LOCAL COURT of NEW SOUTH WALES

Coronial Jurisdiction

Inquest:	**Inquest into the death of** **MICHAEL SUTHERLAND**
Hearing dates:	6 – 9 June 2011 Batemans Bay Local Court
Date of findings:	14 July 2011
Place of findings:	State Coroner's Court, Glebe
Findings of:	Deputy State Coroner H.C.B. Dillon
Findings:	I find that MICHAEL SUTHERLAND died on 3 March 2006 at Cobargo, New South Wales of faecal peritonitis which was not diagnosed before his discharge from the Emergency Department of the Bega Hospital on 2 March 2006.
Recommendations:	***To the Minister for Health:*** I recommend that the Southern NSW Local Health Network consider installing a CT scanner at the Bega Hospital.
File number:	1636/08
Representation:	Mr D Hirsch (Counsel Assisting) instructed by Ms L Darcy (Crown Solicitor's Office) Mr R Sergi instructed by GILD Insurance Litigation Pty Ltdrepresenting Southern NSW Local Health Network Mr G Butler instructed byAvant Law representing Dr D Bonney Ms N Rudland instructed by NSW Nurses' Association representing RNs L Drinkwater, J Phillips and D Tabor. Ms K Doust instructed by NSW Nurses' Association representing RN S Liersch

REASONS FOR DECISION

Introduction

1. Michael Sutherland died in great pain on 3 March 2006 of undiagnosed and untreated faecal peritonitis after being discharged the day before from Bega Hospital. Perhaps even more poignantly, while at the hospital, he was refused the pain relief he needed for his excruciating condition. This inquest has explored the questions of how and why the hospital failed to diagnose his life-threatening condition and, just as importantly, why the treating clinicians at the hospital failed to give adequate pain relief and why they discharged him although he was clearly very ill.

2. Medical diagnosis is an art as well as a science. Diagnosis can be shrouded in uncertainty because signs and symptoms are ambiguous and may point towards a number of differential diagnoses. Viewers of the television program "House" will be familiar with the process of doctors attempting to sift through a number of differential diagnoses. If a patient is obviously sick and a diagnosis has not been reached, it is poor clinical practice for that patient to be discharged from a hospital he or she has attended at least until a diagnosis has been reached and a treatment plan decided upon. Unfortunately, it appears that, in the absence of a firm diagnosis, one or more of the clinicians involved in his care came to a view that Mr Sutherland was feigning his condition in order to obtain opioid drugs. There was no reasonable basis for that opinion but he was sent away and died trying to get home.

3. Following Mr Sutherland's death, his friend Penelope Jones complained to the Health Care and Complaints Commission and later to the State Coroner. In her letter to the State Coroner she wrote:

> I beg you to hold a Coronial Inquiry into this incident… Michael's friends and loved ones are bewildered and angry. He was a capable, kind and gentle man. He was not a "junkie" or addict, nor a mental case. And even if he was…?
>
> I am writing to you because we need to know what happened. The hospital must explain why such a terrible error of judgment occurred and take steps to prevent it happening again. Duty of Care should be extended to everyone.

4. A sudden and unexpected death can raise troubling questions and issues. Civilised societies know that what harms one of its members may harm many others. One of the functions an inquest may serve is to allay suspicions and fears by seeking to find out how that death came about, thus helping the living commemorate the dead with some peace of mind.

5. The primary statutory function of a coroner is to seek answers to the following questions: Who died? When and where did he or she die? What was the cause of death? And what was the manner of the death? In this case, answers to the first four questions are not in issue. The focus of this inquest has been on the question of manner of death, that is, the circumstances of Mr Sutherland's death and what led up to it.

6. Mistakes are unfortunately frequent in complex systems like hospitals. Most, fortunately, do not lead to catastrophes because complex systems generally also have inbuilt defences against the consequences of single errors. Complex systems are, however, always works in progress and can almost always be made safer. Coroners seek to learn from experience to help prevent similar sorts of deaths recurring.

Michael Sutherland

7. Before considering the evidence, it is important to remember that at the centre of the inquest is human being who was loved and mourned by his friends. Michael Sutherland had no family but his close circle of friends described him in most affectionate terms.

8. They depicted him as a gentle man who was kind and generous to others and who had a strong spiritual life based on his Hindu religious beliefs. It seems that he developed his spiritual beliefs following a period working as a correspondent in south-east Asia during the conflicts there in the 1970s. He was a passionate and skilful gardener who produced high quality vegetables for restaurants. While he enjoyed cannabis, sometimes in large amounts, he did not use other drugs, did not drink and had a vegetarian diet.

9. A couple of years before his death,] he had had the terrible experience of seeing a young man burn himself to death before his eyes and suffered post-traumatic stress disorder. He was treated for this. He had also suffered serious physical illnesses previously: Q-fever

and Hepatitis B and C. Most unfortunately for him, he also developed diverticulitis. Eventually, this caused his death.

The issues

10. Before the inquest commenced, an issues list compiled by Counsel Assisting was circulated as follows:

    (i) The clinical history, signs and symptoms elicited or observed by the staff of Bega District Hospital ("the Hospital") on 2 March 2006.

    (ii) The results of investigations performed by the Hospital.

    (iii) The treatment given to Mr Sutherland and the significance or otherwise of his response to that treatment.

    (iv) The provisional diagnosis of constipation and whether this was consistent with the clinical history, signs and symptoms, the results of investigations performed and Mr Sutherland's response to treatment given.

    (v) The provisional diagnosis of drug withdrawal and/or drug seeking behaviour and whether this was consistent with the clinical history, signs and symptoms, the results of investigations performed and Mr Sutherland's response to treatment given.

    (vi) The provisional diagnosis of post-traumatic stress disorder and whether this was consistent with the clinical history, signs and symptoms, the results of investigations performed and Mr Sutherland's response to treatment given.

    (vii) The decision to discharge Mr Sutherland home at 1900 on 2 March 2006 with the medications he was given at that time.

    (viii) Whether and if so what further investigations (including further x-ray views) ought to have been performed by the Hospital and the likely results of these had they been performed.

    (ix) Whether there were any and, if so, what failures of communication by staff at the Hospital regarding the management of Mr Sutherland.

(x) Whether the availability or otherwise of a hospital bed was a relevant consideration in the management of Mr Sutherland.

(xi) Whether the availability or otherwise of CT scanning facilities was a relevant consideration in the management of Mr Sutherland.

(xii) To what extent, if any, would the chances of Mr Sutherland dying on 3 March 2006 have been reduced if:

(a) The clinical presentation (including the history, signs and symptoms, the results of investigations and the response to treatment given) had been managed differently

(b) Further investigations had been done

(c) Any failures of communication had not occurred, and

(d) He had not been discharged at 1900 on 2 March 2006 but rather kept in hospital (or sent to another appropriate facility) for further observation and management.

(xiii) Any recommendations considered necessary or desirable to make in relation to any matter connected with the death including by not limited to:

(a) The management of a patient with an "acute abdomen", and

(b) The management of a patient thought to be exhibiting drug-seeking behaviour.

11. There is no question that Mr Sutherland's condition and deterioration on 3 March was misdiagnosed. In essence, these issues may therefore be distilled into four questions:

- What happened when Mr Sutherland presented at Bega Hospital?
- What went wrong and why?
- What can be learned from this experience?
- What more should be done?

What happened at Bega Hospital?

12. Mr Sutherland had suffered diverticulitis for some time before his death. In the two or three days before he presented at Bega Hospital his pain had been gradually increasing in intensity. He had resisted the suggestion of seeing a doctor or going to hospital but his friend, Antonio Anzevino ultimately persuaded him on 2 March 2006 that he needed urgent medical attention. Mr Anzevino called an ambulance.

13. When the ambulance arrived, the paramedics immediately assessed him. Paramedic Phillip Krucler took a history that Mr Sutherland had been woken by abdominal pain earlier that morning which had increased in intensity. On examining Mr Sutherland, he found that he had pain in the lower quadrant of the abdomen which was tender on palpation. The pain was non-radiating, sharp and constant. Mr Sutherland stated that he believed that the pain was due to constipation. His pulse rate was then 72.

14. He was transported to the hospital where he was triaged at about 0935 hours. Pain across the whole abdomen with guarding and rigidity was noted. Mr Sutherland was also noted to have a high respiration rate of 24 breaths per minute: he was hyperventilating. He was also observed to be diaphoretic or sweating. His pulse rate was then 83. A history of pain for two to three days was taken. Other vital signs were normal. Again, it was noted that constipation may be an issue.

15. On duty in the Emergency Department when he arrived were Registered Nurse Louise Drinkwater and Dr Dorothea Bonney, a Career Medical Officer in charge of the department. As was usual, RN Drinkwater was the first to assess Mr Sutherland. He was seen soon afterwards for the first time by Dr Bonney.

16. RN Drinkwater noticed that Mr Sutherland was in great pain. He was not demanding or loud but was in obvious pain. Soon after he arrived in the Emergency Department, RN Drinkwater sought to obtain pain relief for him. Nurses are not permitted to order pain relief themselves. This is the responsibility of doctors. RNs Drinkwater and Phillips, who was on the afternoon shift, approached Dr Bonney on a number of occasions seeking pain relief for Mr Sutherland. Only at about 1100 was any analgesia provided: a couple of tablets of panadol. This was nowhere near adequate to relieve the pain Mr Sutherland was suffering. Otherwise Dr Bonney refused pain relief.

17. As noted above, panadol was provided once only, at 1110 hours. Mr Sutherland was also given Buscopan at 1110, Maxalon at 1200, diazepam at 1220 and diazepam and Pariet at 1810. Buscopan is an anti-spasmodic medication intended to relieve stomach cramps. Maxalon is an anti-emetic used to prevent vomiting. Diazepam is a sedative and Pariet is used to treat reflux. Mr Sutherland was not vomiting or complaining of nausea or reflux.

18. In her oral evidence, Dr Bonney conceded that throughout the time Mr Sutherland spent in the Emergency Department he was in severe pain. She said that she had come to a view that his principal problem was constipation and that this view had been confirmed by x-ray investigations and by a surgical review conducted at about 1400 by the surgical registrar, Dr Ian Rebello. In statements made to the police and the Health Care Complaints Commission after Mr Sutherland's death, and in court, she said that at the time she had told Mr Sutherland, who was regularly requesting stronger pain relief, that she would not give him morphine because this was contra-indicated for constipation and would make the constipation worse.

19. The x-ray films showed that Mr Sutherland indeed suffered from constipation as he had told ambulance officers and the triage nurse. When she examined him, Dr Bonney found that Mr Sutherland had an empty rectum and provided an enema which was ineffective. She admitted during her oral evidence that he had otherwise not been treated for constipation and was unable to provide any explanation for this.

20. Dr Bonney ordered blood tests, x-rays and a surgical review of Mr Sutherland by the surgical registrar, Dr Ian Rebello. The Bega Hospital did not have CT scanning facilities. A CT scanner was available at a private facility in Bega during business hours. No arrangements were made, however, to transfer Mr Sutherland to the private hospital for that purpose.

21. Dr Rebello examined Mr Sutherland at about 1400 hours. He had a chest x-ray and a supine abdominal x-ray to examine. According to the radiographer, Ms Hillary Winslow, only those films were taken. Ms Winslow's evidence was that a supine abdominal x-ray was taken if constipation was the query from the ordering doctor. She also stated that if bowel obstruction was the issue a supine and an erect abdominal x-ray would ordinarily be taken. The request form from Dr Bonney sought chest and abdominal x-rays but did not specify supine or erect positions. The reason for the request was noted as "acute abdo pain". The abdominal x-ray showed constipation and did not indicate obstruction of the

bowel. The chest x-ray did not evidence signs of free gas (which would have indicated a leaking bowel).

22. Why an erect abdominal x-ray was not taken is not clear from the evidence. In any event, although it would be have been preferable that an erect abdominal x-ray had been taken it is unlikely that this would have made an significant difference in the diagnosis according to the expert evidence.

23. What may well have made a difference, however, would have been a CT scan. CT scans are highly accurate in detecting diverticulitis and ruptures of the bowel.

24. Dr Rebello's examination was conducted under somewhat difficult circumstances because Mr Sutherland, no doubt due to the pain he was suffering, was unable or unwilling to lie flat. He found that Mr Sutherland's abdomen was soft. He found no guarding or rigidity. Mr Sutherland's vital signs were within normal limits and his white cell count was only slightly elevated. Mr Sutherland was difficult to examine in part because he was constantly moving. Dr Rebello's impression was that Mr Sutherland's pain was due to constipation although he did not diagnose the cause of the constipation. His evidence was that if Mr Sutherland had suffered a bowel requiring surgery that he would have been very still to minimise the pain and that he would have detected guarding or rigidity. He stated that if the bowel had been perforated he would have expected blood pressure, heart rate, temperature and white cell count to be affected. Finding none of these signs, his opinion was that Mr Sutherland did not have a "surgical bowel" requiring an operation.

25. He carefully recorded this opinion in his notes and that opinion was conveyed to Dr Bonney. She naturally took it into account in making her own assessment of Mr Sutherland. Dr Bonney, to her credit, sought to deflect any blame for Mr Sutherland from Dr Rebello and admitted that she had made a number of serious mistakes in her treatment of Mr Sutherland.

Dr Bonney's mistakes

26. Dr Bonney admitted making a number of critical errors in relation to Mr Sutherland. First, without a proper or reasonable basis, she prematurely concluded that Mr Sutherland was drug-seeking and gave insufficient weight to evidence that suggested another diagnosis. Second, she failed to treat the constipation that he had. Third, she did not

treat him adequately for the pain she conceded he had been suffering all day. Fourth, she did not observe or take account of information and observations made during the day and especially during the afternoon that indicated that Mr Sutherland was seriously unwell and deteriorating.

(i) Drug-seeking misdiagnosis

27. More significant for an understanding of what happened, and what went wrong, at the Bega Hospital was evidence suggesting that Dr Bonney came to an incorrect view, probably relatively early on, that Mr Sutherland was not significantly unwell but was in fact drug-seeking. This evidence comes from a number of sources.

28. The three nurses who saw Mr Sutherland that day all gave evidence that Dr Bonney had expressed that view to them.

29. After he was discharged and was being driven away from the hospital, Mr Sutherland told Mr Rex Hergenhan in the car that the hospital staff thought he was a "junkie". There must have been more conversation than this in the car because when Mr Hergenhan delivered Mr Sutherland to the house of Mr Bernhard Trentepohl, he told Mr Trentepohl that he had been told by Mr Sutherland that the hospital staff thought he "had been wanting drugs like an addict" and had sent him on his way with a sedative. During the mid-afternoon, two of the nurses, RN Drinkwater and RN Jane Phillips, spoke to the nurse doing telephone triage on the Drug and Alcohol hotline for about 30 minutes or more about Mr Sutherland seeking a drug assessment of him.

30. In the course of that conversation, which became argumentative and difficult due to misunderstandings and miscommunication, RN Susan Liersch recorded that an opinion had been reached at the Bega Hospital that Mr Sutherland was drug-seeking. She took a history, explored health records and spoke twice to Mr Sutherland to test this hypothesis. Her view was that Mr Sutherland had a serious underlying medical problem that was the cause of his pain and that his conduct as described to her was inconsistent with either drug-seeking or drug withdrawal. She conveyed this opinion to RN Drinkwater.

31. Dr Bonney made two statements in the aftermath of Mr Sutherland's death. In neither of them did she mention anything about drug-seeking behaviour. Her oral evidence on this subject was somewhat confusing. This is perhaps unsurprising given the significant amount of time that has passed since Mr Sutherland's death and the fact that Dr Bonney

has obviously thought a great deal about this incident and has anguished over it. Human beings are not video-recorders and memory is subject to reconstruction in the best and most honest of witnesses.

32. In her oral evidence, Dr Bonney at first seemed to deny that on 2 March 2006 she had been of the opinion that Mr Sutherland was drug-seeking. As her evidence developed, however, she appeared to concede that certain features of Mr Sutherland's case had suggested to her on that day that he might have been. She emphasized that Mr Sutherland had not been willing to discuss dietary issues or the causes of constipation but was fixated on pain relief.

33. Other factors may have suggested to Dr Bonney that she was dealing with a drug addict: Mr Sutherland was very skinny and, in Dr Bonney's view, underweight. He admitted to smoking marijuana regularly. He was of "unkempt" appearance. He was pale (although she did not think he was pallid). Although she did not mention this, he also suffered from Hepatitis B and C. It is a matter of common knowledge that Hepatitis C is a disease frequently found in intravenous drug users. Whether this affected her assessment is not known but it is possible.

34. What does seem certain is that at the time Dr Bonney had an uncompromising determination that Mr Sutherland would not be given opiates for pain relief. In her oral evidence, she agreed that Mr Sutherland had asked for "something stronger" and that she had refused it. She said that this was because she did not want to exacerbate his constipation. While that may be so, it seems more likely to me that she considered his entreaties for pain relief to be motivated primarily by a desire for drugs. At one point in the afternoon she was heard by RN Phillips to say, "I'm not going to give you what you are after." This could only be a reference to strong analgesia.

35. Drug-seeking behaviour is a common and well-known phenomenon in our society. Expert evidence on this subject was given in a report of Dr Raymond Seidler. Also in evidence was a NSW Health document entitled "Responsible opioid prescribing: identifying and handling drug-seeking patients".[1] (In fairness to Dr Bonney this document was published well after she saw Mr Sutherland but it makes general observations about indicators of drug-seeking behaviour that were well-understood in 2006 and are therefore of relevance and value here.)

[1] NSW Health December 2008.

36. Because opioids are drugs of addiction, special care is obviously required before they are prescribed. Doctors must be satisfied that a patient is in pain and needs such powerful analgesia. There is no screening tool for drug-seeking behaviour but the NSW Health outlines a number of factors that, taken alone or in combination, should caution doctors. Among the factors listed are that the patient:

- arrives after regular hours or wants an appointment towards the end of office hours;
- states that he or she is travelling through, visiting friends or relatives;
- exaggerates or feigns medical problems;
- provides a convincing, textbook-like description of symptoms but gives a vague medical history;
- provides an aged clinical report and/or x-ray (often from interstate) in support of their request;
- declines a physical examination or permission to obtain past records or undergo diagnostic tests;
- is unwilling or unable to provide the name of his or her regular doctor, or states that the doctor is unavailable;
- claims to have lost a prescription, or forgotten to pack their medication, or says their medication was stolen or damaged;
- shows an unusual knowledge about opioid medications;
- states that specific non-opioid medications do not work, or that he or she is allergic to them;
- pressures the doctor by eliciting sympathy or guilt or by direct threats;
- uses a child or an elderly person when seeking opioids.

37. It also warns that "A doctor should be particularly suspicious if the patient requests a specific opioid medication (by actual name or allusion to it) and is unwilling to try another analgesic."[2]

38. Mr Sutherland's case can be distinguished from these scenarios almost completely. The only features of his case that could possibly have been interpreted against him in this context were a reported refusal to provide a urine sample and his agitation during physical examination. Pain, of course, cannot be measured objectively but it appears that

[2] "Responsible opioid prescribing: identifying and handling drug-seeking patients" p1.

Dr Bonney must have taken the view that Mr Sutherland was exaggerating the degree of pain he was suffering. Although she conceded in her oral evidence that constipation can be a very painful condition, and now concedes that his pain was real and severe, her general approach on 2 March appears to have been to dismiss Mr Sutherland's claims. In one of her statements, she described his behaviour as being "loud and demanding". This was not supported by the nurses' evidence but even if the observation is correct, it is consistent with Mr Sutherland suffering acute abdominal pain.

39. In addition to the opinion of RN Liersch at about 1530-1600 hours that Mr Sutherland's behaviour was not consistent with drug-seeking, the overall clinical picture was inconsistent with that of a person feigning illness or pain to obtain strong drugs. He had been suffering observed stomach pains for two to three days. The pain had increased in intensity. He had been brought to hospital by ambulance. He arrived in the morning. He did not ask for any specific drug or display unusual knowledge of or interest in opioid drugs. He was not deceptive or secretive about his medical history. He did not decline to undergo investigations or examinations but was "unco-operative" (as Dr Rebello reported) only in the sense that he was in obvious discomfort and found it difficult to stay still. He was honest about his use of cannabis. He had no history of drug-seeking behaviour and no signs of past intravenous drug usage.

40. Dr Seidler notes that some of the signs of drug-seekers are that they tend to nominate their choice of drug as "the only thing that works". Mr Sutherland did not do this. Dr Seidler also notes that "the patient will often become aggressive if the drug of choice is not provided rapidly and will attempt to leave the Emergency Department often with loud and potentially violent verbal or physical outbursts." There is no suggestion that Mr Sutherland ever sought to storm out of the Emergency Department. Quite the contrary, he was anxious not to leave. Dr Bonney is reported to have said to RN Phillips during the afternoon, "What is he still doing here? Get him out of my department". When he was finally picked up by Mr Hergenhan at about 1900, Mr Sutherland clung to his bed begging not to be sent away despite the fact that he had not been given any analgesia for several hours.

41. Constipation is a symptom rather than a disease. It results from a colonic or anorectal disorder or from a secondary cause such as a side-effect of drugs or medications. It follows that, to diagnose the disorder, a careful history should be taken together with an

examination of the patient and appropriate investigations. Constipation may signal a number of disorders including obstruction of the bowel and diverticulitis.

42. A diverticulum is a small bulging sac or herniation commonly found near the end of the left colon called the sigmoid colon. Diverticulitis is defined as an inflammation of one or more diverticula. The disease is frequently mild but, as happened in this case, on rare occasions large perforations can occur.[3] As we know from the autopsy, Mr Sutherland suffered from diverticulitis and it was due to this condition that he ultimately suffered the ruptured bowel and the consequent peritonitis.

43. The investigations carried out in the morning and the early afternoon (blood tests, x-rays and surgical review) did not reveal this. X-rays will show constipation (and did) but not diverticulitis.

44. When Dr Rebello conducted his review, he appears to have been either unaware of the three-day history of abdominal pain and the observations made earlier that day by ambulance officers and nurses of sweating and hyperventilating, tenderness, guarding and rigidity or to have placed greater reliance on his own examination and the x-rays and pathology tests, none of which signalled clearly that Mr Sutherland was suffering a surgical bowel. Dr Rebello's examination, of course, was a slice in time only. Probably more critical than this were the observations made over the day that showed – if only Dr Bonney had analysed them with an open mind – that Mr Sutherland's condition was deteriorating.

45. Dr Bonney may not have been the only person in the Emergency Department who thought at the time that Mr Sutherland's pain and general behaviour was drug-related. I accept that all three nurses who dealt with him believed that his pain was genuine. Nevertheless, the objective evidence that suggests that they (or some of them) may have assumed the correctness of Dr Bonney's view that Mr Sutherland's pain was drug-related is to be found in the hospital records.

46. Before he was discharged, one of the nurses filled out an "ED Risk Screening" tool: a checklist or questionnaire to enable the community health team to follow up a patient if necessary. It was noted that Mr Sutherland was alone and felt he needed support; that he felt isolated or lonely; and that he may suffer from a "chronic/complex care condition

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[3] See *Mosby's Medical Dictionary* (8th ed) Elsevier, St Louis (2009).

without a self-management plan". This could only refer to drugs as he was noted to have given a history of using 10 cones of cannabis daily and no other diagnosis of his pain (except constipation, a temporary condition) had been made nor had he been treated for anything.

47. During the afternoon, at about the handover time, a conversation had begun between RNs Drinkwater and Phillips concerning Mr Sutherland and the drug issue. The nurses decided to get in touch with the Drug and Alcohol hotline for advice.

48. RN Drinkwater gave evidence that she had spoken to RN Liersch in the hope of getting help from the Drug and Alcohol Service in preventing the discharge of Mr Sutherland. She said that she had not believed that Mr Sutherland was drug-seeking or in withdrawal but thought that if she could get support from the Drug and Alcohol Service she may be able to do something to change the situation for Mr Sutherland by finding a reason to admit him. She said that she saw this as a "last ditch" effort on Mr Sutherland's behalf because Dr Bonney had made the firm decision to discharge him.

49. RN Liersch took notes either on her computer or in shorthand as she spoke to RNs Phillips and Drinkwater. Among other things, she recorded that "Michael not given any opioids for his pain based on the assumption that his pain is 'a drug seeking behaviour'". This was conveyed to her by one of the Bega nurses. It is not entirely clear whether or not RN Drinkwater (who spent most time speaking to RN Liersch) endorsed this view. She denied it in evidence.

50. RN Liersch also spoke to Mr Sutherland. She recorded that he told her that "he is in severe pain and that he is not being believed." She quoted his comment that "They're sending me home like this because they think I am looking for drugs. I have never had this pain before, what am I going to do?"

51. She also recorded that she was told by the nurse to whom she spoke (most likely RN Drinkwater) that the Emergency Department would not hold Mr Sutherland for a mental health assessment unless they got there very quickly because "he has been in a bed for 7 hours and 'there is nothing medical wrong with him'".

52. Taken at face value, RN Liersch's notes suggest that RN Drinkwater shared Dr Bonney's view that there was nothing medically wrong with Mr Sutherland and, insofar as he really was in pain, this probably related to drug-seeking or drug withdrawal. RN Drinkwater

gave evidence that she did not believe either and was seeking support for her view so as to persuade Dr Bonney that he should be kept for further investigations of a so far undiagnosed medical cause of his pain. It is common ground that the discussion between RNs Drinkwater was argumentative and confused. There is, however, no doubt that RN Liersch was strongly of the opinion that Mr Sutherland was neither drug-seeking nor in withdrawal and that she made this view plain to RN Drinkwater.

53. If RN Drinkwater's evidence is accepted, RN Liersch was providing the support she wanted for her view against that of Dr Bonney. If they were in fundamental agreement during their half- hour conversation, it is difficult to understand why their discussion was argumentative. RN Drinkwater conceded that, after her conversation with RN Liersch, she did not go to Dr Bonney and tell her that the telephone advice from the Drug and Alcohol hotline staff was that this was not drug-seeking behaviour. Her evidence was that she had been hoping to get a Drug and Alcohol person to see Mr Sutherland face-to-face and that, absent this, she felt nothing more could be done. She also gave evidence that she was intimidated by Dr Bonney.

54. It is difficult to make any confident finding about RN Drinkwater's evidence. It may be that she was doing as she said she was or it may be that she in fact accepted Dr Bonney's assessment of Mr Sutherland but was trying to do something about his drug-seeking or drug withdrawal. If she really did not believe that Mr Sutherland was drug-seeking, it is difficult to understand why she did not approach Dr Bonney with that news. In her note made before leaving the hospital that day, RN Drinkwater made no mention of being told by RN Liersch that her opinion was that the patient was not drug-seeking. Yet, according to RN Drinkwater, this is what she had been told and what she had been hoping to hear from the Drug and Alcohol Service.

55. Dr Bonney's voice was dominant in the Emergency Department. I accept that Dr Bonney was or could be difficult to deal with and, of course, as the doctor in charge of the department, had the final say. Although demeanour evidence and the impression a witness conveys when giving evidence can be deceptive, RN Drinkwater, a nurse of about 16 years experience in 2006, did not present as a person who lacked a sense of professionalism or moral courage. Yet, if RN Drinkwater was truly making a "last ditch" effort on Mr Sutherland's behalf as she now says she was, she did not follow through by challenging Dr Bonney or even recording in the notes the advice that contradicted Dr Bonney's ill-founded opinion.

56. In my view, RN Drinkwater took a much more compassionate view of Mr Sutherland than did Dr Bonney and would genuinely liked to have done more to alleviate his pain. Nevertheless, given that Dr Bonney had formed a firm view of Mr Sutherland's likely diagnosis and that the investigations and surgical review conducted earlier in the day had not contradicted Dr Bonney as far as anyone knew, it seems likely that she accepted the doctor's view of the root cause of Mr Sutherland's problems.

57. She seems to have been trying to help him by getting him assessed by the Drug and Alcohol specialists. She gave evidence that she had not wanted to see Mr Sutherland discharged in such pain and that may well be correct. A person suffering great pain due to drug withdrawal ought not be discharged in such a state and I do not doubt that RN Drinkwater knew this and wished to do something about Dr Bonney's decision. No doubt RN Phillips who had made the first contact with RN Liersch also was thinking along the same lines.

58. In the referral form to the Bega Valley Community Health team sent on 2 March, RN Phillips offered a very tentative diagnosis of "?? substance withdrawal symptoms" and the same day faxed a referral to the Alcohol and Drug Service stating "Patient presented to ED 2/3/06 with ? withdrawal symptoms (abdominal pain and diaphoresis). Patient has agreed to referral ? if will be compliant with this".

59. It is well known in courts and in psychology circles that honest witnesses reconstruct their memories of events over time. Those memories frequently become unreliable, not due to deliberate distortion of the truth but due, for example, to witnesses talking to one another and thinking long and hard about critical events, interpreting and re-interpreting them. In my view, it is likely that the nurses have significantly reconstructed their memories of 2 March 2006, not dishonestly but because they have undoubtedly reflected for a number of years about this case and have been appalled by its outcome.

60. The nurses who attended Mr Sutherland during the day seem to have been more sensitive to his true condition. Each of them unsuccessfully approached Dr Bonney on Mr Sutherland's behalf, only to be rebuffed. Dr Bonney had a firm analysis of the situation and was not be dissuaded. Each of the nurses described Dr Bonney as intimidating and one who did not brook opposition to her decisions or opinions. Because of this, they were probably reluctant to challenge her view of Mr Sutherland in the absence of some firm contrary diagnosis and in the light of their own uncertainty about his diagnosis.

While I accept that they were probably reluctant to see Mr Sutherland discharged in obvious pain, the evidence suggests that their tentative view at the time was the problem was more likely than not drug-related.

(ii) No treatment of the perceived problem

61. Even if Dr Bonney thought that the only genuine problem Mr Sutherland was suffering was constipation, she gave him no treatment, apart from an ineffective enema, for it. Standard treatments for constipation include enemas, laxatives such as sorbitol and manual disimpaction under analgesia and sedation.[4]

62. Dr Bonney offered no explanation for her failure to provide treatment for the constipation. It is difficult to accept that this was an oversight because, although the Emergency Department was busy that day, there were only three beds in the unit. At no stage was Mr Sutherland out of sight and mind. Dr Bonney believed that the most likely cause of Mr Sutherland's constipation was abuse of opioid drugs and was therefore self-inflicted. This suggests that her failure to treat the constipation stemmed from a lack of sympathy for people who abuse substances.

(iii) Withholding of pain relief

63. While Dr Bonney did not have any other diagnosis than constipation during the day, she admitted during her oral evidence that Mr Sutherland had been in severe pain. In her evidence she also conceded that she had known at the time that Mr Sutherland was in great pain. This seems to be supported by her x-ray request that noted that Mr Sutherland was suffering "acute abdo pain".

64. This evidence is difficult to assess. Dr Bonney's evidence is also subject to the problems of reconstruction. She was very obviously remorseful and ashamed of the way she had treated Mr Sutherland. She had at least the good grace to accept full responsibility for what had happened to him. It is difficult to accept, however, that she was fully aware at the time of how agonising Mr Sutherland's pain was. I believe that she either thought he was exaggerating his symptoms to obtain opioid drugs or that he was undergoing severe but temporary symptoms of drug withdrawal that could adequately be treated with sedatives.

[4] Gordion WO Fulde (ed) *Emergency Medicine: The principles of practice* (5th ed) Elsevier, Sydney 2009 p.389

65. One of the first principles of medical care is that severe pain must be treated. There may be reasons why pain relief is denied to a patient for a short period, for example, to prevent critical symptoms being masked, but generally the proper approach is to relieve pain then deal with the illness or condition.

66. If, as now seems clear, Mr Sutherland's bowel was ruptured or on the point of rupturing when he was brought in to Bega Hospital, his pain must have been very severe indeed. In my opinion, the reason it was not relieved was because Dr Bonney had, from a relatively early stage, formed a fixed view that his underlying problem was substance abuse. This was why she only offered Panadol at about 1100. Her opinion was bolstered in her mind by the surgical review. Although Dr Bonney made a gross error of judgment, I do not believe that she deliberately and unethically withheld pain relief.

(iv) Last chance: the afternoon of 2 March 2006 – signs of deterioration not acted on

67. Although opportunities to diagnose Mr Sutherland had been missed during the morning and early afternoon, all would not have been lost had his deterioration been noted during the afternoon shift some time after 1500 hours.

68. RN Tabor was working in the High Dependency Unit that afternoon but was asked to assist the Emergency Department at about 1530 hours. At about 1600 hours, Mr Sutherland spoke to him and told him that he felt his blood sugars were low and asked for a cup of tea. RN Tabor noticed that he was sweating and checked his vital signs. Mr Sutherland had a pulse rate of 153 bpm, a respiratory rate of 24 breaths per minute and a blood sugar level of 13.4mmol[5]. Initially Mr Tabor checked the pulse rate with a machine but, concerned that an error had been made, he rechecked manually and confirmed the reading. Mr Sutherland's temperature and blood pressure were normal but the tachycardia, hyperventilation and elevated blood sugar levels were troubling. RN Tabor then reviewed the previous observations which had been made at 1130. He found significant change in the pulse rate which had been 98 bpm when last checked.

69. The tachycardia and diaphoresis were clear signs of deterioration and Mr Sutherland had reported abdominal pain to RN Tabor. He knew Mr Sutherland was potentially seriously unwell so he spoke to RN Phillips and Dr Bonney. In his evidence at the inquest, RN

[5] Normal levels are about 4-6 mmol.

Tabor said that he would have shown the observations chart to Dr Bonney to demonstrate the changes he had noted.

70. Dr Bonney was unmoved by the evidence placed before her that Mr Sutherland was exhibiting signs of toxicity. She confirmed that he was to be discharged and ordered no further investigations. RN Tabor recalled that Dr Bonney said something at that stage about drug withdrawal and he gained the impression that she had decided that nothing more could be done for Mr Sutherland.

71. Presumably because Mr Sutherland had no one to pick him up from hospital at that time, he remained in the Emergency Department. At about 1700, Mr Tabor appears to have taken another set of observations. Now his pulse rate was up to 170 bpm. RN Phillips then conducted an electro-cardiogram (ECG) which also recorded a heart rate of 170bpm. She showed it to Dr Bonney whose only comment was “That’s a perfect sinus tachycardia”. Dr Bonney spoke to Mr Sutherland and told him that he was going home.

72. This took some time to arrange. Eventually, after RN Phillips had rung various churches and other charitable agencies, Mr Rex Hergenhan, a Seventh Day Adventist, volunteered to transport Mr Sutherland the 80 or 90 kilometres home.

What went wrong and why?

73. In two reports, Dr Ronald Benson, a consultant physician, identified a number of errors of clinical judgment that resulted in misdiagnosis and premature discharge of Mr Sutherland.

74. In his report of 18 September 2009, he wrote:

> Much attention has been given to factors that were not significantly abnormal such as x-rays and blood tests.
>
> More important are the significantly abnormal clinical signs documented from admission to discharge and the failure to attend to the patient’s complaint of abdominal pain.
>
> Some reasonable consideration of the abdominal pain would have negated constipation or drug abuse as the cause and raised suspicion of serious illness.
>
> There were three significant clinical findings: fast respiratory rate, fast pulse rate and abdominal pain which were documented by nursing staff throughout and present on discharge but not explained.

Adequate investigation of any of the three clinical findings may have led to the diagnosis.

75. In his earlier report of 15 January 2007, Dr Benson stated that hyperventilation and diaphoresis (on a background of significant abdominal pain) “are signs of serious illness”. He said that severe abdominal pain at the time of discharge ought to have been further investigated and was “an absolute contraindication to discharge.” He also stated that a pulse rate of over 165 bpm “is an absolute unquestionable indication of a serious medical or surgical state and is an absolute contraindication to discharge from hospital”. He emphasised that a pulse rate of over 165 bpm “is an absolute indication that the clinical state is deteriorating” and required further investigation either at Bega Hospital or a larger facility.

76. His view was that even if the patient had had no abdominal pain and was known to have ingested drugs, with a pulse rate of over 165 he ought not to have been discharged from hospital. During his oral evidence he explained that the heart cannot keep up such a rate for a lengthy period and will ultimately fail unless the rate is reduced to within healthy parameters.

77. Dr Benson considered that the clinicians at Bega Hospital had developed “a mindset that the previous drug history was relevant to the current problem of abdominal pain and may have distorted clinical judgment.” Even so, he cautioned that “in the presence of a pulse rate of over 165 the patient must be observed for a such a period as is needed to clarify the clinical state.”

78. By late afternoon, regardless of any previous tentative diagnoses, Mr Sutherland was a patient reporting severe abdominal pain, a tender abdomen with guarding and rigidity, a pulse rate of over 165 bpm, sweating at times, hyperventilating, with elevated blood sugar levels (an indication of stress, in this case due to sepsis) and, according to the observations, deteriorating in condition. Earlier in the day, Mr Sutherland had been restless and walking around. By late afternoon he was sitting almost motionless in a chair with a towel or blanket over his head, another readily observable sign of change. These clear signs of significant deterioration were given little or no weight by Dr Bonney who steadfastly maintained her view that Mr Sutherland’s problems were drug-related.

79. Associate Professor Gordion Fulde, head of the St Vincent’s Hospital Emergency Department, has identified a number of “red lights” warning emergency department staff against potential pitfalls. He writes, “If pain is severe and unrelieved, worry! You have

probably missed something. Continuing out of character pain is a very common feature of misdiagnosis – so rethink!"[6] If a patient is in pain he urges, "Always listen to the patient, go through the details of the pain (avoid leading questions!) This way you will probably get the diagnosis. Treat pain very early."[7] And he warns, "Repeated questions or protests, eg, the patient, the patient's mother, anybody who keeps telling you 'they are sick' or 'this is not normal for the patient', are the key indicator of pathology going on."[8]

80. Professor Fulde also offers a number of "Emergency Department 'Laws'" of relevance in this case: "Law 1: All patients are trying to die before your eyes"; "Law 3: Be flexible" and "Law 4: Treat the patient, not just the tests".[9] He suggests that "you must always think in terms of worst case scenarios" and that "many sick patients defy any discrete label or have a diagnosis backed up by clearly abnormal tests… If in doubt, observe." He also emphasises that the "clinical impression (is this patient sick?) has been repeatedly shown to be highly accurate in picking up sick patients where scores, protocols, tests have not clearly 'ruled in' a diagnosis…If in doubt, watch, observe, ask."[10]

81. Had these "laws" been followed in the Bega Hospital, it is almost certain that Mr Sutherland's deteriorating condition would have been detected, further investigations conducted and perhaps his life saved. Why were they not?

82. Cognitive psychology, as well as common sense, has demonstrated that we are able to make many of our day-to-day decisions because we can call on past experience (which includes errors) virtually without consciously thinking about them.[11] We make a large number of our decisions by taking mental shortcuts, using "rules of thumb" or "heuristics" developed from experience and training.

83. Professor James Reason, an expert in cognitive psychology and a specialist in the field of human factors, the study of human error in complex situations, has observed that, "human beings are furious pattern matchers. When confronted with an unplanned-for

[6] "The seriously ill patient: tips and traps" in Fulde op cit p.351.
[7] Ibid. p.351.
[8] Ibid. p.351.
[9] Ibid. pp 352, 354-355.
[10] Ibid pp 352-355.
[11] See, for example, Tversky, A & Kahneman "Judgement under uncertainty: heuristics and biases: bias in judgments reveals some heuristics of thinking under uncertainty" *Science* Vol. 185, No.4157 (1974); Croskerry, Poovaiah "The Cognitive Imperative: Thinking about how we think" *Academic Emergency Medicine* Vol 7, No.11 (2000); Redelmeier et al "Problems for clinical judgment: introducing cognitive psychology as one more basis science" *Canadian Medical Association Journal* Vol 164, No.3 (2001); Groopman, J *How Doctors Think* Scribe, Melbourne, 2007.

situation we are strongly disposed to identify a familiar pattern and, where necessary, apply a problem-solving rule that is part of our stock of expertise."[12]

84. Reliance on these mental shortcuts or "heuristics", useful as they are generally are, carries with it the risk of making mistakes. Professor Jerome Groopman contends that misdiagnosis rarely results from technical error but that "the failure to diagnose reflects the unsuspected errors made while trying to understand the patient's condition."[13] A normally useful or good rule of thumb may be misapplied because of a failure to take into account contra-indications to the norm.

85. Dr Donald Redelmeier has analysed various cognitive errors that tend to lead to misdiagnosis:

> These errors [can] include the "availability" heuristic (in which people judge likelihood by how easily examples spring to mind), the "anchoring" heuristic (in which people stick with initial impressions), "framing effects" (in which people make different decisions depending on how information is presented), "blind obedience" (in which people stop thinking when confronted with authority), and "premature closure" (in which several alternatives are not pursued).[14]

86. Professor Groopman also believes that "stereotypes can prejudice thinking so conclusions arise not from data but from such preconceptions". This is a cognitive error labelled "attribution".[15]

87. Using these categories, it can be seen that a number of cognitive errors were made by Dr Bonney and perhaps others. In particular, and most significantly, she stereotyped Mr Sutherland as a substance abuser and attributed his symptoms to that characteristic. She also applied the "availability" rule of thumb (constipation and opiate abuse easily sprang to her mind) and prematurely closed her mind to other alternatives.

88. Unfortunately, it appears that the nurses, due to Dr Bonney's forcefulness, and previous unpleasant experiences of disagreeing with her, as well as her position of authority, complied with her wish that Mr Sutherland be discharged without directly challenging her. They were not necessarily blindly obedient but they were unwilling to confront Dr Bonney's confidence in her own judgment and her determination to discharge Mr Sutherland despite their uneasiness and despite the fact that no firm diagnosis had been

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[12] *The Human Contribution: Unsafe acts, accidents and heroic recoveries* Ashgate, Farnham UK, 2008 p.45.
[13] "Diagnosis: what doctors are missing" New York Review of Books Vol 56, No 17, 5 Nov 2009.
[14] Redelmeier, D "The Cognitive Psychology of Missed Diagnoses" *Annals of Internal Medicine* Vol 142, No.2 (2005) 115-120 at p.115.
[15] Groopman (2009).

reached rationally on the basis of investigations and observations. This was not evidence-based medicine as that term is properly understood.

89. Although the diagnosis of drug withdrawal or drug-seeking was uncertain (as evidenced by the discharge notes made by RN Phillips), Dr Bonney acted as though a certain diagnosis had been reached and could not or would not change course. The Emergency Department was small and busy and perhaps Dr Bonney felt under pressure to keep patients moving. For whatever reason or combination of reasons, she failed to listen to her patient or to respond to his changing clinical picture.

What can be learned from this incident?

90. Risk and uncertainty are inherent in clinical medicine. Signs and symptoms are frequently unspecific. Doctors, however, are not judges whose task is to make firm decisions between competing hypotheses as quickly and cheaply as is reasonably possible on evidence presented to them by third parties. Their roles are active not passive. They are investigators whose job it is both to analyse the evidence before them and, if necessary, to seek further evidence to solve the problem.

91. In his book *How Doctors Think,* Professor Groopman considered the problem of uncertainty. He noted a tendency in humans to deny uncertainty: "the proclivity to substitute certainty for uncertainty is one of the most remarkable human psychological traits. It is both adaptive and maladaptive and therefore both guides and misguides."[16]

92. If "it is the purpose of every emergency department to assess, resuscitate, diagnose and treat, both definitively and symptomatically, the patients who walk or are wheeled through the door"[17], in many cases a rush to judgment must be avoided at all costs. Great diagnostic caution is needed especially if an appropriate history cannot be obtained or if, as was the case here, an adequate physical examination cannot be carried out. Indeed, according to Groopman, sometimes uncertainty must be embraced:

> Paradoxically, taking uncertainty into account can enhance a physician's therapeutic effectiveness, because it demonstrates his honesty, his willingness to be more engaged with his patients, his commitment to the reality of the situation rather than resorting to

[16] Scribe, Melbourne, 2010 p. 152-153.
[17] Fulde "The seriously ill patient" op cit p.350

> evasion, half-truth or even lies. And it makes it easier for the doctor to change course if the first strategy fails, to keep trying. Uncertainty sometimes is essential for success.[18]

93. Second, the corollary of this is that a changing (and, particularly, a deteriorating) clinical picture requires reassessment of any preliminary or differential diagnoses.

94. Third, sometimes patients need an advocate to stand up for them, to urge that their symptoms be reassessed. Nurses are often in the best position to work as advocates for their patients as they are the first-line observers and will, or should be, the first to pick up signs of change. Indeed, the Bega nurses agreed in evidence that one of the important roles of a nurse is that of an advocate for their patients. In hospitals, clinical directors and nursing supervisors are probably best-placed to ensure that the nurses' advocacy for patients plays a vital role in preventing unnecessary deaths by supporting nurses who seek to challenge overbearing senior staff on reasonable clinical grounds.

95. Fourth, for nurses to work effectively with doctors, a culture of inclusiveness and teamwork must be fostered in emergency departments and hospitals generally. Authoritarian behaviour or attitudes on the part of doctors towards nurses or senior staff towards junior staff are counter-productive if those in subordinate positions are too intimidated to perform their roles effectively. More importantly, if staff members in subordinate positions are culturally discouraged from pointing our mistakes directly, or are discouraged from doing so by overbearing or dictatorial supervisors, the environment but may be positively dangerous to patients.[19]

96. Fifth, the failure to diagnose Mr Sutherland as a sick patient ultimately flowed from a failure to take him and his complaints seriously. John Berger's *A Fortunate Man: The Story Of a Country Doctor* has been recognised as a classic account of medical practice. He wrote:

> In illness many connections are severed. Illness separates and encourages a distorted, fragmented form of self-consciousness. The doctor, through his relationship with the invalid and and by means of the special intimacy he is allowed, has to compensate for these broken connections… What is required of him is that he should recognise his patient with the certainty of an ideal brother…This individual and closely intimate recognition is required both on a physical and psychological level. On the former it constitutes diagnosis…
>
> On the psychological level it means support…

[18] Groopman (2010) p.155

[19] See Gladwell, M "The Ethnic Theory of Plane Crashes" in *Outliers,* Penguin, London 2008 pp177-223 in which the author discusses the cultural difficulties of subordinates challenging leaders who have made errors and how cultural norms discouraging such challenges in dangerous situations may be modified.

> The whole process, as it includes doctor and patient, is a dialectical one. The doctor in order to recognise the illness fully … must first recognise the patient as a person: but for the patient – provided he trusts the doctor and that trust finally depends on the efficacy of his treatment – the doctor's recognition of his illness is a help because it separates and depersonalises the illness.[20]

97. Idealistic as this account of the relationship may seem, it is evident that proper diagnosis and treatment of the very sick patient is built in many, perhaps most, cases on a foundation of empathy on the part of the doctor for the patient and trust in the doctor by the patient. As difficult and demanding as hospital environments can be on staff, they need to be places where such relationships are understood and fostered. How that is done is a critical management issue.

Should more be done?

98. I was informed by her counsel that Dr Bonney has already been the subject of a complaint concerning this incident to the Health Care Complaints Commission and been subjected to disciplinary proceedings by the Medical Council. It was suggested that therefore I need not refer this matter to the Health Care Complaints Commission or the Medical Council. Dr Bonney no longer works in hospitals but practises as a part-time General Practitioner. I do not doubt that she is extremely remorseful and will in future act with much greater professionalism than she did in this case. I am also conscious that it is now over five years since Mr Sutherland's death. Nevertheless, in my view, her professional conduct fell far short of the expected standards. I am unaware of the terms of the complaint dealt with previously by the Medical Council nor of the factual basis on which the Council dealt with Dr Bonney.

99. It may be that an issue in the nature of double jeopardy or estoppel arises because the concerns these findings raise have already been dealt with. On the other hand, if the complaint to the HCCC and the facts the HCCC or Medical Council dealt with previously are significantly different from those I have found in this inquest, it may wish to consider some form of disciplinary action in addition to that it took previously. I therefore propose to refer these findings to the Health Care Complaints Commission for consideration of that question.

[20] Writer and Readers Publishing Co-operative, London, 1976 pp 69, 73.

100. It was obvious that the Bega Hospital nurses have very much taken to heart the lessons learned from this case. I understand that the culture at Bega Hospital has improved and that nurses take their advocacy roles extremely seriously. No doubt this inquest and my findings will reinforce their determination without formal recommendations being made.

101. A CT scanner is not available in the Bega Hospital. Had one been available and used on this occasion it is likely that a diagnosis of diverticulitis or possibly peritonitis would have been made and the need for surgery would have become immediately apparent. I propose to make a formal recommendation that the Local Health Network consider installing a CT scanner in the Bega Hospital.

Conclusion

102. The failures at the Bega Hospital stand in stark contrast with the compassion and natural insight of the good Samaritans who sought to help to Mr Sutherland and his friend Penelope Jones who became his posthumous advocate.

103. Antonio Anzevino persuaded the Ambulance Service, over some initial scepticism and resistance, that Mr Sutherland was genuinely in need of an ambulance. He recognised that Mr Sutherland was in great pain and needed medical help.

104. Rex Hergenham, who had never met Mr Sutherland before, volunteered to drive him a long distance home. So painful was the drive for Mr Sutherland that he was unable to take him all the way home to Yowrie but had to pull off the highway at Cobargo to find a place for Mr Sutherland to rest. They drove to Bernard Trentepohl's house.

105. Mr Trentepohl did not know Mr Sutherland very well but, when Mr Hergenhan's vehicle arrived with Mr Sutherland on the night of 2 March, he took Mr Sutherland in and gave him his own bed for the night. He checked on Mr Sutherland throughout the night before finally going to sleep himself. With Mr Trentepohl, John Batten maintained an overnight vigil. Due to his concern for Mr Sutherland, Mr Batten also called Bega Hospital a couple of times to inquire whether Mr Sutherland could be admitted. (Tellingly, Mr Sutherland said to him that he did not want to go back there.)

106. As I noted in my introduction, following Mr Sutherland's death, Penelope Jones complained to the HCCC and later to the State Coroner. She and Mr Anzevino attended

each day of the inquest, a considerable distance from their homes. All these people recognised Mr Sutherland as a human being and a very sick one when he was discharged from Bega Hospital. I commend them and the example they set for the helping professions. I now turn to the formal findings and recommendations.

Findings under s 81 Coroners Act 2009

107. I find that Michael Sutherland died at Cobargo, New South Wales on 3 March 2006 due faecal peritonitis not diagnosed before his discharge from the Emergency Department of the Bega Hospital on 2 March 2006.

Recommendations pursuant to s 82 Coroners Act 2009

To the Minister for Health:

108. I recommend that the Southern NSW Local Health Network consider installing a CT scanner at Bega Hospital.

Magistrate Hugh Dillon
Deputy State Coroner