect x-ray views and that ordinarily he would need to see 4 to 5 air fluid levels in order to diagnose a small bowel obstruction. He said that he did not think that acute small bowel obstruction was the most likely diagnosis. In statement dated 7 July 2009,Dr Koshman stated ---

69. “Given the circumstances including information available to me I believe that my actions including advice I gave to the doctor from Shellharbour were appropriate.”

70. He then went on to say that the doctor caring for her had a number of options including observing and monitoring, admitting her, seeking further input from the hospital and further radiological input.

The diagnosis of constipation

71. Dr Truskett said a diagnosis of constipation would be reasonable if the information provided to Dr Koshman was limited to that set out above. Two issues arise however, namely whether Dr Koshman was in fact given more information and whether it is appropriate to rely upon only the information provided in order to form a proper diagnosis.

Was more information given to Doctor Koshman?

72. It is clear from the evidence of Dr Truskett that the presence of vomiting would be very rare with constipation. It follows that the presence of vomiting is a clinically significant indicator that the patient's condition was not constipation.

73. Dr Koshman’s statement and the letter to the hospital dated 25 November 2007 make no reference to vomiting. Dr Tsia was undoubtedly given a history of vomiting by Mrs Dennison. It is logical to assume that Dr Tsia would tell Dr Koshman this fact. The second letter prepared by Dr Tsia records the plan from Dr Koshman that an enema and anti-emetics be given. Anti-emetics are given to stop vomiting. The letter records the plan was for Mrs Dennison to return if the nausea and vomiting worsens. The letter written by Dr Koshman on 25 November 2007 to the hospital confirms that his plan involved the giving of anti-emetics.

74. The evidence supports the conclusion that it was highly probable that Dr Koshman was it fact given more information than claimed.

Reliance upon information from Dr Tsia

75. Although I am satisfied Dr Koshman was given more clinically significant information than he asserted, it was not appropriate in this case to make a diagnosis only on the information given.

76. Dr Koshman did not ask whether Mrs Dennison was in fact constipated or whether she had opened her bowels, something according Dr Leslie that should be asked. He did not ask how many air fluid levels were seen on the x-ray. He was told there were a “few “. Given that Dr Koshman considered the existence

of 4 to 6 air fluid levels were clinically significant, the question that logically arises is what in fact constitutes a "few". It was not asked.

77. It is also of particular concern that Dr Koshman failed to look at the x-rays that were in fact available.

Why the x-rays were not viewed

78. Dr Tsia says he gave Dr Koshman the patient registration number (MRN) over the phone. There was a pause and he assumed Dr Koshman was viewing the x-ray.

79. At the inquest, Dr Koshman could not recall being told of the MRN although he does recall being given the patient's name. It is reasonable to assume that if Dr Tsia had bothered to give a patient's name, then provision of the MRN, which allows a doctor within the network to access significant x-ray information, would also be given.

80. Regardless whether or not the MRN was given, Dr Koshman was aware from the telephone discussion that x-rays were in existence. He has provided 2 main reasons for not viewing the x-rays.

81. The first explanation was essentially one of a physical inability to view them. The letter to the Director of Clinical Services dated 25 November 2007 states he was unable to check the x-ray himself because he was scrubbing in theatre at Wollongong Hospital for an emergency operation.

82. This explanation is picked up in the Hospital Root Cause Analysis, which states –

> "The medical officer at the regional hospital was scrubbing for surgery and was unable to view the x-ray at the time of the telephone consultation."

83. There was as fairly conceded by Dr Koshman at the inquest, in fact nothing to prevent him from viewing the x-rays. There are numerous computer terminals throughout the hospital and he in fact stopped the scrubbing procedure in order to take the telephone call.

84. This explanation of an inability to view x-rays is at odds with the explanation provided in his statement. He stated he expected hard copy films would have been available at Shellharbour when speaking with the medical officer but that his experience was it could take a few hours for the actual films to be put on to the computer system for viewing at Wollongong. He said he was doubtful that they would have been available when he spoke to the doctor from Shellharbour.

85. This explanation does not sit comfortably with the fact that he was an experienced doctor who would receive calls on a regular basis seeking a surgical opinion and was familiar at that time with the PACS x-ray system.

86. The explanation is inconsistent with the fact that hard copies are not in fact produced by the PACS system and are available for viewing at the same time throughout the network. Dr Koshman advanced at the inquest that he was referring to a portable x-ray system available in the emergency department that produces hard copies. There was however, nothing in the information provided to suggest Mrs Dennison was in such a condition that a portable system had been used. Nor is there anything in Dr Koshman's statement to suggest that he was referring to such a system.

87. I consider it is unlikely Dr Koshman turned his mind to the availability of the x-ray. If he did in fact turn his mind to it, the logical and proper step would be to simply check the system.

The decision to recommend discharge from hospital

88. Dr Truskett is critical of the decision to discharge Mrs Dennison when there existed a differential diagnosis of bowel obstruction.

89. Dr Truskett described making a diagnosis and determining a treatment plan as involving risk management of the patient. A primary diagnosis may be relatively benign, such as a diagnosis of constipation. A differential diagnosis of another condition may potentially have far more serious consequences for patient safety. In the case of bowel destruction there can be bowel ischemia that leads to bowel necrosis and perforation. Dr Truskett says bowel destruction should not be managed as an outpatient. He stated that where a diagnosis of bowel obstruction was entertained, it would have been mandatory that Mrs Dennison be admitted to hospital for ongoing management.

90. As for the diagnosis itself, Dr Truskett is also critical of the features of bowel obstruction that Dr Koshman said he would expect to see, namely abdominal pain, distension, no flatus or stools, dehydration and violent non-stop vomiting. Dr Truskett stated –

> "This represents the extreme case of bowel destruction. Far more subtle presentations can occur and he should be aware of this".

Conclusion in relation to issue 2

91. There was a significant failure on the part of Dr Koshman to properly assess and question the information provided over the phone and a critical failure to view the x-rays .The result was a flawed diagnosis and treatment plan for Mrs Dennison.

Issue 3. The level of communication between the 2 doctors and general communication problems

92. The level of communication between Dr Tsia and Dr Koshman would be described as poor. Amongst the deficiencies was an assumption that Dr Koshman was viewing the x-ray and not asking if this was the case; a lack of discussion about an apparent new treatment using an enema; a failure by Dr Koshman to ask a number of clinically significant questions; the absence of a proposed plan by Dr Tsia and an failure by Dr Koshman to state his diagnosis.

93. Dr Truskett said the way a doctor communicates their concerns to another doctor is not done well. Efforts are being made to address these deficiencies in medical training.

94. One of the problems identified by both Dr Leslie and Dr Truskett is the lack of assertiveness by some medical staff in conveying their concerns.

95. In the case of Dr Tsia, he was described without criticism as being timid in nature.

96. Dr Truskett considered that Dr Tsia should have been more assertive and should not have agreed to the discharge of Mrs Dennison. He stated --

> "If Dr Tsia as a senior medical officer was concerned about the advice given, then he has a duty of care to challenge the assessment made by the surgical registrar by this telephone assessment."

97. Another way of stating this duty is the principle of patient advocacy. Not in the sense of a dispute with hospital management but rather acting in the best interests of the patient.

98. One of the difficulties in this inquest is that on one view of the evidence, Dr Tsia was not concerned with the treatment plan, as he believed administration of an enema to be the new method to address bowel obstruction. If this was the

case, he had a duty to ask questions about it given it went against his past medical training in such a significant way.

99. If it was, as set out in his statement, that he did not implement the normal treatment due to the advice given by a more senior doctor, he had a positive duty to challenge the proposed plan.

100. This lack of assertiveness and lack of patient advocacy arises in part according to Dr Leslie and Dr Truskett from under equal power balance -- a junior doctor feeling obliged to take the advice of a more senior doctor.

101. Dr Truskett described it as a cultural issue within the medical profession involving a power hierarchy at play.

102. I was advised that the Southern Hospitals Network has been provided funding to establish a Simulation training Centre at Wollongong Hospital. Given the comments by experienced doctors at the inquest, there is much to be said for the inclusion of appropriate assertiveness training as part of the Simulation Centre program.

Conclusion in relation to issue 3

103. It is undoubtedly the case that further education is vital to address this perceived imbalance and to educate doctors to be appropriately more assertive in their dealings with other medical officers in the best interest of their patient. This is a proper matter for a recommendation.

Issue 4.Communication between the doctors by telephone

104. The Hospital says that the system of a medical officer at a satellite hospital having a telephone consultation with a registrar at Wollongong hospital is the practice of all hospitals within the Southern Network that have emergency departments. They are Shellharbour, Shoalhaven, Bulli and Milton.

105. The Hospital says that this reflects the practice in other health services in NSW and in other states and territories of Australia.

106. Arising from the Root Cause Analysis investigation into the death of Mrs Dennison, a telephone consultation check list was introduced in May 2009.This checklist required both doctors to follow a number of steps including reviewing the x-rays and referring to the verbal or written x-ray report if available at the time of consultation.

107. The telephone checklist was superseded by the State Clinical Handover policy and “Caring Together” action plan, which was introduced to improve clinical handovers. It is clear that a very large number of incidents affecting patient safety stem from inadequate communication and transfer of critical information.

108. The standardised approach to communication between health professionals at handover that has application to discussions between doctors located at different hospitals is known as “ISBAR”---introduction, situation, background, assessment, and recommendation.

109. The consensus at the inquest was that this is a valuable initiative in improving patient safety. There was also a view that there was merit in including the more practical steps of the telephone checklist in the training of medical officers.

110. Dr Leslie made the valid comment that unless staff has the opportunity to be properly trained the new policies and procedures will be of little benefit. What is of potential concern is that “ISBAR” training is not available to staff employed as locums. This issue was not the subject of direct relevance to the death of Mrs Dennison and evidence from the Hospital was not understandably presented.

As locums would inevitably be engaged to work at times after hours, the need for those doctors to be trained is even more apparent.

Conclusion in relation to issue 4

111. Better communication between the doctors may have led to a different outcome for Mrs Dennison. There is a proper basis for a recommendation for continued ISBAR training.

112. Although not a formal recommendation, I comment that there appears merit in ISBAR training being made available to all medical staff in the Southern Hospitals Network. I ask that my comment be brought to the attention of the relevant agencies that provide locum staff and to that section of the Hospitals Network that oversees the engagement of locum staff.

Issue 5. The transfer of patients to Wollongong Hospital.

113. Apart from the need for better communication skills particularly over the phone, there needs to be clarity as to who has the ultimate responsibility for the transfer of a patient to Wollongong Hospital.

114. The Hospital states that since the death of Mrs Dennison, guidelines have been implemented for Hospitals within the Southern Network in relation to the transfer of trauma patients requiring urgent clinical intervention procedures who attend at an emergency department and who require a higher level of care at another hospital. They contain the procedural steps to take and a non-exhaustive list of situations that indicate a need for transfer.

115. Although not directly the subject of the inquest and accordingly not a case for a formal recommendation, Dr Leslie expressed concerns about the delay experienced in the transfer of patients from Shellharbour to Wollongong Hospital. Among the numerous factors that may determine when and if a transfer of a patient occurs, Dr Leslie noted that the benchmark timeframes for treatment of a surgical patient at Wollongong Hospital do not commence until the patient arrives at Wollongong. A patient otherwise requiring transfer to Wollongong Hospital could hypothetically remain at Shellharbour for a period that does not lead to a breach of the time standards at Wollongong Hospital.

116. It is clear that it is the doctor who sees and physically examines the patient who is in the best position to determine what is in the patient's best interests. It is undoubtedly the case that ultimate responsibility for the decision to transfer should rest with the referring doctor i.e. in this case it would involve the Shellharbour Hospital doctor.

Conclusion in relation to issue 5

117. Given concerns expressed about the lack of assertiveness by some medical staff and the existence of an imbalance between doctors of various seniority, there should be a recommendation that there be further education of medical staff and all those who are involved in the process of patient transfer that ultimate responsibility and authority for the transfer of patients from one hospital to another remains with the referring clinician in the sending hospital.

Issue 6.Morbidity and Mortality Meetings

118. Morbidity and Mortality meetings play an important role in hospital safety.

119. They provide an opportunity for various hospital staff to discuss in an informal setting the treatment of a particular patient, to discuss complications and errors in treatment and other ways to prevent a repetition of errors or complications. They provide an important source of identification of deficiencies in systems and policies with in a Hospital, which may affect patient care. The meetings are held not to accuse or blame but rather to improve patient care.

120. They are a regular feature in most public and private hospitals.

121. The reason no meeting was held in relation to the death of Mrs Dennison was that remarkably, no such meetings were ever conducted at the Hospital until their introduction in April 2008.

122. It is noted that an Area Policy document was issued in 2008 requiring hospitals in the Southern Network, including Shellharbour Hospital to conduct regular morbidity and mortality meetings.

Conclusion on issue 6

123. A meeting to discuss Mrs Denison's death did not occur because there was no system in place for such meetings at the Hospital. This significant deficiency in the Hospital's focus on patient safety has now been addressed.

An Avoidable Death

124. The medical system is no different to other organisations in that from time to time human error will occur. The consequences however, of serious errors in a Hospital system can endanger patient safety. Accepting that no system is perfect, there were nevertheless, marked failings in the care of Mrs Dennison.

125. Significant clinical errors of judgement occurred at both Shellharbour and at Wollongong Hospital. Serious failings in the level of communication between the doctors occurred .It is irresistibly the case that Mrs Dennison should never have been discharged from Hospital on 16 November 2007.Mrs Dennison's death was avoidable.

126. The challenge for an organisation is to learn from such a tragic death and introduce changes in procedures to minimise a recurrence. It is hoped that the family will take some comfort that the Hospital has taken some steps to address deficiencies in their policies and have joined in supporting the recommendations to the Minister for Health, which it is hoped, will improve patient safety in the future.

127. The Court extends to the Dennison family its sincere condolences for their loss.

SIGNATURE

Signature	
Name	Magistrate Ian Guy
Capacity	Deputy State Coroner
Date	21 December 2010