

SOUTH



AUSTRALIA

FINDING OF INQUEST

An Inquest taken on behalf of our Sovereign Lady the Queen at Adelaide and Tanunda in the State of South Australia, on the 6th, 10th, 24th and 25th days of March and the 8th day of May 2003, before Wayne Cromwell Chivell, a Coroner for the said State, concerning the death of Shirley May Pratt.

I, the said Coroner, find that, Shirley May Pratt aged 66 years, late of 98 Mildred Street, Kapunda, South Australia died at the Royal Adelaide Hospital, North Terrace, Adelaide, South Australia on the 10th day of July 2000 as a result of acute necrotising haemorrhagic mediastinitis.

1. Introduction

1.1. Mrs Pratt died on 10 July 2000 at the Royal Adelaide Hospital. She had been admitted there on 6 July 2000, having been transferred from Kapunda Hospital by ambulance. She had developed complications following an elective endoscopy operation performed at the Kapunda Hospital by Mr Sam Gue, General Surgeon, on 5 July 2000.

1.2. Cause of Death

A post mortem examination of the body of the deceased was performed by Dr Nicholas Rodgers, under the supervision of Associate Professor Robert Rowland, both of the Institute of Medical and Veterinary Science at the Royal Adelaide Hospital on 13 July 2000. The cause of death was diagnosed as “acute necrotising haemorrhagic mediastinitis”, with antecedent causes identified as “oesophageal perforation (surgically treated) due to gastroscopy procedure”.

- 1.3. I will use the word “endoscopy” as being interchangeable with “gastroscopy” in the context of this case.
- 1.4. The Pathologists commented:
- '1. The appearances of the sutured lesion in the lower oesophageal wall (see alimentary tract, page 3) were consistent with a surgically treated oesophageal wall defect (perforation).
 2. Perforation of the oesophageal wall often results in acute inflammation of the organs (including heart) and tissues located within the mediastinal compartment (mediastinitis).
 3. Mediastinitis is a life-threatening condition, which even if diagnosed early and treated surgically is associated with a high mortality rate.
 4. Oesophageal perforation is a recognised complication of endoscopy of the upper gastrointestinal tract including gastroscopy.
 5. The age of mediastinitis as estimated at the autopsy is consistent with the oesophageal trauma occurring at the time of the gastroscopy procedure on 05.07.2000.
 6. Extensive necrotising, haemorrhagic and suppurative inflammation involving a surgical site impairs healing process and often results in local tissue necrosis and surgical wound dehiscence.' (Exhibit C3a)
- 1.5. I accept the opinions expressed by the pathologists herein, and find that the cause of death was as they have diagnosed.

2. Background

- 2.1. At my request, this case was reviewed by Mr Tom Wilson, a Surgeon with wide experience in surgery of the upper gastro-intestinal tract, and in endoscopy procedures. He has conducted a very thorough review of the medical records herein, and has very usefully set out the relevant events as part of his report as follows:

'Ms Pratt underwent an elective gastroscopy at Kapunda Hospital at 1:50 pm on the 5th of July 2000. The procedure was performed by Mr Sam Gue who had seen Ms Pratt a month earlier with a history of heartburn and reflux. She had had a documented hiatus hernia on an endoscopy performed in 1992 by Mr Gue. The anaesthetist for the endoscopy was Dr Robert Lecons. Sedation provided for the procedure was 30mg Fentanyl and 300mg Propofol. From the endoscopy report, on first introduction of the endoscope the patient began heaving, necessitating removal of the scope. Following further sedation, the scope was re-introduced and note was made of blood slightly coating the region of the gastro-oesophageal junction and upper stomach. Because of this, a good view was not obtained. It was recommended that she be observed for a few

hours following the procedure because of concern about the events during the endoscopy, and it was planned to re-scope her on Mr Gue's next visit in a month's time.

From review of the recovery nursing notes, Ms Pratt's observations remained stable between 1410 and what I presume was the final observation at 1700 hours (this last observation is documented at 1500 hours, but followed the previous documentation at 1620 hours and I assume represents an entry error). She is, however, documented as experiencing abdominal discomfort requiring two Paradex tablets at 1620 hours and further documented to still be in discomfort at 1700 hours. Her documented time of discharge from hospital was 1800 hours.

She is then documented as re-presenting to the Emergency Department at the Hospital also at 1800 hours that evening. She was seen by Dr Van Dissel who was attending the Hospital to see some other patients, but was not on duty that evening. He describes her as experiencing pleuritic chest pain and shortness of breath. She was seen to be in distress. She required 15mg IV morphine in incremental doses between 1800 and 1930 hours to achieve adequate analgesia. The possibility of a pneumothorax or a ruptured oesophagus with mediastinitis was considered. A sub-optimal chest x-ray did not show an obvious pneumothorax. On initial discussion between Dr Van Dissel, Dr Lecons and Mr Gue, it was decided to treat her with intravenous antibiotics and observe.

Both Dr Van Dissel and Dr Lecons remained concerned about Ms Pratt and reviewed her later the same evening at the Hospital. Dr Lecons performed a second chest x-ray, which at that time demonstrated a sizeable left-sided pleural effusion. Once again the possible diagnosis of a perforated oesophagus was entertained. Further discussion was made with Mr Gue and as her condition appeared stable a final decision was made to continue observation with antibiotics in hospital at Kapunda overnight.

There is some dispute as to whether consideration of transfer to a major hospital was made at that time. Mr Gue's statement implies that he recommended transfer both at his initial 'phone call at approximately 7:00pm that evening and again at the second 'phone call at 10:30 to 11:00pm that evening. Dr Van Dissel does not recall these recommendations, but states that he felt that as her condition had remained stable, a planned delayed transfer the following morning would be appropriate.

Review of the nursing notes indicates that Ms Pratt did remain stable overnight but did require continuing oxygen therapy and some further morphine doses. By the following morning she had developed a mild fever.

Ambulance retrieval to the Royal Adelaide Hospital occurred at 10am on the 6th of July 2000. Initial assessment at the Royal Adelaide Hospital suspected oesophageal rupture following the endoscopy and this was confirmed on a barium contrast study. Plans were set in place for surgical exploration and repair later that afternoon. This was carried out by Professor David Watson at 4:00pm. A large amount of fluid was discovered in the left pleural cavity with appearances consistent with oesophageal perforation. A 1.5cm perforation was found approximately 5cm above the gastro-oesophageal junction. The perforation was repaired but note was made of the tissue being extremely friable. Two large pleural drains were placed to allow continued drainage of the mediastinum. A gastrostomy was inserted to decompress the stomach and a feeding jejunostomy inserted to allow enteral nutrition.

There appears to have been satisfactory progress over the first few days in the Royal Adelaide Hospital Intensive Care Unit, but on the 10th of July her condition relatively suddenly deteriorated and investigations revealed a moderate sized pericardial effusion. Three hundred mls of blood-stained fluid was drained from this pericardial effusion but there was continuing deterioration and she died shortly thereafter at 4:00pm on the 10th of July 2000.

Her post mortem carried out on the 13th of July revealed extensive necrotising haemorrhagic mediastinitis with abscess formation. Secondary pericarditis with a haemorrhagic pericardial effusion was noted. The site of the repair of oesophageal perforation was noted to be extremely friable with a persisting 5mm defect at its upper end. Extensive friable inflamed tissue was noted through the mediastinum and peri-aortic soft tissue and peri-oesophageal soft tissue. Fluid culture from the pericardial and pleural spaces revealed a coagulase negative staphylococcus and a candida albicans.'

(Exhibit C11a, p1-3)

3. Issues arising at the Inquest

3.1. A number of issues arose concerning the standard of treatment given to Mrs Pratt at particular stages after the endoscopy operation on 5 July 2000. It is convenient to set out these stages in chronological order.

3.2. Events before 5:00pm

Mr Gue told me that after the endoscopy operation was completed he gave the recovery nurse an instruction that "Mrs Pratt should be observed for at least three to four hours" (T159). The case notes (Exhibit C8a) simply record the instruction that she should be "observed for a few hours". Mr Gue explained that he gave this instruction because he was concerned about the blood on the endoscope, and thought that Mrs Pratt might have suffered a scratch or tear of the inner lining of the oesophagus, known as "Mallory Weiss Syndrome" (T168).

3.3. After he had completed his operation list for the day (Mrs Pratt was his second to last patient), Mr Gue said that he saw Mrs Pratt in an office in the Outpatients Department. He said that Mrs Pratt walked in with the recovery nurse, and that he asked her whether she was in any pain or discomfort to which Mrs Pratt replied "no" (T159). He said that he told Mrs Pratt the reason why he discontinued the procedure, and that he would try again in a month's time.

3.4. This evidence contrasts somewhat with the note in the "Special Nursing Record", part of the Exhibit 8a, which states that at 1620 (4:20pm) Mrs Pratt complained of abdominal discomfort. She was given Paradex for the pain. There is a later note

which is stated to have been made at “1500”, but is more likely to have been made at 1700 (5:00pm) which states “still in discomfort”.

- 3.5. Mrs Pratt’s daughter-in-law, Bridget Pratt, corroborates the fact that the nurses were aware of Mrs Pratt’s pain. In her affidavit (Exhibit C7a), she states:

I contacted the hospital at 4-00 p.m. before netball training to see if she (Shirley) was ready to be discharged. I was told that she was in a fair amount of discomfort and they were going to keep her a while longer and would ring me when she was ready.

When I returned from training, my husband said the hospital had rung at about 1730 to collect Shirley. I arrived at the hospital at about 1745, and the sister said that she was still in a lot of discomfort and to get her home, and make sure she took her pain tablet (Mersyndol), and the tablet she takes for her hiatus hernia as she probably had everything stirred up when the camera was down there.

Shirley and her husband live a two-minute drive from the hospital, and as a matter of fact you can see the hospital from their front door.

Shirley was in quite a lot of pain as we drove home and told me what had happened on the way. We arrived home and she seemed to have trouble getting out of the car with the pain in her chest.

We went inside and I told her to take her tablets. She started to do so and I noticed that she had gone very still and seemed to be having trouble swallowing. I asked her a couple of times if she was all right, but there was no answer. By this time she had grabbed hold of my arm and could only make this terrible moaning type sound. I then asked her if I should take her back to the hospital when again she didn’t answer.

I made the decision to take her back.

We had been home less that five minutes.

Shirley really had trouble getting to the car and at one stage I thought she was going to collapse. Her pain seemed so intense that talking and crying out could not be done, and she had the most horrific expression on her face.' (Exhibit C7a, p1-2)

- 3.6. It is difficult to know what to make of the inconsistency between this evidence and the evidence of Mr Gue that shortly before this Mrs Pratt seemed to be in no discomfort at all. It could be that Mrs Pratt put on a brave face when Mr Gue asked her if she was in discomfort. It could be that the nursing note made at 4:20pm was made at a time when her pain was increasing. Certainly by the time Mr Gue left the hospital, at between 4:30 and 5:00pm, Mrs Pratt’s condition had deteriorated but I do not find that Mr Gue knew the extent of her discomfort.

- 3.7. Mr Wilson commented that it is not clear whether the endoscope itself was instrumental in Mrs Pratt's perforation, or whether the perforation occurred spontaneously as a result of convulsions associated with the "heaving" during the operation. He said it was possible that a "Mallory Weiss" tear had occurred initially, and that:

'The patient's relatively stable state prior to discharge from hospital raises the possibility that the perforation was not full thickness at this time, or that relatively little mediastinal contamination had occurred at that time.' (Exhibit C11a, p3)

- 3.8. In those circumstances, Mr Wilson said that the decision to allow Mrs Pratt to leave the hospital "does not seem to have been inappropriate" (Exhibit C11a, p3).

- 3.9. 5:00pm to 6:30pm

Dr Van Dissel is a General Practitioner in Kapunda who happened to be in the Hospital seeing his patients when Mrs Pratt re-presented with her daughter-in-law. He said that he was called to see Mrs Pratt by the nursing staff. She was obviously in distress.

- 3.10. Dr Van Dissel performed a chest x-ray (there were no radiology services available so he had to do this himself), which was not of good quality although he thought it was sufficient to exclude a pneumothorax, which is air in the pleural cavity (Exhibit C9, p5).

- 3.11. Dr Van Dissel telephoned Dr Robert Lecons who is a General Practitioner in the same practice, and who gave the anaesthetic during the endoscopy procedure. Dr Lecons told Dr Van Dissel that Mrs Pratt did not aspirate (inhale vomit) during the procedure, and so this excluded another of Dr Van Dissel's differential diagnoses.

- 3.12. Dr Van Dissel then telephoned Mr Gue, who at that stage had dropped off his wife and his surgical instruments at home, and was on his way to Ashford Hospital to see other patients. The telephone call took place at about 6:30pm. There is a stark difference of opinion between the two doctors as to what took place during this telephone conversation.

- 3.13. Dr Van Dissel said that he told Mr Gue that Mrs Pratt had re-presented with severe pain and shortness of breath, and that the x-ray had excluded pneumothorax. The possibility that Mrs Pratt may have been having a heart attack (she had a history of

chest pain in 1997) was discussed, but Dr Van Dissel said this was not high on his list of differential diagnoses (T97).

- 3.14. The possibility that Mrs Pratt's condition was due to an injury suffered during the endoscopy procedure was also discussed. Dr Van Dissel wrote “? ruptured oesophagus +/- mediastinitis” in the case notes. Mr Gue also acknowledged that this possibility was considered and said that he recommended that Mrs Pratt be given intravenous antibiotics to cover this possibility.
- 3.15. The main area of contention is that Mr Gue asserts that he suggested to Dr Van Dissel at that stage that Mrs Pratt should be transferred to another hospital. His evidence about which hospital was somewhat inconsistent. When he gave evidence at the inquest, Mr Gue said that he suggested that she be transferred to the Lyell McEwin Hospital in Elizabeth. He produced his notes which he said were made shortly afterwards, at about 7:15pm, which state:

'7:15 max rang discussed the pain chest x-ray clear to start Flagyl and Claforan IV. Ring 10pm? TR.

→ suggest transfer to L Mac'

(Exhibit C10d)

- 3.16. The final passage “→ suggest transfer to L Mac” is obviously written with a different pen.
- 3.17. Mr Stanley cross-examined Mr Gue extensively about his notes. An examination of the notes gives the clear impression that the passage about transfer to the LMH was written later than the subsequent notes, in a different pen, and was jammed in between notes already there.
- 3.18. This evidence is in contradiction to what Mr Gue told Detective Senior Constable Brown who interviewed him on 23 April 2001. The record of interview is Exhibit C10c. Mr Gue, after discussing the antibiotics, said:

'This was at 7.15 or 7 o'clock. This discussion went on a little while and Max said, well he is not quite sure, maybe she is having heart attack. He wants to keep her there for a little while. So I didn't argue with him. Okay. How, remember that, I want to make it very, very clear that in the first instance I said to him, “Send her to a public hospital in Adelaide”.' (Exhibit C10c, p12)

3.19. Mr Gue went on to emphasise that he was not criticising the Kapunda Hospital, but:

'I am just saying that every hospital can't be like Royal Adelaide Hospital.....So I said to him that the best thing is to send her to a public hospital. They can investigate and treat accordingly.' (Exhibit C10c, p12-13)

3.20. When cross-examined by Mr Stanley, counsel for Dr Van Dissel, about which hospital he suggested Mrs Pratt be sent to, Mr Gue was vague and rather evasive. He said that the subject was of little importance, and that it didn't make any difference which hospital he mentioned (T184).

3.21. Dr Van Dissel denied vehemently that there was any suggestion by Mr Gue that Mrs Pratt be transferred anywhere during that first conversation. He said that if he had received that advice from Mr Gue, he would have complied with it. He argued that, after all, Mrs Pratt was not his patient, and he had never treated a patient with a suspected oesophageal rupture before. He also pointed out that it would have been pointless to send Mrs Pratt to the Lyell McEwin Hospital since it is not a primary teaching hospital, and was in no better position to treat a ruptured oesophagus than Kapunda Hospital was. He was clearly affronted by the suggestion that it was his decision to keep Mrs Pratt at Kapunda and that Mr Gue had advised him to do otherwise (T116).

3.22. I have regard to the following factors after considering this issue:

- Dr Van Dissel was not Mrs Pratt's treating doctor;
- Dr Van Dissel had never treated this condition before;
- Mr Gue was a specialist Surgeon whose role it was to be aware of possible complications from his surgery and give advice to General Practitioners about them;
- The apparent pointlessness of a transfer to the Lyell McEwin Hospital;
- The highly suspicious appearance of Mr Gue's notes.

I find that I am not satisfied that Mr Gue advised Dr Van Dissel to transfer Mrs Pratt to another hospital during this first telephone conversation. In my opinion, a more plausible interpretation of this evidence is that it was agreed between them that they would speak later in the evening, and that Mrs Pratt would be treated conservatively in the meantime. I make this finding on the balance of probabilities.

- 3.23. Mr Wilson told me that in his opinion, having regard to Mrs Pratt's condition when she re-presented at Kapunda Hospital, and in particular the development of severe pain, "I guess it's pretty easy to be wise in retrospect, but I think that in the circumstances there was to my mind sufficient concern with the development of the acute pain after the procedure when she was sent into hospital that the perforation should have been considered, and I think from my reading was considered, and once you start to consider that being a possibility, then I think it is best to follow that through and I would have suggested transfer at that time" (T262-3).
- 3.24. 7:30pm to 11:00pm
Dr Van Dissel left the Kapunda Hospital for a professional meeting in a nearby town. He said that he was sufficiently concerned about Mrs Pratt's condition to discuss her case with a colleague during the meeting. He left the meeting early, at about 9:30pm, and travelled back to Kapunda and went to the Hospital, arriving between 10:00pm and 10:15pm.
- 3.25. By the time Dr Van Dissel returned to the Hospital, Dr Lecons, who was also concerned about Mrs Pratt's condition had also returned to the Hospital and had decided to take a further chest x-ray. On examination of the x-ray, both Dr Lecons and Dr Van Dissel noted a large pleural effusion (fluid in the pleural cavity) on the left side. Dr Van Dissel said that the most likely cause of this condition was a perforated oesophagus (T103).
- 3.26. Mr Gue telephoned the Kapunda Hospital at 11:04pm (he produced the telephone record, Exhibit C10b), as he had not heard from Dr Van Dissel as had been previously arranged. There is also a disagreement about the contents of this telephone conversation.
- 3.27. Dr Van Dissel told me that Mr Gue did raise the question of a transfer to a metropolitan hospital with him at that time, in response to which Dr Van Dissel pointed out the logistical difficulties in a transfer at that time of night. He said that they resolved that Mrs Pratt should be transferred in the morning (T104).

- 3.28. Dr Lecons said that following the telephone conversation, he questioned Dr Van Dissel as to whether Mrs Pratt should not be transferred “there and then”. He said that Dr Van Dissel explained that he doubted whether an operation could be performed that night in any event, and that he thought that Mrs Pratt was too uncomfortable to be transferred by road ambulance at that time of the night. Dr Lecons said that he thought that approach was reasonable (T38).
- 3.29. Dr Lecons said that Dr Van Dissel did not mention to him that Mr Gue had recommended a transfer to Adelaide, and that if he had known that Mr Gue had given that advice, he would have been “absolutely certain” that Mr Gue’s opinion would have been a decisive factor (T52).
- 3.30. Mr Gue, on the other hand, told me that the results of the second x-ray made the diagnosis of a perforated oesophagus certain, and that he told Dr Van Dissel that Mrs Pratt should be transferred to Adelaide without delay (T202-3). Indeed, Mr Gue insisted that, by the end of the conversation, he understood that Mrs Pratt would be transferred that night (T161).
- 3.31. The note made by Mr Gue in Exhibit C10d (allowing for the doubts that I have already expressed about the prominence of these notes), is more ambiguous than the evidence he gave at the hearing:

'Rang 11pm Max & Robert fluid left side stable to be transferred on'
(Exhibit C10d)

- 3.32. Mr Gue’s responses to questions put by Detective Senior Constable Brown on 23 April 2001 is also less clear:

'A:And she was stable, and I again suggested that she should be transferred, and we discussed about what could be the cause of fluid in the chest, and I said that the most probable cause is probably perforation, and I think Robert said that they were going to keep an eye on her because her obs are stable, and transfer her in the morning.....'

Q: So they adhered to your recommendation, if you like, that she should be transferred to the RAH and that was obviously done?

A: Except that I wanted them to transfer her the day before.'

(Exhibit C10c, p13-15)

- 3.33. The evidence before me is clear that at the very latest, Mrs Pratt should have been transferred at the time the results of the second x-ray became apparent. Mr Wilson said:

'At this stage the diagnosis of a significant oesophageal perforation was far more likely, and the most appropriate course of action would have been urgent surgical intervention, which would have necessitated transfer to a major teaching hospital. There appears to have been some conflict between Dr Van Dissel's and Dr Lecons' statements and Mr Gue's statement regarding the decision to transfer Mrs Pratt at this time. Although the ultimate outcome may not have been different with earlier surgical intervention, the risk of mortality from ruptured oesophagus and mediastinitis undoubtedly increases significantly the longer the condition is left unattended.'

(Exhibit C11a, p4)

- 3.34. In my opinion, it is not possible to form a clear conclusion as to the precise contents of the telephone conversation between Dr Van Dissel and Mr Gue at just after 11:00pm on 5 July 2000. It is apparent the two men were not of one mind as to the correct approach to Mrs Pratt's condition. I suspect that there was a misunderstanding between them, that Mr Gue suggested a transfer, Dr Van Dissel pointed out the logistical difficulties, and Mr Gue failed to press the point further.
- 3.35. In my opinion, the principal responsibility in this situation fell upon Mr Gue. He was the Surgeon who had performed the operation, he was the person who had experience with this condition, and he should have been familiar with the possible complications from his surgery, and the appropriate treatment should they arise. Dr Van Dissel, on the other hand, had no experience of this condition and was not in a position to disagree with Mr Gue about the inherent risks of delaying treatment.
- 3.36. Mr Wilson told me that, had he been in the surgeon's position in this case, he would have expected to have been informed of Mrs Pratt's progress, and would have expected to have been called upon to make decisions about whether or not she should have been transferred to another hospital. The clear impression he gave me was that he would certainly not leave such decisions to General Practitioners with no experience in this specialised area of surgery (T241-2).

- 3.37. Would a transfer at 11:00pm on 5 July 2000 have made a difference?

I have already referred to Mr Wilson's opinion that the outcome of Mrs Pratt's condition may not have been different, although the risk of mortality was higher the longer the condition was left unattended.

- 3.38. The statement of Professor David Watson, who performed the surgery on Mrs Pratt on 6 July 2000 which was tragically unsuccessful, is that Dr Van Dissel's misgivings about a transfer on the evening of 5 July were unfounded. He said:

'She would have had the same treatment that she had the next day, and that would have been initiated on arrival. Effectively a contrast x-ray to look for the leak, which would have confirmed the leak. With that diagnosis she would have proceeded to the operating theatre later that night and had the same operation that she had the next day, which involved an open thoracotomy incision, washing out of the pleural cavity, repair of the leak and the placement of drains.....so exactly the same treatment but it would have happened earlier.....there would have been an available on-call surgical registrar who would help deal with that. I was actually on call for the whole week. So I would have done the same procedure a day earlier. The commonest time we operate on these things is after hours.....usually after midnight.'

(Exhibit C5b, p4-5)

It was for Mr Gue to have been aware of this, so that he could have informed Dr Van Dissel of the facilities available at the Royal Adelaide Hospital, and insisted upon a transfer if that was appropriate.

- 3.39. As to Mrs Pratt's prognosis, Professor Watson said that Mrs Pratt's condition was complicated seriously by the delay in treatment. He said:

'I think the problem is that she had 24 hours of contamination in that area which has already set up a infective process in her chest, plus she has had the onset of a major operation when she has been unwell to try and fix the – control the problem. I think the combination of those two things is sufficient to cause her death.'

(Exhibit C5b, p10)

- 3.40. Having said that, Professor Watson acknowledged that Mrs Pratt's condition was extremely serious in any event. He said that even if Mrs Pratt had been transferred within six hours of the perforation, her chances were still not good. He said:

'Yes, there is still a significant mortality. I can't give you the exact figures without going away and looking up – we try not to see too many of these cases, but the mortality risk if it was recognised immediately and she was sent down it was probably in a lady – in a patient of her age and background, 40-50%. By the time we got to her the next day it was sort of up around 80-90%.'

(Exhibit C5b, p12)

- 3.41. Professor Watson acknowledged that those figures are somewhat speculative, but emphasised that whatever the starting point, the risk of mortality approximately doubled as a result of the delay (Exhibit C5b, p14).

4. **Conclusions**

- 4.1. In my opinion, the following conclusions are appropriate having regard to the evidence before me:

- Mrs Pratt died as a result of complications arising from a perforation of her oesophagus during an endoscopy procedure performed by Mr Sam Gue, General Surgeon, at the Kapunda Hospital on 5 July 2000.
- When Mrs Pratt re-presented to the Kapunda Hospital at about 6:00pm on 5 July 2000, she was in significant pain which indicated that the oesophageal perforation had occurred.
- Dr Van Dissel, in consultation with Mr Gue and Dr Lecons, the anaesthetist, treated Mrs Pratt conservatively at that time with pain relief and antibiotics. Ideally, Mrs Pratt should have been urgently transferred to a major teaching hospital such as the Royal Adelaide Hospital for corrective surgery.
- Mr Gue should bear the responsibility for the fact that Mrs Pratt was not transferred at that time since he was the specialist in charge of her treatment.
- Mr Gue's ability to supervise Mrs Pratt's treatment was made more difficult by the fact that he had left Kapunda by the time Mrs Pratt's complications became apparent.
- When an oesophageal perforation was diagnosed at about 11pm on 5 July 2000, Mrs Pratt should have been urgently transferred to a major teaching hospital. Instead, a decision was made to delay her transfer to the next morning.
- Again, I am of the view that the primary responsibility for the failure to transfer Mrs Pratt should rest with Mr Gue. There was a misunderstanding between him and Dr Van Dissel about what was to occur. Mr Gue should have insisted, as the treating Consultant, upon transfer.
- The delay until the morning of 6 July 2000 to the Royal Adelaide Hospital significantly increased (indeed approximately doubled) the risk of a fatal outcome.

- 4.2. The facts in this case are remarkably similar to the circumstances surrounding the death of Mrs Lorraine Wellington, which was the subject of an inquest conducted by Mr Garth Thompson in May 1993 (Inquest Number 23 of 1993). Mrs Wellington died from complications of laparoscopic surgery performed at the Yorketown Hospital by a visiting surgeon who had returned to Adelaide by the time the complications became apparent. The General Practitioner in whose care she had been

left attempted to treat her conservatively rather than arranging an early evacuation.

Mr Thompson said:

'By leaving the care of the patient to other persons, the surgeon himself has to delegate a responsibility that is his own. He is responsible for the adequacy of the surrogate post-operative care. It is not satisfactory to leave the post-operative team to contact him in the event that "things might go wrong"

..... Part of the surgeon's expertise extends to post-operative care. There should be a system in place whereby the onus is fairly and squarely on the surgeon to initiate contact with the person providing post-operative care...." (see Findings, p74)

4.3. I agree with those comments.

4.4. Mr Wilson sets out in his report a number of comments arising from the circumstances from Mrs Pratt's death. These include:

- Gastrointestinal endoscopy requires specialist training, not only to achieve technical competence but also for the performing practitioner to know how to interpret findings after the procedure and institute appropriate management procedures. The Conjoint Committee for the Recognition of Gastrointestinal Endoscopy Training now provides recognition for this training although, prior to 2000 when Mr Gue commenced using this technique, such formal training was not required.
- Rural and remote patients are often at a disadvantage in terms of access to diagnostic and other medical services, and gastrointestinal endoscopy procedures are often performed by visiting specialists who, because of logistics, are often not present after the standard recovery time. Although major complications are rare, specialist interpretation of clinical signs in the event of serious complications is necessary. Access to good specialist advice is therefore critical should an adverse event occur.
- Few rural centres are able to deal with major surgical interventions necessary for a problem such as oesophageal perforation, even if appropriate specialist care is available. The need for access to a major surgical facility to deal with such a problem is clear. Mr Wilson suggested that formal links between endoscopists who perform invasive procedures in rural settings and the major teaching hospitals, and indeed between the rural and remote hospital and the major teaching hospitals, should be established so that if an emergency occurs the processes of communication and transfer are more readily activated.

5. Recommendations

- 5.1. In this case, it is clear that Dr Van Dissel did not have a good idea of how to obtain emergency treatment for Mrs Pratt in the late evening of 5 July 2000. On Professor Watson's evidence, had a transfer occurred at that time, Mrs Pratt would have received appropriate emergency treatment no matter what the time of day or night.
- 5.2. It is inherent in Mr Wilson's comment, however, that if Mr Gue had a formal arrangement with a major teaching hospital which could be activated in the event of an emergency, Dr Van Dissel's knowledge of the subject would not have been decisive. Mr Gue could have made all the necessary arrangements for Mrs Pratt's transfer by activating a retrieval to the Royal Adelaide Hospital without undue trouble.
- 5.3. Accordingly, I recommend:
- 1) That where medical specialists perform invasive surgical procedures in rural and remote areas, they should develop appropriate arrangements with a major teaching hospital for emergency evacuation and transfer to that hospital in the event of an emergency.
 - 2) Such specialists should also develop a clear and unambiguous emergency plan in the event that they are no longer present in the area where the procedure was carried out after the standard recovery time has elapsed, whereby immediate and effective contact between the general practitioner and the specialist can be established, and an evacuation to a major teaching hospital can be implemented if required.

Key Words: Medical treatment; endoscopy, perforated oesophagus, hospital treatment.

In witness whereof the said Coroner has hereunto set and subscribed his hand and

Seal the 8th day of May, 2003.

Coroner