CORONERS ACT, 1975 AS AMENDED

SOUTH  *AUSTRALIA*

FINDING OF INQUEST

An Inquest taken on behalf of our Sovereign Lady the Queen at Adelaide in the State of South Australia, on the 22nd, 23rd and 24th days of October 2002, the 28th and 29th days of November 2002, the 5th day of December 2002 and the 28th day of March 2003, before Anthony Ernest Schapel, a Coroner for the said State, concerning the death of Irene Butler.

I, the said Coroner, find that, Irene Butler aged 72 years, late of Unit 3, 28 Evan Avenue, Salisbury, South Australia died at Lyell McEwin Hospital, Elizabeth Vale, South Australia on the 28th day of February 2000 as a result of haemorrhage from penetrating duodenal ulcer.

1. Introduction

1.1. The deceased, Irene Butler, aged 72 years lived alone in her unit at 3/28 Evan Avenue, Salisbury.

1.2. On 20 February 2000 she was found collapsed on the floor of her bedroom by the police. The South Australian Ambulance Service attended some time after 10am and established that the deceased had been on the floor of her bedroom at least since some time on 18 February 2000. A friend had last spoken to her on the telephone on that day. The SA Ambulance report, which is part of Exhibit C7, describes the deceased as having an altered conscious state and as being confused to events, time and place.

1.3. The deceased was conveyed to the Lyell McEwin Health Service (the Hospital) where she was initially examined in the Emergency Department. The cause of her collapse was explored at that time and a number of differential possible diagnoses were made.

1.4. At about 1:40pm that afternoon an important piece of information about the deceased was reported to medical staff in the Emergency Department. The information came from a shopkeeper known to the deceased. The shopkeeper informed medical staff that on 16 February the deceased had told the shopkeeper that the deceased had wanted to see a doctor regarding bleeding from her rectum, but that she did not want to see a Dr Kat about it. Another doctor, Dr Sim, was recommended to her. It was not clear to the shopkeeper as to whether the deceased had contacted that practitioner. This conversation was noted in the deceased's clinical record, virtually in the terms I have described. There is nothing in the record of this conversation to identify the shopkeeper, but the information imparted seems to me to be none the worse for that because the Emergency Department doctor who had spoken to the shopkeeper spoke to the deceased about that and the deceased confirmed that she had been having black bowel motions for the past two days. She also said that she had passed faeces from her vagina for the last two weeks. She said that she had not contacted Dr Sim about the matter. The statement about passing faeces per vaginam could not have been correct as the deceased did not have any vaginal pathology such as a fistula, that could account for such a condition. I heard evidence in the inquest that suggested, however, that the deceased may have gained this impression from a passing of a bowel motion that she may not have been aware of. Her statement that she had passed black bowel motions the last two days can be taken, in my view, as a statement that she had done so for the two days prior to her collapse and is very consistent with her statement to the shopkeeper that she had been experiencing per rectal bleeding. A black bowel motion can be a reflection of internal gastro-intestinal bleeding. The product passed from the body is called melaena. I heard evidence that history concerning the passing of melaena is a matter to be taken very seriously in a clinical diagnostic setting.

1.5. There can be no doubt that internal haemorrhaging could have accounted for the reported black bowel motions and her collapse.

1.6. The deceased was admitted to the Hospital. In the early hours of the morning of 28 February 2000, the day she was due to be released, the deceased was found seated on a toilet with no signs of life. Resuscitative measures were unsuccessful. She had died.

1.7. A post mortem examination was conducted in respect of the deceased's body. A large penetrating ulcer was present in the deceased's duodenum. It measured

approximately 40mm in diameter. A medium sized artery was eroded in the centre of the ulcer. The ulcer penetrated into the body of the pancreas. The deceased's small and large intestines contained a large quantity of blood and altered blood. The large duodenal ulcer penetrating into the pancreas, containing as it did the disrupted artery within it, had led to massive gastro-intestinal haemorrhaging and this had caused her death (Post Mortem Report of Dr E Foster Smith Exhibit C2a).

1.8. I find the cause of death to be haemorrhage from penetrating duodenal ulcer.

1.9. The large duodenal ulcer remained undiagnosed for the entire time the deceased had been admitted as a patient of the Hospital. It therefore remained untreated and it ultimately took her life. In this inquest, I examined how it was that the deceased's large duodenal ulcer was neither diagnosed nor treated while she was a patient at the Hospital, particularly bearing in mind a documental clinical history of the passing of black bowel motions, a state of affairs symptomatic of gastro-intestinal bleeding.

2. The deceased's presentation on 20 February 2000

2.1. The deceased was seen by Dr Demelza Tieng-Han Toh in the Emergency Department of the Hospital after she was brought in by ambulance. Her examination of the deceased commenced at 12:04pm. Dr Toh noted that the deceased had told her that she had been on the floor of her unit for as much as 68 hours. Dr Toh took a history from the deceased who at first did not mention anything about per rectal bleeding or the passing of black bowel motions. Dr Toh caused a complete blood examination to be performed. This revealed a number of abnormalities. The deceased had an abnormally high platelet count, abnormally high CK and CKMB counts and an abnormally low potassium count. None of those results are specifically indicative of gastro-intestinal bleeding. The deceased had a haemoglobin count that was within normal limits. A low haemoglobin count may have indicated that she had suffered recent blood loss, but according to expert evidence that I heard in the course of the inquest, this normal result may have been misleading because dehydration that no doubt would have occurred during the period of the deceased's immobility in her home, could have resulted in the raising of the haemoglobin count, thereby restoring what might otherwise have been a low count due to bleeding, to a count that appeared to be normal. The high CKMB count was consistent with the deceased having had a recent acute myocardial infarction (heart attack), but again, according to expert

evidence, this also may have been a reflection of her immobility. It is worthwhile observing at the outset that the deceased's collapse was not due to a myocardial infarction. The post-mortem examination did not reveal any evidence of such. The abnormal platelet count, while consistent with many things, could also have been associated with bleeding. The abnormal potassium level was not related to any bleeding. I return to the significance of these findings later.

2.2. At 1:40pm that day, Dr Toh received the phone call from the shopkeeper to which I have already referred. She then spoke to the deceased who made the statement about having experienced black bowel motions for two days, as I say, a symptom very much suggestive of internal bleeding into the gastro-intestinal tract. Dr Toh made a note of both the conversation with the shopkeeper and of her conversation with the deceased. The note forms a separate page of the deceased's Clinical Record. The information contained within this note was, during the course of the inquest, to generate considerable debate, both in terms of its significance, and in terms of whether it was properly evaluated or understood by the medical practitioners who were to be responsible for the deceased's care while she remained in the Hospital. There can be no doubt that at some point in time the note made its way onto the deceased's Medical Record (Exhibit C7) which is essentially the whole file relating to her hospitalisation. Two practitioners were later to claim that they did not see the document. However, it became clear to me during the course of the inquest that it was included in the Medical Record at a very early stage.

2.3. At Dr Toh's instigation, the deceased on the day of her presentation was, at Dr Toh's instigation, seen by a surgical registrar, a Dr Martin Bruening, and by a medical registrar, a Dr Heinz Tilenius. The precise cause of the deceased's collapse could not be immediately ascertained as there were competing possibilities. Faecal occult blood test or tests were performed on 20 February. This is a test conducted clinically to determine whether there may be blood in the faeces. A sample of the stool is taken and the result of a test conducted with respect to the sample becomes available quickly. It appears from Dr Toh's note that the result of a test that she conducted was recorded as negative, but that when Dr Bruening conducted such a test, the result was expressed to be in the positive. The result of this test would not necessarily signify a serious internal bleed. Nevertheless, it was important information to be considered in conjunction with the information that had been obtained from the shopkeeper and

from the deceased herself. In any event, the result of this test, or tests, was ultimately recorded as positive for faecal occult blood in Dr Toh's notes.

2.4. Dr Toh, whose involvement in the deceased's examination and treatment began and ended in the Emergency Department on 20 February, recorded a number of possible differential diagnoses. She noted as possible causes of the collapse cardiac arrhythmia, and anaemia, given evidence of per rectal bleeding. Other differential diagnoses included hypokalemia (low potassium) and constipation. Dr Toh also noted melaena as a possibility. This of course was not a diagnosis as such because melaena (black bowel motion) is the product of the underlying pathology causing it, in this case, a gastro-intestinal bleed. However, it is plain to me that Dr Toh had given the possibility of an internal bleed proper consideration. She considered it to be a possibility, but was more concerned about the deceased's possible cardiac pathology. She had been reassured by the normal haemoglobin result. Dr Toh also detected an abdominal mass which turned out to be the manifestation of urinary retention. The deceased was also found later to have an E Coli urinary tract infection. Both of those conditions were effectively treated. The presence of the urinary tract infection was also of some significance as it was another candidate for the cause of the deceased's collapse.

2.5. Dr Bruening, the surgical registrar, examined the deceased at about 5pm on 20 February. It was his only examination of her. He was alive to the issue of melaena. He noted that word in the Clinical Record. He also noted that the deceased had a considerable amount of faeces in her rectum, but that it was not melaena. He noted it in this fashion:

> 'Psychiatric Registrar – faeces ++, not melaena'

Dr Bruening told me in evidence that he repeated the faecal occult blood test and it was positive, although as he pointed out, it does not necessarily mean that blood is present.

2.6. Dr Bruening's assessment was also one which leant towards a cardiac problem as being possibly responsible for the deceased's collapse, but acknowledged that the history obtained by Dr Toh and the positive faecal occult blood test 'would raise the suspicion that there was something in the gastro-intestinal tract that perhaps required further investigation' (T182). Dr Bruening said that the usual diagnostic procedure in

relation to a suspected gastro-intestinal tract bleed would be an endoscopy or colonoscopy, both of which are performed under general anaesthetic. I was to hear much about these possible procedures in the course of the inquest. Dr Bruening suggested that an endoscopy or colonoscopy is a procedure which carries with it significant risk to a patient who had recently suffered a myocardial infarction.

2.7. Dr Bruening told me that he initiated the administration of a bowel chart for the deceased. This procedure monitors the bowel motions of the patient to determine the macroscopic appearance of the faeces, in particular to see whether the patient passes melaena. He told me that the test for occult blood is usually undertaken in conjunction with the bowel chart. I did not doubt that Dr Bruening did initiate this as it appears from the bowel chart in Exhibit C7 that the first bowel motion monitored occurred on the morning of 21 February 2000.

2.8. Dr Bruening could not recall seeing Dr Toh's notes of her conversation with the shopkeeper. It is possible that he did not see them as if he had, he may well have written his own notes as a continuation of that note, given that it was part of what was meant to be a continuous clinical record. He made his notes on a fresh page of the Clinical Record. However, he said that Dr Toh had related the information to him. Dr Bruening told me that as he was a surgical registrar and that the issue of the deceased's diagnosis and management was a medical one, he considered it more appropriate for physicians to examine her. He was asked by Ms Hodder, Counsel Assisting the Coroner:

> 'Q. So is it accurate to say that you in your assessment hadn't found any positive clinical signs to suggest melaena but that that was always a possibility and that that was something for the physicians to look for.
>
> A. That's exactly right. That's why I suggested a bowel chart and continuing testing for haemoccult, and like I said before the break, once the patient's admitted under the physicians my advice is either taken or not, it's up to them.' (T96)

He was asked by me:

> 'Q. Now you of course weren't to know the manner in which this woman was ultimately to die on the 20th, but how much weight did you give to the information that there was available that she had been experiencing the passing of melaena or black bowel motions or whichever way it was phrased.
>
> A. I think we gave very high weight to that. That's why we asked the physicians to become involved. That's why I re-tested the haemoccult and that's why I asked for a

> bowel chart. But to a certain degree we also have to examine what's available at the time. We have a history that I wasn't able to ascertain at the time of the examination from the patient and we have to use all the evidence that we have to make a judgment. Now I made the judgment at the time that in my mind I didn't think that this woman was actively bleeding nor had had recent evidence of gross melaena. I'm still not 100% convinced that her initial presentation to the hospital was related to her GI bleed. It may have been but certainly there were other factors that could have been causing it and I think we put a lot of emphasis on that. We've all written in the A & E notes melaena, melaena, melaena and then it's up to the physicians as to the timing of when they want to do things.' (T105)

2.9. Dr Bruening acknowledged that he also had understood that the deceased herself had said that she had passed black bowel motions. He thought that he may have asked her about that as well, but could not recall 'getting anything particularly coherent out of Ms Butler' (T107).

2.10. The medical registrar, Dr Tilenius, examined the deceased after Dr Bruening. Dr Tilenius also gave evidence before me. He commenced his examination at 7:15pm on 20 February. He also noted the following on the Clinical Record:

> 'Passed faeces p.v. ~~for~~ ~~last~~ (sic) 3/52 ago
> And black bowel motions'
>
> (Exhibit C7)

The abbreviation 'p.v.' signifies per vaginam and 3/52 signifies 3 weeks.

2.11. Dr Tilenius' examination was the only occasion he saw the deceased. At first he thought the deceased was confused, but as the examination progressed, he formed the view that she was fully oriented.

2.12. Dr Tilenius had spoken to Dr Bruening, had read his record and as well, Dr Toh's notes of her assessment. In evidence in chief he could not recall whether he had seen Dr Toh's note about her conversation with the shopkeeper and about her conversation with the deceased about black bowel motions, but it is plain from the note set out above that he had information concerning the deceased passing faces per vaginam and black bowel motions. As to the source of that information he said that he had only spoken to Dr Bruening about the case. He had no recall of having spoken to Dr Toh. On his own note, he had originally written 'passed faeces pv for last 2/52'. This, of course, accurately reproduced the information in Dr Toh's note, but Dr Tilenius told me that the deceased herself said that she had passed faeces per vaginam in one

episode three weeks ago. Dr Tilenius also said that she told him that she had been experiencing black bowel motions (T141, 142). He had originally written in his notes the words 'recent pv bleeding episodes?', the underlying information for which had possibly come from a source other than the deceased. However, he had crossed those words out, possibly because he was unable to confirm that with the patient herself.

2.13. Dr Bruening in answer to me acknowledged that he probably did have access to Dr Toh's notes about her conversation with the shopkeeper because that was in reality the only documented information thus far as to black bowel motions. This had prompted him to include reference to this in his own notes and to explore this issue with the deceased. I think this must be correct. The information contained in his notes, in its original form before his alterations, is an almost verbatim reproduction of Dr Toh's notes. I have no doubt that when Dr Tilenius examined the deceased Dr Toh's note was with the rest of the documentation that had been raised thus far. There is no reason to suppose that both his notes and Dr Toh's notes did not remain and travel with the rest of the deceased's Medical Record from the time of Dr Tilenius' examination onwards.

2.14. Dr Tilenius made a number of notations in the Clinical Record as to his own impressions of possible causes of the deceased's collapse. He included as possibilities bradycardia (slow heart rate) due to hypokalemia (low potassium), urinary retention, a gastro-intestinal bleed (alongside which he inserted a question mark) and underlying malignancy (again with a question mark). Interestingly, he did not include reference to the possibility of a recent acute myocardial infarction. As far as his possible differential diagnoses were concerned, he summarised his thinking as follows:

> 'Well a fall of unknown aetology but in combination with a lady who is hypocalcemic and to have bradycardiac episodes on the ECG, and also she had urinary retention and with a history of black bow motions, certainly very suspicious of the gastro intestinal bleeds. And I've written also down although I'm not going to step forward now, but I've also written down query underline malignancy, the main reason was this initial mass could people which most likely was the full bladder in this lady. However having said that as it was mentioned by my colleagues previously I had to document it and to take that seriously because once the diagnosis is in question then it has to be followed up.' (T126-127)

His reason for including a question mark alongside his note relating to the possibility of a gastro-intestinal bleed was as follows:

> 'There was no certainty as such if she had a gastro-intestinal bleed because only taking from the history it was certainly suggestive, having said that the only way of proving it is really whether, if it's an upper gastro-intestinal bleed is finding the source of bleeding which means either endoscopy or colonoscopy.' (T129)

As a measure of Dr Tilenius' concern about the possibility of bleeding, he stopped her aspirin medication as aspirin is a common cause of gastro-intestinal bleeding. Her dosage of 300mg per day was a significant one.

2.15. Dr Tilenius acknowledged that the most appropriate diagnostic measure for bleeding would have been an endoscopy. He did not order one. The deceased was stable at the time and he thought that in due course such a procedure would be considered by the consultant who would have examined the deceased the following day. Dr Tilenius also raised the issue as to the desirability of performing an endoscopy where there was a question mark concerning possible recent cardiac pathology as had possibly been revealed by her very high CK count and by an abnormal ECG (electrocardiogram). However, he acknowledged that the high CK count could have been reflective of the fact that the deceased had been lying on a floor for an extended period of time. In addition, the ECG result was not necessarily reflective of a recent myocardial infarction as opposed to an old one. I observe here that the post-mortem examination only revealed old myocardial scarring. There is no evidence that the deceased had recently suffered a cardiac arrest.

2.16. Dr Tilenius also reflected upon the real value of regular testing for faecal occult blood because of its intrinsic unreliability and 'because gastro-intestinal bleeds are very often intermittent, and cannot exclude a GI bleed' (T144).

2.17. Dr Tilenius also referred to the desirability of a gastroenterologist assessing the deceased to determine the appropriateness and desirability of performing an endoscopy. In the event, no gastroenterologist became involved in the deceased's management and an endoscopy was never performed.

2.18. Dr Tilenius arranged for the deceased's admission to the wards of the Hospital. Up to that point, she had been managed in the Emergency Department.

2.19. By the conclusion of Dr Tilenius' examination much was known about the deceased as far as the possibility of a gastro-intestinal bleed was concerned.

(a) it had been reported from a second-hand source that the deceased had said that she had been suffering per rectal bleeding;

(b) the deceased had told two practitioners, Dr Toh and Dr Tilenius, that she had been experiencing black bowel motions; I pause here to add that there is no evidence that she had denied to either Drs Toh, Bruening or Tilenius that she had experienced the same;

(c) she had a high platelet count, consistent with, but not determinative of, recent bleeding;

(d) she had returned a positive faecal occult blood test;

(e) she had collapsed recently and had lain on the floor of her unit for two days or more.

All of this information had been adequately documented. All of that documentation, I find, was available to the medical staff who took over her management at the Hospital on 21 February and remained responsible for that management until her death on 28 February. It is against that background that the events of 21 February and following have to be examined.

3. The deceased's management from 21 February 2000 until her death

3.1. On 21 February 2000, the deceased came under the care of a team of medical practitioners and she remained under their care until her death on 28 February 2000. This team comprised an intern, a general registrar and a consultant physician. She was also under the care of nursing staff.

3.2. The intern was an overseas trained doctor by the name of Ata Ahmadi. The fact that Dr Ahmadi was an intern in a sense belied his wider experience as a medical practitioner overseas. He obtained his original qualification in Afghanistan in 1988. He had practised in Afghanistan for a short period. He left Afghanistan and practised in Pakistan as a medical officer with foreign committees, who were establishing health programs, hospitals and health centres, for about two years. He came to Australia in 1991. Dr Ahmadi had undergone internship in Afghanistan. Between

1991 and 1996 he did not work in Australia as a medical practitioner. From 1996 to 1998 he studied for an examination that would enable him to practice here. He passed that exam and in January 2000 commenced full-time employment as an intern at the Hospital. He was still employed as an intern at the time with which this inquest is concerned and eventually passed a clinical examination that entitled him to practice in his own right in Australia. Dr Ahmadi told me that prior to February 2000, he had obtained experience in dealing with gastro-intestinal ulceration and gastro-intestinal bleeding. He had not specialised in this area, but knew about gastro-intestinal symptomatology and illness before the deceased's presentation. At the Hospital, Dr Ahmadi was junior to registrars employed at the Hospital. Dr Ahmadi was interviewed by the police about this matter. I received a transcript for that interview in evidence (Exhibit C11). Dr Ahmadi also gave evidence before me.

3.3. The registrar involved in the deceased's care was a Dr Sodienye Tetenta who obtained his medical qualifications in 1995 from the University of Nigeria. He had practised as a medical practitioner since 1995. He resigned from the Hospital in July 2002. Dr Tetenta's present whereabouts are unknown. He was not called at the inquest. However, he was interviewed by the police and I received a transcript of that interview in evidence (Exhibit C4a). The accuracy of the transcript was verified by the affidavit of the officer who conducted the interview, Detective Senior Sergeant Akermanis. Dr Tetenta was senior to Dr Ahmadi but junior to the consultant.

3.4. The consultant involved in the deceased's care was Dr Maria Dellamalva. Dr Dellamalva obtained her MBBS from the University of Adelaide in 1988. She has a Fellowship of the Royal Australian College of Physicians which she obtained in 1988. Her consultancy at the Hospital involved general medicine. It was a part-time appointment. Dr Dellamalva worked at the Hospital three days a week. The rest of her time was spent working at the Royal Adelaide Hospital and in the conduct of a private practice in general medicine. Dr Dellamalva was senior to Drs Ahmadi and Tetenta. Dr Dellamalva was also interviewed by the police. I received the transcript of her interview in evidence (Exhibit C12). Dr Dellamalva also gave evidence at the inquest.

3.5. I also heard live evidence from Professor David Shearman. Professor Shearman was not involved in the management of the deceased. At the request of Counsel Assisting the Coroner, Professor Shearman provided two reports which essentially consist of an

overview of and commentary upon the management of the deceased at the Hospital, with particular reference to the issue examined in this inquest, namely whether the deceased's gastro-intestinal bleeding should have been diagnosed and treated. Professor Shearman's reports were received in evidence at the inquest (Exhibits C14 dated 13 December 2001 and Exhibit C13 dated 18 February 2001). He told me that he received his original medical qualification from Edinburgh University in 1962. He has been a Fellow of both the Royal and Royal Australasian College of Physicians since 1970 and 1972 respectively. He has wide experience as a gastroenterologist and as a consultant physician. He has been a professor of medicine at the Royal Adelaide Hospital and has continued to practice in gastroenterology and general medicine both privately and at St Andrew's Hospital. Professor Shearman was critical of many aspects of the deceased's management at the Hospital, especially the management conducted by the team of practitioners led by Dr Dellamalva. Professor Shearman was of the view that the deceased's penetrating duodenal ulcer should have been diagnosed, its potential for bleeding recognised and that she should have been treated accordingly. I will deal with some aspects of his criticism later in these findings.

3.6. There was considerable variation between the accounts given by Drs Ahmadi, Tetenta and Dellamalva concerning the nature of information surrounding the deceased's symptomatology and the evaluation of that information. In addition, there were marked differences between the approach to the deceased's management as described by Dr Dellamalva in her police interview on the one hand and in her evidence before me on the other.

3.7. It is as well to deal firstly with what Dr Tetenta told the police in his interview. I adopt a cautious approach to this material. Dr Tetenta was not called at the inquest and therefore did not have the opportunity to expand upon what he had said. He was not cross-examined. I therefore adopt a cautious approach to anything Dr Tetenta may have said which might reflect adversely on himself or other medical practitioners involved in this matter. I also adopt a cautious approach to evidence given in the inquest that might reflect adversely on Dr Tetenta and which he has had no opportunity to challenge.

3.8. Dr Tetenta was interviewed on 18 May 2001, 15 months after the events at the Hospital in February 2000. As with the other practitioners interviewed by the police about this matter, I am prepared to act on the basis that before Dr Tetenta's interview

he had a limited opportunity to refresh his memory about the events of February 2000. It is apparent, however, that when he was interviewed, the interviewing officer had possession of the deceased's Medical Record and that Dr Tetenta had access to them. Dr Tetenta was asked to examine Professor Shearman's report of 18 February 2001 (Exhibit C13).

3.9. On the face of it, Dr Tetenta appeared to have an adequate recollection of his involvement in the matter. He said that according to the Medical Record his involvement commenced on 22 February 2000 because his name first appears in relation to an examination that was conducted at 10:20am that day. He admitted that he and Dr Dellamalva had taken over the care of the deceased. He described his own role as:

> 'Principally day-to-day care of the patient and consultation with the consultant.'
> (Exhibit C4a, p2).

He said that he had reviewed the medical notes and the patient's history up to the time of the commencement of his involvement. Dr Tetenta said he had no clear recollection of reading 'the shopkeeper's note'. He had read Dr Bruening's note. I have already referred to the fact that Dr Bruening's notes were on a sheet separate from Dr Toh's notes. Dr Tetenta proceeded to say more specifically that he had not in fact seen the shopkeeper's note, but did acknowledge that he had seen reference to a:

> 'Possible history of abdominal, of bleeding, per vagina of (sic) per rectum which was then assessed.'
> (Exhibit C4a, p4)

The assessment to which he referred was that conducted by the surgeons. He was, of course, referring to Dr Bruening, the surgical registrar. His view was that the deceased's presentation was consistent with septicaemia causing confusion and the fall. Dr Tetenta seemed at pains to point out that by the time he first saw the deceased on 22 February, she had already been seen by Dr Dellamalva the day before. This may not be correct as other recollections differed. However, as far as Dr Tetenta is concerned, I am prepared to act on that basis. By the time Dr Tetenta had become involved he said:

> 'I was happy that the patient had been screened down in a sequential manner, referred by the surgical unit to who made a notation which says that the patient does not have any surgical problems at this point. Seen by the admitting unit and subsequently sent to us,

> and in discussing with the patient, there had been no clear-cut mention of rectal bleeding.'
>
> (Exhibit C4a, p7-8)

Dr Tetenta said the deceased was very free with information about herself, was lucid, clear and able to answer questions in a clear-cut manner but had, herself, not mentioned anything about problems with her bowel motions. He said he had taken a history from her and there had been no history of abdominal pain or rectal passage of blood. Dr Tetenta did not say in terms whether he had specifically questioned the deceased about these matters, but it is implicit from what he said that he believed he had. Dr Tetenta's impression that the faecal blood test conducted on admission was negative whereas in fact it was positive.

3.10. Nevertheless, Dr Tetenta agreed that the shopkeeper's information which he did not see was vital. He said:

> 'Yes. If a patient comes in unconscious with a history of GI blood loss, then the patient would have got an immediate endoscopy, or one done within four hours. It would have been done straight away. If the information – if the information, and as we note here, the admitting doctor had been put a history of question mark, so I even wonder if the doctor who brought the patient in on the first occasion had this, because if they did have this information, they would have called the gastroenterologist on-call. This clearly states that the patient was having PR bleeding. If you have blood coming out the rectum, you do not wait. You do an immediate investigation. So I have to question, I cannot speak for the doctor who saw the patient, but if I did see this on a patient I was admitted, the patient would first of all not have gone to the ward but gone to a high dependency unit, and they would have got an immediate surgical consult. Again, I cannot speak for the surgical doctor who saw the patient, but I made his history as possible PV vaginal bleeding, whereas what the ED doctor states here is rectal bleeding. So, obviously, one would have to question if he saw this, because if he did see this, he would not have put question mark.'
>
> (Exhibit C4a, p11)

He said he had no idea when the shopkeeper's note had first appeared and that he certainly did not have access to it. He said:

> 'If this information had been available, this patient would have had an endoscopy performed in the first six hours while she was admitted. It would have been done.'
>
> (Exhibit C4a, p12)

He also said that the history from the shopkeeper would have made a significant difference, but that the deceased had not told him about rectal bleeding.

3.11. Dr Tetenta's attention was not drawn specifically to recorded comments of the deceased herself in relation to passing black bowel motions. Dr Toh's note and Dr Tilenius' note both referred to this. I am prepared to infer that Dr Tetenta would have demonstrated a similar attitude to the importance of that information.

3.12. In passing comment about the need for and desirability and urgency of an endoscopy, Dr Tetenta did not raise the issue of possible cardiac pathology standing in the way of such a procedure.

3.13. Dr Tetenta's claims that he did not see Dr Toh's shopkeeper's note and therefore had not fully evaluated that information flies in the face of Dr Tilenius' evidence that the note must have been on the file when he had access to it and that there was no reason to suppose the note would not thereafter travel with the file. Dr Ahmadi's evidence sheds light on this aspect of the matter.

3.14. Dr Ahmadi was the intern. He claimed to have little input into the deceased's management. He was reluctant to be drawn into expressing any opinion as to the appropriateness of Dr Tetenta's or Dr Dellamalva's clinical judgments and decisions. He said that one of his roles was to make notes in the Clinical Record of examinations performed by Dr Tetenta and/or Dr Dellamalva. He said he reviewed the whole matter of the deceased's presentation and on 21 February he had noted in the Clinical Record the results of various examinations, such as the complete blood examination, that had already been performed.

3.15. Dr Ahmadi said that he first saw the deceased at 1:05pm on 21 February with Dr Tetenta and Dr Dellamalva who was on duty at the Hospital that day. He made a note of that examination and it is present as part of the Clinical Record. He said that the matter was handed over to him and Dr Tetenta by Dr Tilenius who had explained that the two principle aspects of her presentation were a possible cardiac problem and urinary retention. He also said there was mention of her per rectal bleeding in the past, but that since the deceased's admission, there had been no abnormal finding.

3.16. Dr Ahmadi said that Dr Toh's note of 1340 hours on 20 February, the shopkeeper's note, was on the Medical Record. He said he read it and tat Dr Tetenta was well aware of it and that he had read it. He was asked:

> 'Q. During the course of your preliminary discussion with Dr Tetenta about Ms Butler, did Dr Tetenta say anything to you about that note.

A. He briefly commented about that note as being a very reliable source (sic – this is plainly unreliable) of information because it was just indirect information and it was one piece of information on the one hand; on the other hand since he been with us, there was no problem related to that.' (T168)

This evidence contradicts Dr Tetenta's statement to the police that he was not aware of the shopkeeper's note.

3.17. Dr Ahmadi also said that Dr Tilenius' note had also been on the file.

3.18. He said that both he and Dr Tetenta were present when Dr Dellamalva first examined the deceased on 21 February at 1:05pm. Again, this is contrary to Dr Tetenta's recollection that he did not see the deceased until 22 February. Dr Ahmadi's note of this examination reads as follows:

'21.2.00 Medical Dr Dellamalva
1305 seen
pleasant, alert & oriented
Obs stable afebrile
P: stool culture
urine culture'

(Exhibit C7)

Incidentally, this is the only note that records the presence of Dr Dellamalva who was to say in evidence that she saw the deceased on four occasions.

3.19. Dr Ahmadi said that if the deceased had made a complaint of some specific discomfort or problem, it would have been recorded. The note does not record any enquiry of the deceased, nor of her response, that may have been made about her having experienced black bowel motions. Notes made of subsequent examinations at which Dr Ahmadi was present do not refer to this issue.

3.20. By the time of the examination of the afternoon of 21 February, the deceased had passed a bowel motion that had been loose and offensive but otherwise unremarkable. It was not melaena.

3.21. Dr Ahmadi said that under the heading 'Plan' in his note he had recorded the fact that he had been advised to do a stool culture and urine culture. It does not record any other instruction. It is clear that Dr Ahmadi carried out those instructions as a stool culture and urine culture were performed. The stool culture was negative for presence

of blood. The urine culture revealed the urinary tract infection to which I have referred.

3.22. Dr Ahmadi said that their main finding was concentrated towards the deceased's possible cardiac pathology and urinary tract infection.

3.23. In cross-examination, Dr Ahmadi said that Dr Tetenta had expressed the view that the shopkeeper's information was unreliable. Dr Ahmadi, who had seen the note, did not understand that the note also revealed a first hand conversation between Dr Toh and the deceased about black bowel motions when it plainly did. Dr Ahmadi was asked whether he considered whether the shopkeeper's information was unreliable himself. He said:

> 'A. I was not in a position to make that sort of judgment, because that was done by two senior doctors and me and my editor was responsible for a reassessment of that report and, as I mentioned, I was not in a position to force or contradict my senior. I was having limited authority.
>
> Q. Did he convey to you what he thought or why he thought it was unreliable.
>
> A. I think from the overall picture, because there was few information which we return with there which is happening one after another, and they didn't have symptom while she was with us. It is just my assumption, maybe because she was just seeing the patient without the symptom and finding or hearing or reading about those history and unknown period of time and I'm just assuming maybe that was his understanding, because I cannot be sure from his point of view.' (T207-208)

3.24. Dr Ahmadi did not recall whether Dr Tetenta had asked the deceased about rectal bleeding, passing of faeces per vagina or black bowel motions, but he could clearly recall the conversation with Dr Tetenta about the reliability of the shopkeeper's note. Nor could he remember any conversation at which he was present between Dr Dellamalva and Dr Tetenta about the possibility of a gastro-intestinal bleed. He did not have any such discussion with Dr Dellamalva as 'it was not my duty or responsibility, it was Dr Tetenta's role and duty'. He also said:

> 'A. All I remember, especially myself, was following advice and order of my senior regarding those finding for which we have at the time, which was a cardiac abnormal finding and her abnormal urinary tract infection and urinary retention. I remember I was advised and I told her to chase and get involved with those things.
>
> …
>
> Q. So you didn't see it as your role to be continuing to explore that *(gastro-intestinal bleeding)* as a possible complication in Mrs Butler's case.

A. I had to go by my senior management plan and advice and I couldn't do it independently.' (T213-214)

3.25. Dr Ahmadi was asked:

'Q. Did you suggest to either Dr Tetenta or to Dr Dellamalva that the patient herself ought to be asked about whether she had had black bowel motions.

A. I don't remember saying that but I remember I have discussed that part whether we need to do anything about it with Dr Tetenta, but I already mentioned that part of the discussion.

Q. If she had been asked that question, in her presence, would you have noted her answer.

A. That's right, yes. I remember from my notes and from my writing, so whenever we ask her if she was feeling fine and there was no documentation of any bleeding objectively and subjectively she never told us anything about this, and all along, when I see from my note from my memory, once he was just having chest pain and we were following that, and other time he was telling us about shoulder pain, which we knew that was a chronic shoulder problem, we referred her to physio. On another occasion I think the transient discomfort overnight which was settled in the morning, so these are the things she was telling us all appeared, she was there, if I remember everything.' (T222)

3.26. Asked as to what he might have done if the deceased herself had told him about black bowel motions, he said:

'I would have followed the management which I would follow. Initially, you basically examined basic blood, you check for occult blood and if you think it is upper GI system you go and do endoscopy to make sure it is not upper GI problem. If you find it is negative for the bleeding you may just do colonoscopy and barium swallow other investigation.' (T223)

3.27. Dr Ahmadi understood that the only haemoglobin test that was performed was the one that had been conducted on 20 February when she had first arrived at the Hospital. That had been normal. Dr Ahmadi did acknowledge, however, that the high platelet count could possibly be indicative of internal bleeding, but said at the time there was no consideration of that 'and all these abnormal findings were reported to senior doctors who were responsible for assessment and management of the patient'.

3.28. Dr Dellamalva, the consultant, was called to give evidence. The salient features of her evidence are as follows:

(a) Dr Ahmadi's note of the examination of 21 February at 1:05pm was incomplete;

(b) Dr Tetenta had brought the Clinical Record to her attention and she had read Dr Toh's accident and emergency note, Dr Bruening's note and Dr Tilenius' note. She did not see the shopkeeper's note. As to the significance of that note she said:

> 'I think that entry is - it doesn't tell us who the shopkeeper was, it doesn't allow us to verify that story at all. It's really hearsay from that particular doctor from this shopkeeper. I think I would really want to try and evaluate that information further prior to proceeding with any further investigations. I think we were doing our own investigations while she was in hospital and really observing this woman for signs of ongoing bleeding. I think the fact that the blood tests indicated that she'd had a recent myocardial infarction really negated us performing any invasive procedures in order to investigate that further.' (T301-302)

(c) Dr Tetenta was present at the first examination on the afternoon of 21 February;

(d) She examined the deceased on four occasions while she was in the Hospital, namely on 21, 23, 25 and 26 February;

(e) The deceased told her on 21 February and again subsequently that she had not been experiencing black bowel motions and that Dr Ahmadi had been present when she had said this;

(f) That she believed that the deceased's presentation was consistent with a recent acute myocardial infarction – the CKMB results were very much suggestive of that;

(g) That she ordered a repeat of CKMB tests;

(h) That she recognised the possibility of there having been a gastro-intestinal bleed and for that reason ordered a confirmation of the bowel chart as well as a further haemoglobin test and the stool culture;

(i) That she considered performing an endoscopy to explore the possibility of a gastro-intestinal bleed but because of her suspected underlying cardiac pathology, this carried a risk. She was asked as to whether if she had seen reference to the deceased having told Dr Toh about black bowel motions it would have prompted her to take action in relation to the possibility of a gastro-intestinal bleed and she said:

> 'No, because I think in view of the fact that her tests indicated that she had a recent myocardial infarct, it was really going to be quite dangerous to

perform anything more invasive in this woman on the information that we had.' (T303)

(j) That on 26 February she ordered an ultrasound on the deceased's abdomen because of non-specific pain. She said:

> 'She - because of this fairly non-specific pain and the fact that we hadn't excluded gastro-intestinal bleeding positively, and the fact that we couldn't perform an endoscopy on this woman because she'd had a recent myocardial infarct and it would have been quite dangerous to do so in that respect - the ultrasound is really a screening test to see if there are any other abnormalities that might be causing some of her symptoms. And I thought it was prudent to do that if we were contemplating discharging this woman in the next few days.' (T270)

Dr Dellamalva later asserted in her evidence that the ultrasound had no real connection with the detection of gastro-intestinal bleeding.

3.29. Dr Dellamalva told Detective Senior Sergeant Akermanis, as she later said in evidence, that she had not seen Dr Toh's note of her conversation with the shopkeeper and the deceased. She said there was no suggestion at all that the deceased had any gastro-intestinal bleeding, although said at another point that she had ordered a repeat haemoglobin test performed to assess whether she had a gastro-intestinal bleed of some sort. She said to Akermanis that there was some suggestion of per vaginal bleeding, query melaena, but that the history was not clear. She said that it was unfortunate that the information recorded by Dr Toh had not been brought to her attention. She said that in the light of that information, the deceased should have been admitted to a surgical unit. She said it was unfortunate that the deceased had not been endoscoped as that would have been the only way that they could have found the duodenal ulcer. As to her course of action if she had seen the information obtained by Dr Toh she told Akermanis:

> 'I would've actually asked the patient again, as difficult as it is to get a history from her, it was extremely difficult to get a history from this lady because she was really quite confused, and if there was any suggestion that she had black bowel actions, then certainly she would've been further investigated. I mean, I can't actually see that anyone had done a perirectal examination, except the A and E doctor, and he has found 'hard non-tender rectum', and it's very hard to see whether or not this is positive or negative for faecal occult bloods.'
>
> (Exhibit C12, p11)

She specifically told Akermanis that Dr Toh's information was a 'very important piece of information' and that if she had been privy to it at the time, she would have endoscoped her. She also made this comment:

> 'No, I mean I think had we known that this was a key ingredient of her history, I think the appropriate channels would have been pursued, but clearly there was enough evidence on the results I have in front of me to account why she may have had a collapse.'
>
> (Exhibit C12, p15)

3.30. In my opinion, the evidence of Dr Dellamalva is in stark contrast to what she told Akermanis. The impression left by her evidence before me was that the information obtained by Dr Toh would have made little difference in terms of her management. She did not tell Akermanis anything about her concerns regarding the use of the endoscope as far as her suspected cardiac pathology was concerned.

3.31. Dr Dellamalva explained in her evidence that Akermanis had not given her sufficient access to the casenotes during the interview, and in particular she had not been reminded about the significance of the CKMB results which had led her to believe that there was evidence of an acute myocardial infarction and that therefore it would have been too risky to perform an endoscopy. And yet, it is plain from the transcript that she did see the CKMB result in the casenotes during the interview because she makes reference to it at page 7 and stated that it had signified 'some sort of myocardial event' to her. In short, Dr Dellamalva thought that her account to Akermanis had not been a fully informed once given under the disadvantage of not having access to the casenotes.

3.32. Dr Dellamalva was also at loggerheads with Dr Ahmadi. As a result of some of her evidence, Dr Ahmadi was recalled. He said that he had not been ordered to perform a further haemoglobin test. If he had been ordered to do that on 21 February, he would have noted it and he would have seen that it was carried out. His note of that examination contains no reference to a further haemoglobin test, whereas it refers to Dr Dellamalva's orders for stool and urine cultures that were in fact carried out. Dr Ahmadi also said that if the deceased, as Dr Dellamalva claims, had been asked by her whether she had experienced black bowel motions and the deceased had denied that, he probably would have noted that. He did not.

3.33. Dr Dellamalva said that she had taken Dr Ahmadi to task about his note-taking skills and had refused to pass his work on that basis. Dr Ahmadi denied that this had ever occurred.

3.34. I found Dr Dellamalva to be an unreliable witness. She was seriously contradicted by what she had said to the police and her explanation for those contradictions was in turn also contradicted by the content of her police interview. While I was also not impressed with Dr Ahmadi's demeanour and attitude in the witness box, I think he probably told me the truth about his note-taking.

3.35. In making my assessment of Dr Dellamalva's credibility, I do not take into account anything said by Dr Tetenta in his interview with the police. I formed my view about Dr Dellamalva's reliability based upon the content of her evidence and upon her demeanour when confronted with the obvious differences between her account in the witness box and her account to the police.

4. The criticisms of Professor Shearman

4.1. The evidence of Drs Ahmadi and Dellamalva was such that beyond Dr Tilenius' assessment on 20 February, there was little to suggest that any or any proper consideration was given to the possibility that the deceased was suffering from gastro-intestinal pathology, whether or not that had accounted for her collapse. I find that Dr Toh's note of 1340 hours on 20 February was on the Medical Record when the deceased's management was taken over by Drs Ahmadi, Tetenta and Dellamalva. Dr Tilenius plainly saw it, as did Dr Ahmadi. It is astonishing that such important information was not properly taken on board and evaluated.

4.2. I am not satisfied on the balance of probabilities in this matter that after 20 February 2000 any or any proper enquiry was made directly of the deceased as to whether she had been experiencing per rectal bleeding or black bowel motions. I am also not satisfied that a repeat haemoglobin test was ordered to be carried out. My impression from Dr Ahmadi's evidence was that if it had been ordered, he would have facilitated it. I am also not satisfied that Dr Dellamalva gave any or any adequate consideration to the performance of an endoscopy. Contrary to her evidence in the inquest, she told Akermanis that she would have performed one if she had appreciated the content of Dr Toh's 'shopkeeper's note'. In the light of that, it is difficult for me to accept Dr Dellamalva now when she says that she considered it, but did not consider it

appropriate until more was known about the deceased's cardiac pathology. The fact that the deceased was going to be discharged on the day of her death without anything having been put in place as far as an endoscopy is concerned, also leaves me with a sense of disquiet.

4.3. Professor Shearman was principally critical of the deceased's management within the Emergency Department on 20 February. He was somewhat critical of what had taken place there as well, with the exception of Dr Toh who in my view did everything she could for the deceased. I think the same applies to Drs Bruening and Tilenius. The deceased was stable and they saw her only the once. She was to be seen by a Consultant the following day.

4.4. Professor Shearman's criticisms of what took place from that point onwards are many and varied. He was of the view that insufficient regard was given to the information both provided by the shopkeeper and by the deceased herself. I think this criticism is manifestly correct. I agree with Professor Shearman that it was important information and it should have been taken seriously.

4.5. Professor Shearman had other criticisms:

(a) There should have been another haemoglobin test performed. He was of the view that reliance should not have been placed on the normality of the result achieved on 20 February because the deceased would no doubt have been dehydrated and the reading, for reasons I have explained, may have been misleading. I agree that a further haemoglobin test should have been carried out. According to Professor Shearman, whom I accept, it could possibly have been diagnostic of bleeding if it had been shown to fall, a very likely outcome on Professor Shearman's evidence.

(b) That an endoscopy should have been performed. Professor Shearman acknowledged the risk involved in this in a patient with suspected cardiac pathology. However, he thought that insufficient consideration had been given to the possibility that the abnormal CKMB result may have been reflective of the deceased's having been prone on the floor of her unit for an extended period. Plainly an element of clinical judgment had to be exercised, weighing up the risk associated with performing and endoscopy as against the risk of not performing it and leaving a patient who has a serious gastro-intestinal lesion undiagnosed. Professor Shearman was of the opinion that there was little to suggest that such a

balancing exercise had occurred or that any effort had been put into bringing the deceased up to a state of health whereby an endoscopy could be performed in relative safety. In my view, he is correct because, as I say, the evidence from Dr Dellamalva that such an exercise was performed is not to be relied on.

(c) Professor Shearman was critical of the fact that two much stock was perhaps placed upon faecal occult blood testing of the deceased's stools while she was in the wards. He described a situation where, as had probably happened in this case, the deceased's bleeding had stopped and that it was only a matter of time before it restarted, possibly fatally. In the intervening period, there would be little bleeding such that a negative faecal occult blood result would have limited significance. Much the same applied to the test for blood that was ordered by Dr Dellamalva on 21 February which was also negative.

4.6. Professor Shearman states in his report of 18 February 2001 (Exhibit C14) that 'Appropriate management would have reduced but not abolished the chance of mortality'. He told me that a practitioner performing his or her first endoscopy could not have failed to detect an ulcer of this magnitude. He said that concomitant with the endoscopy, the compromised artery may have been sealed off, reducing the likelihood of further bleeding. Of course, it cannot be said with certainty that such a procedure would have succeeded. It seems to me, however, that such a procedure would have improved the deceased's chances of survival.

5. Conclusions

5.1. On or about 18 February 2000 the deceased collapsed in her home and remained prone on the floor until discovered by the police on the morning of 20 February 2000.

5.2. The evidence established that there may have been a number of explanations for that collapse including gastro-intestinal bleeding and a urinary tract infection. Cardiac arrhythmia from a recent acute myocardial infraction can be ruled out.

5.3. The deceased was taken to the Lyell McEwin Hospital where she was examined by Dr Toh. On the afternoon of 20 February 2000 Dr Toh was told by a shopkeeper who knew the deceased that the deceased had told her that she had been experiencing per rectal bleeding. Dr Toh asked the deceased about this and established from the deceased that she had been experiencing black bowel motions. I find that the

deceased had accurately related to Dr Toh those experiences and that on the balance of probabilities the black bowel motions were reflective of gastro-intestinal bleeding.

5.4. I find that the deceased told Dr Tilenius that she had been experiencing black bowel motions and that she accurately conveyed her experiences to him.

5.5. I find that Dr Toh's and Tilenius properly documented their findings and that both of their notes were placed on and travelled with the Medical Record for the duration of the deceased's hospitalisation.

5.6. I am not satisfied that proper evaluation of the recorded statements made by the deceased concerning her having experienced black bowel motions was made by medical practitioners responsible for her care on and after 21 February 2000.

6. Recommendations

6.1. I have no recommendations to make under Section 25(2) of the Coroners Act 1975.

Key Words: Hospital Treatment;

In witness whereof the said Coroner has hereunto set and subscribed his hand and Seal the 28th day of March, 2003.

Coroner