CORONERS ACT, 2003

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 30th and 31st days of August 2005, the 1st day of September 2005 and the 10th day of November 2005, by the Coroner's Court of the said State, constituted of Anthony Ernest Schapel, Deputy State Coroner, into the death of Christopher Lazopoulos.

The said Court finds that Christopher Lazopoulos aged 34 years, late of 4/3 Blyth Street, Parkside, South Australia died at Royal Adelaide Hospital, North Terrace, South Australia on the 28 March 2002 as a result of multi-organ failure with right-sided tension pneumothorax. The said Court finds that the circumstances of his death were as follows:

1. Introduction and reason for Inquest

1.1. Christopher Lazopoulos, who was 34 years of age at the time of his death, died at the Royal Adelaide Hospital (RAH) on 28 March 2002. He had been admitted to the RAH on 7 March with a diagnosis of a ruptured spleen and with complications of broken ribs.

1.2. The deceased had presented to the Emergency Department of the RAH complaining of abdominal pain on both 19 and 28 February 2002, as well as on 5 and 6 March. On each of those occasions he was discharged without having been admitted to hospital. It was not until 7 March 2002 that a definitive diagnosis was made. All of those presentations to the RAH occurred by way of ambulance arrival.

1.3. In addition to these presentations, the deceased had also presented to the clinics of two different general practitioners on various days in March of 2002, in the main

complaining of pain. He was referred to the RAH on two of those occasions, namely the occasions of 5 and 7 March 2002.

1.4. Ultimately the deceased died on 28 March 2002 at the RAH, not of complications of his ruptured spleen but of multi-organ failure with a right-sided pneumothorax, complications of degenerative lung function associated with fractured ribs, no doubt sustained at the same time as his spleen injury. In this Inquest I explored how it had come to pass that a man who had constantly complained of pain to the RAH Emergency Department was not admitted upon any of those earlier presentations to the hospital and I explored whether more appropriate medical intervention should have been delivered. I also examined whether earlier diagnosis and admission would have altered the fatal outcome. In addition, I examined whether appropriate resuscitation measures had been administered to him when the deceased suffered what was to be a fatal cardiac arrest on the day of his death.

2. The deceased's cause of death

2.1. Following the deceased's admission to the RAH on 7 March 2002, he underwent a laparotomy and splenectomy for his ruptured spleen. This took place later that day. As well, probable pneumonia was diagnosed and the deceased was admitted to the Intensive Care Unit (ICU) on 9 March 2002 with worsening respiratory status. His respiratory status deteriorated with the development of respiratory failure and adult respiratory distress syndrome (ARDS) requiring him to be intubated on 11 March 2002. The deceased's lungs collapsed and consolidated and pleural effusions developed. There can be little doubt that the deterioration in the deceased's lung function and respiration was the consequence of broken ribs. At post-mortem, four fractured ribs on the left hand side were identified. I was told, in a nutshell, that pain and discomfort associated with broken ribs can cause breathing difficulties and a reluctance to cough in the first instance. Infection can then develop and this can result in pneumonia followed by a break down of lung function in due course. Associated with the deceased's respiratory difficulties was a staphylococcal infection and ultimately a suspected sepsis.

2.2. On 28 March 2002, the day of his death, the deceased underwent a tracheostomy to assist with his respiration. A tracheostomy involves the surgical installation of a tube directly into the trachea. Not long after the tracheostomy was performed, and upon

his return from theatre to the ICU, the deceased went into cardiac arrest. The breakdown of his lung tissue had resulted in the development of a tension pneumothorax which consists of the entry of air, via the lungs, into the pleural cavity. This may have been caused by the additional air pressure created in the lungs associated with artificial ventilation consequent upon the tracheostomy; I add here that there is no suggestion that the insertion of the tracheostomy was not an appropriate nor properly conducted procedure. The compression or tension of the air in the pleural cavity can lead to physical restriction and to a compromise in cardiac output. The restriction may lead to cardiac arrest. Unless the compression of the air constituting the pneumothorax is relieved by drainage or by thoracocentesis, which is effected by the insertion of a needle into the chest cavity, heart function is unlikely to be restored and the person will die. This is essentially what transpired with Christopher Lazopoulos. He developed a right-sided tension pneumothorax and in spite of efforts at resuscitation, and in particular efforts in attempting to relieve the tension pneumothorax, he died.

2.3. Professor Roger Byard, a specialist forensic pathologist at the Forensic Science Centre, performed the post-mortem examination upon the deceased's body. Professor Byard expresses the opinion that the cause of deceased's death was multi-organ failure with right sided tension pneumothorax. I find that to be the cause of the deceased's death.

3. <u>Chronology of material events leading to the deceased's admission to the RAH</u>

3.1. <u>First presentation at the RAH – 19 February 2002</u>

The deceased first presented at the RAH on 19 February 2002. He presented at the Emergency Department of the hospital at around 6:41 pm. At about 8:00 pm he was seen by a Dr Graham Grove who was at that time an intern. The deceased told Dr Grove that he had been experiencing right flank pain for about four days and that it was constant but worse on movement. He seems to have made a point of telling Dr Grove that the pain was relieved by morphine. Dr Grove examined the deceased and noted on the Emergency Department record (UR9) that he possibly had a renal stone (that is a kidney stone) or was possibly drug seeking in the light of the deceased's claim that his pain was relieved by morphine. There was no suggestion by the deceased on this occasion that he had suffered any recent trauma. Dr Grove noted his clinical observations that included reference to the fact that the deceased's chest

was clear and that his abdomen was soft with no masses and with bowel sounds present. Dr Grove discharged the deceased from the Emergency Department having provided him with some morphine. I mention here that Dr Grove's superior was critical of Dr Grove having provided the deceased with morphine in the particular circumstances.

3.2. Second presentation at the RAH – 28 February 2002

The deceased again presented to the Emergency Department of the RAH on 28 February 2002. Again, as it happens, he was seen by Dr Grove. The time was approximately 10:40 pm when he was first seen by that doctor. Dr Grove noted on a fresh UR9 form that on this occasion the deceased was complaining of left flank pain of two days duration. The pain was described as severe and constant with no aggravating nor relieving factors. On this occasion Dr Grove noted that the deceased said that he had been in a fight that evening but had sustained no injuries and it was specifically noted that the deceased had said that he had not been punched in the abdomen. It is to be observed, however, that he had told ambulance officers that he had been so kicked and punched. The deceased mentioned that he had been taking methadone and was slowly being weaned off that drug but went on to demand morphine. This caused Dr Grove, because of his previous experience with the deceased on 19 February, to note in the record *"this is definite drug seeking behaviour"*. The deceased refused to provide Dr Grove with a urine specimen. Dr Grove noted that the deceased had said that he had not passed any kidney stones since his previous presentation. Dr Grove told the deceased that he would not be given any morphine. When the latter demanded morphine for a second time, Dr Grove told him that he could provide the deceased with other medication for his pain but refused to administer morphine. Dr Grove offered an alternative painkiller which he noted that the deceased *"took"* and then "*stormed off"*.

3.3. Dr Grove, in noting his diagnosis at the foot the clinical record, recorded the words *"drugs – seeking"*.

3.4. This appears to be the first occasion on which the deceased claimed that he had been in a traumatic situation, namely a fight.

3.5. Presentation at the Fullarton Family Practice – 4 March 2002

On 4 March 2002 the deceased presented at the Fullarton Family Practice and he was seen by Dr Simon Spedding. Dr Spedding provided a statement verified by affidavit (Exhibits C15 and C15.a). In addition, I have had access to the practice's clinical record in relation to the deceased. That became Exhibit C4.b.

3.6. The deceased told Dr Spedding that he had fainted as a result of having taken Tegretol for seizures. Significantly, the deceased told Dr Spedding that he had fractured four ribs. There was no diagnostic information available at the time which confirmed that claim, but Dr Spedding states that he had no reason to doubt it. I pause here to observe that indeed there is no evidence before me as to the origin of the deceased's claim in this regard, but as we will see in due course, at post mortem the deceased had in fact at some point in time suffered the fracture of four of his ribs on the left hand side. How the deceased knew or believed that he had four fractured ribs on 4 March 2002 remains undetermined.

3.7. Dr Spedding recommended that the deceased obtain an x-ray. Again, the deceased requested morphine for the pain but Dr Spedding refused this as he was aware of the deceased's drug abuse difficulties. Dr Spedding believes that he spoke to Mr Lazopoulos about the desirability of the deceased attending hospital.

3.8. Dr Spedding did not make any notation in his record as to the origin of the deceased's claimed broken ribs nor any note of the circumstances in which he may have sustained the same. However, Dr Spedding states that the deceased would quite often come to the practice and see him after fights that the deceased had experienced during "business deals". Dr Spedding quite often observed bruising said to have been so sustained. In addition, Dr Spedding points out that on 4 March 2002 the deceased told him that he had fainted and the claim of fractured ribs seems to have been made in that context, as if to suggest that they were possibly sustained as a result of the fainting episode. There is no evidence that the deceased told Dr Spedding on this occasion that he had been in a recent fight, as he had told Dr Grove on 28 February 2002.

3.9. Presentation at the Fullarton Family Practice – 5 March 2002

There is no evidence that the deceased had sought any medical treatment in the period between his presentation to Dr Spedding on 4 March 2002 and his presentation to the same practice on 5 March 2002.

3.10. On 5 March 2002 Dr Spedding noted that the deceased had left-sided chest pain and upon examination noted that there were no breath sounds in that area. On this occasion he referred Mr Lazopoulos to the RAH as he thought that Mr Lazopoulos possibly had a pneumothorax. Although the deceased refused an ambulance when he was with Dr Spedding, it is clear that he did travel by ambulance to the RAH on this occasion. Dr Spedding compiled a letter of referral to the RAH. The South Australia Ambulance Service notes, which form part of the RAH clinical record, records a history of left flank pain with broken ribs sustained from an unknown cause, query assault/fall. The ambulance record specifically notes that the deceased had been discharged from the RAH the previous Wednesday with the same complaint. This appears to be a reference to the deceased's attendance at the RAH on 28 February 2002. The ambulance record states that upon an initial survey of the deceased he was noted to have abnormal breathing, although it does not precisely describe the observed abnormality.

3.11. Third presentation at the RAH – 5 March 2002

On this occasion the deceased was seen by a Dr Ghazwan Ashak (as he was then called) at 2:40 pm. Dr Ashak now goes by the name of Dr Ghazwan Channo. Dr Channo gave evidence before me in the course of the inquest. In 2002, he was a Resident Medical Officer attached to the RAH Emergency Department.

3.12. Dr Channo noted that the deceased was complaining of lower left rib pain for a duration of four days. The pain is recorded as having been exacerbated by coughing and by taking a deep breath. The pain was said not to respond to regular analgesia. Dr Channo also noted a complaint that the deceased had been suffering from loin pain which was constant.

3.13. When the deceased presented to the RAH on this occasion he was clearly in possession of the referral letter from Dr Spedding which was dated 5 March 2002. The ambulance record notes that the deceased was in possession of a doctor's letter at

the time of his transfer to the RAH by that service. It was obviously a reference to Dr Spedding's letter. The letter stated:

> *'Dear Doctor. Thank you for seeing Christopher Lazopoulos, aged 34 years, he has fractured some ribs recently and is having difficulty breathing. Please would you reassess him.'*

3.14. The letter then goes on to give some detail of the deceased's past medical history as well as a detailed list of the deceased's recent medication.

3.15. Dr Channo has noted on the RAH UR9 form for that presentation an almost identical medical history, and in almost identical order, to the history as listed in the referral letter. Moreover, Dr Channo has noted in the hospital record the medication in the same detail and order as appears on the referral letter. In those circumstances the inference that Dr Channo had access to and read the referral letter is clear. There was some initial reluctance on the part of Dr Channo to acknowledge that as a fact, but when the obvious was pointed out to him, namely the coincidence of his notations in respect of past history and recent medication, he acknowledged that it was more likely than not that he had access to the referral letter (T86).

3.16. Dr Channo ordered a chest x-ray of the deceased. That x-ray was performed and in due course a radiological report was prepared within the RAH. However, the report was not made available to Emergency Department staff at the time of the deceased's presentation on that day and it also does not appear to have made its way onto the relevant RAH file. Rather, it was separately provided to the State Coroner's Office at some later point in time. I will return to the significance of this report in due course but its contents do not appear to have played any part in any diagnosis considered or made by Dr Channo at the time of the deceased's presentation on 5 March 2002. There is an issue as to whether it should have.

3.17. However, Dr Channo was able to gain access to the actual x-rays taken. He showed those x-rays to a colleague, a Dr Karen Williams, who at that time was a first year registrar working within the Emergency Department of the RAH and senior to Dr Channo. Dr Channo did this because he had little experience in the interpretation of x-rays.

3.18. It appears that a diagnosis, that had part of its basis the actual x-ray films, was in fact made while the deceased was at the Emergency Department that day. Dr Channo

noted on the record that the deceased had a fractured rib but that there was otherwise no abnormality detected on the x-rays. Dr Channo claimed that he did not make that diagnosis. He said that the diagnosis of a fractured rib was made by his colleague Dr Williams after she had examined the x-rays.

3.19. The unseen x-ray report dated 5 March 2002 became Exhibit C.9. The contents of the report are as follows:

> *'There is no pneumothorax identified. There is no displaced rib fracture seen. There is an area of patchy opacification seen at the left base which may be due to collapse but an underlying infective process cannot be excluded and clinical correlation is recommended. There is a small left sided pleural effusion also. Otherwise the rest of the lung fields appear clear. Cardiomediastinal contours and hilar structures appear unremarkable.'* (Exhibit C9)

3.20. The report makes no mention of there being multiple rib fractures. The reference to there being no displaced rib fracture seen is consistent with there being a rib fracture depicted in the x-rays but that it was not a displaced fracture. A displaced fracture occurs where the two ends of the broken rib have been displaced in relation to each other. Such a situation will more readily be seen on x-ray. The reference to there having been an area of patchy opacification seen at the left base and there having been a small left side pleural effusion were observations that were to have later significance in terms of the deceased's deterioration after he was admitted on 7 March 2002. In short, the suspected pathology described in the report was prophetic of the illness that was to lead to the deceased's death.

3.21. After the diagnosis of a fractured rib was made, not based as I have said on any x-ray report as such, but simply on the basis of the observation of the x-rays themselves and the deceased's presentation, the deceased was provided with a painkiller Panadeine Forte and was discharged. It is unclear whether Dr Spedding's referral letter was really taken on board.

3.22. <u>Presentation to Fullarton Family Practice – 6 March 2002</u>

The deceased presented again to the Fullarton Family Practice on 6 March 2002 and this time complained of having been poisoned after taking nine Nurofen tablets which he said had been given to him by the RAH the day before. The deceased said that these tablets had resulted in him suffering abdominal pain. Dr Spedding had access to Dr Channo's clinical record from the day before and gleaned from that that a chest

x-ray had been performed and that nothing abnormal had been detected. Specifically, Dr Spedding interpreted Dr Channo's notes as indicating that no fractured rib had been diagnosed. The notes made by Dr Channo in my view can be interpreted in that way as his writing leaves something to be desired. Furthermore, Dr Channo had failed to complete that part of the UR9 form that requires the "*Discharge Diagnosis*" to be noted. However, there clearly had been a diagnosis made of a fractured rib and this diagnosis was noted elsewhere on the form by Dr Channo. I pause here to observe that nothing particularly turns on whether or not Dr Spedding made the correct interpretation of Dr Channo's notes because, as we will see, the deceased later that day presented yet again to the RAH Emergency Department, and yet again was discharged after a diagnosis that was wide of the mark.

3.23. On this occasion the deceased again asked Dr Spedding for morphine which was refused. Dr Spedding gave him four Panadeine Forte tablets and suggested that he see a Dr Mead for further advice regarding medication. Dr Spedding was aware that Dr Mead had been involved in the deceased's methadone administration regime and believed that Dr Mead may have considered it appropriate for further and stronger pain relief to be administered in the light of the deceased's complaints on that day.

3.24. This appears to have been the last occasion on which Dr Spedding saw the deceased. Although the deceased had consulted Dr Spedding on 4, 5 and 6 March 2002, there does not appear to have been any claim by the deceased that he had received any chest or abdominal injury as the result of a fight or other trauma except to the extent that there was an unspoken suggestion perhaps that he may have sustained an injury as a result of fainting. There is no note made by Dr Spedding in his record of any claim of assault, only of the fainting episode.

3.25. Fourth presentation at the RAH – 6 March 2002

After the deceased had seen Dr Spedding on 6 March 2002, he proceeded again to the RAH Emergency Department by ambulance. The ambulance record which forms part of the RAH casenotes records a history of the deceased having had a tight painful stomach since the day before. It also makes reference to the deceased experiencing tachycardia (increased heart rate). This was confirmed by nursing observations taken on presentation to the RAH.

3.26. Dr Benjamin Woolven, a Resident Medical Officer, examined the deceased on this occasion. He saw the deceased shortly after 4:00 pm that day. On this occasion, Dr Woolven made notes of his examination of the deceased on a fresh UR9 form. Prior to Dr Woolven's examination, the deceased had undergone a triage assessment, the details of which were recorded on that UR9 form. The form reveals that the presenting complaint/triage assessment was *"Abd pain ? urinary retention + constipation"*. That was an entry applied to the document in handwriting, presumably by a triage nurse. However, the form as it existed when Dr Woolven received it also makes a computerised reference to the previous attendances on 19 and 28 February 2002 and 5 March 2002. The document recorded the discharge diagnosis in relation to the attendance on 19 February as being *"Query renal stones"*. The discharge diagnosis in relation to the attendance on 28 February 2002 is recorded as *"Flank pain oral GIT"*. The discharge diagnosis in respect of the attendance on 5 March 2002 is recorded as *"# RIBS"*, which means fractured ribs. These previous diagnoses are plainly visible on the front page of the form and were thus readily available to Dr Woolven. Dr Woolven commenced writing his notes on that page.

3.27. Dr Woolven recorded the presenting complaint on this occasion as abdominal pain and distension. He has also recorded the following in relation to the deceased's recent history:

> *'Since left ED last night gradual onset and worsening of abdominal pain and distension. Pain sharp, constant felt throughout abdomen, into chest and left shoulder 15/10 intensity exacerbated by movement. Cannot sleep, anorexia, HNV last 26/24. Bowels open yesterday afternoon diarrhoea º blood º mucus. No urge to use bowels/bladder. ºN ºV. Has passed flatus '*

3.28. The reference to *"15/10 intensity"* in the above note means that when asked to describe the intensity of his pain on a scale of ten, the pain was described as fifteen out of ten, in other words severe. The reference to *"HNV last 26/24"* means that the deceased had not urinated in the past twenty six hours.

3.29. Dr Woolven noted that the deceased was alert and oriented during the examination, that his tongue was a little dry, that his chest was clear and that his abdomen was distended, soft and moderately tender throughout. He also noted that bowel sounds were present but there was no urge to urinate. Dr Woolven planned to place a catheter into the deceased's bladder in the event that the latter was unable to pass urine, and to order an abdominal x-ray, but noted that the deceased then passed about

300 millilitres of urine and experienced some relief of his symptoms afterwards. Consequently, neither the catheterisation, nor the abdominal x-ray were performed.

3.30. Dr Woolven discharged the deceased and noted a discharge diagnosis of urinary retention/constipation which mirrored the triage assessment. By the time of his discharge, the deceased's tachycardia seems to have abated.

3.31. It is worthwhile observing here that Dr Woolven noted the deceased's past medical history and current medication in almost identical terms to the manner in which those two matters were noted in Dr Channo's UR9 form from the previous presentation on 5 March 2002, except that in two instances Dr Woolven has failed to replicate from Dr Channo's notes entries which Dr Woolven found in the witness box to be illegible. (T264) Accordingly, there is no doubt in my mind that Dr Woolven had access to the UR9 form compiled by Dr Channo during the previous evening's presentation on 5 March 2002. I also note here that Dr Woolven in his own notes in relation to the presentation on 6 March 2002 made reference to the deceased having left the Emergency Department the night before. I enlarge on all of this later.

3.32. Dr Woolven's notes of this attendance do not make any reference to any event experienced by the deceased that may have involved abdominal trauma such as a fall or a fight.

3.33. Presentation to Dr Mead – 7 March 2002

A letter dated 7 March 2002 apparently signed by Dr Damian Mead of the Brian Burdekin Clinic made its way to and forms part of the RAH clinical record. Although Dr Mead was not called to give evidence in the Inquest, nor provided a statement, the letter speaks for itself. The presence of the letter on the RAH file, together with Dr Spedding's statement that he suggested that the deceased see Dr Mead, leads to the inescapable conclusion that the deceased had seen Dr Mead on 7 March 2002 and had brought the letter with him when he again presented to the RAH Emergency Department on that date.

3.34. Dr Mead's letter begins in this fashion:

> *'Please admit Mr. Lazopoulos for investigation of abdominal pain, fever and tachycardia. I understand he has been presented to RAH over the past 3 days.'*

3.35. The deceased has plainly told Dr Mead that about six days ago he took Tegretol and two glasses of wine and fainted, and that as a result he had fallen and fractured ribs on the left hand side which Dr Mead noted as having been diagnosed on x-ray at the RAH. The letter goes on to explain that the deceased on the following day had developed severe generalised abdominal pain and that he had reported to Dr Mead on 7 March 2002 different pains, involving a burning pain on drinking and a severe abdominal bloating pain which increased with movement and jolting. The letter refers to a claim by the deceased that he had been constipated for three days and had passed some, but not much, wind. In addition, the letter describes left hand rib pain but no cough, with breathlessness. It also describes the deceased as having taken aspirin and codeine for pain. Dr Mead's examination, as revealed in the letter, makes reference to the deceased being pale and distressed with a pulse rate of 160. In addition, a chest examination revealed a lack of air entry in one of the lungs. Dr Mead suggests differential diagnoses including pneumonia. The letter reveals also that he was given some methadone that date.

3.36. Fifth presentation at the RAH – 7 March 2002

The deceased again presented to the RAH on 7 March 2002 shortly after 5:00 pm. He was clearly in possession of the letter from Dr Mead. It was on this occasion that a diagnosis of a ruptured spleen was made and he was admitted to hospital.

3.37. For current purposes I do not need to go into the details of this presentation, nor indeed into much of the detail of what transpired during the course of his admission until his death on 28 March 2002. However, I make the observation that on 7 March 2002 the deceased is recorded as having told RAH medical staff that he had fallen onto steel or iron on his left hand side eight days ago and that he had fractured ribs (note the plurality of that assertion) on the left hand side. He described continuous pain all week which had increased the day before and on that day.

3.38. A laparotomy was performed and his ruptured spleen was removed uneventfully. However, the ruptured spleen appears to have been the least of the deceased's medical concerns as by 28 March 2002 he developed a severe lung illness as well as sepsis which culminated in his death on 28 March 2002.

4. **The age of the deceased's injuries**

4.1. Before I embark upon a discussion of the deceased's medical treatment it is pertinent to ascertain whether the evidence allows for any finding to be made as to the age of the deceased's injuries. This is relevant to the issue as to whether those injuries should have been diagnosed and properly evaluated earlier than the fifth presentation to the RAH Emergency Department on 7 March 2002.

4.2. That the deceased had four rib fractures on the left hand side, as well as an injury to his spleen, is clear. In addition, the evidence seems all one way that the injuries were suffered by virtue of the same traumatic event. Dr Mark Finnis is an intensive care specialist and was involved in the deceased's care within the RAH Intensive Care Unit following his eventual admission. He also played a significant role in the efforts to resuscitate the deceased on the day of his death. Dr Finnis told me that fractures of the lower ribs in the chest wall have a very high association with splenic injury (T229) and that in this particular instance it was incomprehensible that the fractures to the ribs, situated as they were overlying the spleen, did not occur at the same time as the spleen injury. I accept that evidence. No-one has suggested to me that the injuries were not so associated.

4.3. As to how and when those injuries were sustained is another issue. The deceased himself made various statements as to the occasion of and the circumstances in which he had suffered trauma consistent with having caused the injuries. Although the deceased presented to the RAH with pain on 19 February 2002, there was no suggestion that he had been involved in any traumatic event. He said on this occasion that he was tender on the right flank, the pain being of four days duration. The broken ribs and injury to the spleen were in due course located on the left side.

4.4. The presentation to the RAH on 28 February 2002 was the first occasion on which the deceased mentioned that he had been in a situation involving trauma. He had told the ambulance officers that he had been assaulted that day and had been kicked and punched about the abdomen. He told Dr Grove on that presentation that he had been in a fight that night but had sustained no injuries and had not been punched in the abdomen. The pain he described had been in existence for the previous two days. On this occasion it was recorded as being left flank pain.

4.5. On 4 March 2002, the possibility that the deceased had fractured ribs was raised for the first time. As seen earlier, he told Dr Spedding that he had fainted as a result of taking the Tegretol tables, a claim he was to repeat to Dr Mead. He does not appear to have stated when it had been that he had experienced the fainting episode. On the following day, when Dr Spedding saw him again, it was recorded that the deceased had left-sided chest pain and that there were no breath sounds in that area.

4.6. On that same day, namely 5 March 2002, he described to ambulance officers a *"(L) flank pain?"* with fractured ribs of an unknown specific cause *"(?) assault/fall"*. Dr Channo of the RAH Emergency Department did not record anything said by the deceased about trauma, but recorded a history of pain in the left lower rib of four days duration.

4.7. On 6 March 2002, the deceased does not appear to have said anything, or anything that was recorded, to either ambulance personnel or to Dr Woolven about trauma. The deceased on 7 March 2002 did, however, relate the fainting episode to Dr Mead where he said he had fallen over and fractured left ribs, having taken Tegretol, about six days ago. On the same day, at the RAH, it is recorded that he said he had fallen onto his left hand side eight days ago, had fractured his ribs on the left side and had continuous pain all week.

4.8. The deceased at times appears to have been a poor historian as far as exactness of timing is concerned, but he appears to have been consistent in ascribing his broken ribs to the fainting episode. He had told his girlfriend Michelle Monaghan that he had fallen after drinking alcohol whilst on various medications, although he does not appear to have told her exactly when that fall happened. (Statement verified by affidavit, Exhibits C3, C3.a) This also appears to be in keeping with what he told Drs Spedding and Mead and what he said at the RAH on 7 March 2002. Although on 4 March 2002 he did not with precision tell Dr Spedding of the occasion when the fainting episode had occurred, he said he had not slept for four days. One might draw a preliminary conclusion from that association of ideas that he had suffered the fainting episode on about 28 February 2002. Although he told Dr Mead on 7 March 2002 that the fainting episode had occurred about six days earlier, which would place the event on or about 1 March 2002, he told RAH staff that his fall had occurred eight days earlier which would bring it back to 27 February 2002.

4.9. Some clinical findings suggest that the deceased's spleen injury had been present for some time prior to his last presentation to the RAH on 7 March 2002. Dr Finnis told me at T185 that the x-rays, CT scans and histology after the spleen was removed suggested that the spleen injury *"had been there for some days"*, although it was impossible to say with precision. Dr Finnis also said that there was a very well defined second incidence of delayed rupture from a splenic injury at the seven to ten day mark after the original trauma (T233), and postulated that the deceased's rupture occurred very close to his final presentation to the RAH. In addition, the lung and chest x-ray taken on 5 March 2002 in his view indicated changes present with likely pathology developing for a number of days prior to that.

4.10. Associate Professor Mark Fitzgerald, who is the Director of the Emergency and Trauma Centre at the Alfred Hospital in Melbourne, provided an overview of the deceased's treatment for the State Coroner. I received in evidence his report, Exhibit C14, and he also gave evidence at the Inquest. I return to Associate Professor Fitzgerald's opinions in a broader context presently, but he was asked in evidence to provide an opinion as to the age of the deceased's injuries. He expressed the following beliefs:

> 'A. Yes, on or about this day I believe he had an abdominal injury which caused splenic laceration, probably with development of sub-capsular haematoma, so he didn't have any acute bleeding to the abdominal cavity and subsequently the capsule ruptured and he bled. He also had associated rib fractures which impinged on the left lower lobe of his lung. The information that was discovered on 7 March suggested that this had been there for some period of time.
> Q. In particular, in your opinion, it was consistent with having been present on the 28 February.
> A. I can't be absolutely sure about that, but that's what I believe was the case.' (T292)

He also expressed the view that the deceased's statement on 7 March 2002 to RAH staff that he had fallen eight days earlier was probably reflective of the occasion when he had suffered the original spleen injury as well as the ribcage injury and that the actual rupture of the spleen may have occurred in the two days prior to his last presentation on 7 March 2002 (T305).

4.11. I accept the opinions and conclusions of both Dr Finnis and Associate Professor Fitzgerald. On 28 February 2002 the deceased presented to the RAH with severe and constant left flank pain. He claimed he had been in a traumatic event, albeit a fight,

not a fall. In my view, the deceased's own statements, his symptomatology and the clear views expressed by Dr Finnis and Associate Professor Fitzgerald all lead to the inescapable conclusion that the deceased had suffered the spleen injury and the broken ribs at a time shortly before or on 28 February 2002. Although he may have not told the truth as to how be sustained his injuries, I do not think that this detracts from the clear finding that in whatever manner he may have sustained the injuries, he had sustained them at about that time. I do not believe, however, that the deceased had the injuries on 19 February 2002, the occasion of his initial presentation at the RAH.

4.12. Therefore, in my view, the presentations to the RAH on 28 February 2002, and 5 and 6 March 2002 and the diagnostic evaluations made on those occasions have to be examined in the light of the fact that the deceased was carrying the spleen and rib injuries over the period covered by those dates.

5. Efforts at resuscitating the deceased on 28 March 2002

5.1. Before embarking upon a discussion of the events in February and March 2002 within the RAH Emergency Department, it is appropriate to deal relatively briefly with an issue surrounding Dr Finnis' handling of resuscitative measures that were undertaken in an effort to revive the deceased after he had suffered the fatal cardiac arrest on 28 March 2002 in the RAH Intensive Care Unit. Those measures involved Dr Finnis attempting to decompress the right-sided tension pneumothorax that had developed not long after the tracheostomy had been placed in the deceased's airway.

5.2. Associate Professor Fitzgerald, who as I have indicated provided the Court with an overview of the deceased's treatment at the RAH, made certain comments both in his report and in his evidence that brought into question the clinical decisions that Dr Finnis had made. The deceased arrested in the Intensive Care Unit and this was, as one would expect in this environment, detected quickly. Dr Finnis suspected rightly that the deceased had developed a tension pneumothorax on at least one side of his chest, no doubt caused by air escaping into the pleural cavity from the deceased's scarred lung tissue. As seen earlier, the compression of the escaping air and the consequent distortion of the organs within the chest can in plain terms physically obstruct proper heart function and this is what undoubtedly happened in the deceased's case. Cardiopulmonary resuscitation was applied, but no amount of it was

going to assist in these circumstances unless the obstruction to heart function was relieved. Dr Finnis attempted to relive the tension pneumothorax by allowing the air to escape from the affected cavity with the attempted insertion of a chest drain which involves the introduction of a tube into that cavity. Dr Finnis had no idea what side of the deceased's chest was affected. There was no way to determine this clinically, so Dr Finnis formed the intention to perform this procedure on both sides of the chest. He began by making an attempt to decompress the left side but the pneumothorax was in fact on the right. When the attempt was made on the left side, air did emerge from what was believed to have been the pneumothorax. However, this emission had not been caused by decompression within the chest cavity, but from air escaping from an extrapleural location. At port-mortem, it was clearly observed by Professor Roger Byard, a forensic pathologist, (report verified by affidavit, Exhibits C2, C2a) that the drain was not in the chest cavity. In short, and Dr Finnis accepts this, that the escape of air from an extrapleural location misled him into believing that he had relieved a pneumothorax. That had not in fact been the case as the pneumothorax was on the right side. The attempted decompression therefore had no effect in relieving the pneumothorax, and the cardiac arrest was not reversed. It was considered that no further attempts at resuscitation would be appropriate and Mr Lazopoulos was declared deceased. I pause here to add that there is a real question mark as to whether the deceased would in any event have survived.

5.3. Associate Professor Fitzgerald thought that a better way of relieving the suspected pneumothorax would have been thoracocentesis of both sides of the chest. As discussed earlier, thoracocentesis is a procedure whereby a needle designed for this purpose is inserted quickly into the chest on both sides thereby, hopefully, decompressing the chest. It is a procedure commonly utilised at accident sites for victims who have suffered a chest injury and then developed a consequent pneumothorax.

5.4. The issue of chest drain decompression versus thoracocentesis in the deceased's case was thoroughly ventilated during the Inquest. I heard a lot of evidence about it. Evidence was given by both Dr Finnis and Associate Professor Fitzgerald in relation to this issue and differing views were voiced. In so far as Dr Finnis was called upon during the Inquest to justify his actions, I express the view that he did so. I accept Dr Finnis' evidence that the tissue of the deceased's lungs by 28 March 2002 had

deteriorated through infection to such an extent that the administration of thoracocentesis, to his mind, could have involved a substantial and prohibitive risk of puncturing the unaffected lung thereby complicating matters further without necessarily saving his life, but creating in his view a unsalvageable problem. While Associate Professor Fitzgerald did not resile from the view that thoracocentesis would have been the preferred option, given the direness of the situation at hand, I did not understand him to be overly critical of Dr Finnis having not adopted that procedure. Associate Professor Fitzgerald could see the dilemma. He said:

> '… I'm not convinced that the pneumothorax, or the treatment of the pneumothorax, had any impact on the eventual outcome of the case, because by the time it happened he was so severely physiologically impaired, in such poor respiratory condition, this was really an end, requiring high pressures to ventilate just to keep oxygen going to his lungs, and his lung ruptures, once it starts happening, even if it happens on one side, then it will happen again, or happen on the other side, because the pathology has established itself. I can understand the dilemma. It is a difficult situation, but what I honestly believe - and I have no evidence to support this - is that they were confronted with a situation where, when looking at the patient, that deteriorates to a point with almost irreversible pathology, and it created a dilemma for them, because if it had happened a week or two earlier and they didn't know how the patient was going to go, it may be they would have done it very quickly, because they knew it would have had an impact. I think it is very unfortunate what happened, but it is a common way that people die with this sort of underlying lung problem.' (T336-T337)

Associate Professor Fitzgerald conceded at T340 that the matter boiled down to a difference of opinion. I think it is a concession that was validly made. I my view, Dr Finnis made a professional clinical decision in the best interests of a very sick patient, a decision that unfortunately did not bring about the desired outcome. Associate Professor Fitzgerald felt that it was understandable that Dr Finnis was deceived by the escape of air from an extrapleural location as indicating decompression. I agree with that observation and it is difficult to say on the evidence of both Dr Finnis and Associate Professor Fitzgerald that the outcome would have been any more favourable if Dr Finnis had utilised an alternative procedure or that the deceased's chances of survival would have been improved. In short, I do not think any criticism attaches to the efforts of Dr Finnis.

6. <u>The presentations on 28 February 2002 and 5 and 6 March 2002</u>

6.1. I have concluded that on 28 February 2002 when the deceased presented at the RAH Emergency Department he was carrying a splenic injury as well as fractured ribs.

I need say little about this presentation and about Dr Grove's handling of the situation other than that, in the light of the previous presentation on 19 February 2002, where the deceased appeared to be drug seeking, there was on the face of things, for any reasonable person in Dr Grove's situation, reason to believe that the deceased was drug seeking yet again. I also accept Dr Grove's explanation that in any event he was unable to provide meaningful clinical input because, as he recorded, the deceased *"stormed off"* when refused morphine. In those circumstances, Dr Grove in my view cannot be criticised.

6.2. On the other hand, in my judgment what transpired on 5 and 6 March 2002 at the RAH was characterised by a perplexing catalogue of missed diagnostic opportunities.

6.3. As seen, the deceased presented at the RAH on 5 March 2002 with Dr Spedding's letter of referral. The letter made reference to broken ribs and difficulty in breathing. While one rib fracture was confirmed upon an examination of the x-ray films, the x-ray report dated 5 March 2002, which was prepared by a radiological registrar, was not seen. Dr Karen Williams, who Dr Channo states was the practitioner who viewed the x-ray and reached the conclusion of a broken rib, claimed in evidence that she had no recollection of any of this. This is perhaps not surprising as she did not see the deceased nor have any further input in the examination. On the other hand, Dr Channo made a note of her involvement on his UR9 form and there seems little doubt that Dr Williams did in fact examine the x-rays.

6.4. Dr Williams gave evidence in the Inquest. In the course of her evidence, she was invited to examine the x-rays taken on 5 March 2002 in the light of the fact that the x-ray report which she did not see referred to anomalies that might have suggested a collapsed lung, an underlying ineffective process and a small left-sided pleural effusion. Dr Williams was asked by Ms Hodder, Counsel Assisting, whether she could see the area of patchy opacification at the left base that was suggested in the report as being possibly due to collapse or an ineffective process and she said:

> 'I imagine that they are talking about this region here because it's not as clear.' (T174)

She also agreed that the x-rays revealed a possible small effusion as the report also stated. However, Dr Williams was of the view that neither abnormality would have caused her particular concern. For instance, upon reading the x-ray report, she did not think that its contents would have necessitated an urgent call to the patient in the

period after he had been discharged (T145). To be fair to Dr Williams, there is no suggestion that she actually saw and examined the deceased on 5 March 2002. She had simply been asked to view the x-rays. In addition, Dr Williams did later say in her evidence at T152 that if she had received the report she most likely would have called the patient to see how he was going with a view to possibly administering antibiotics. There is no suggestion, however, that she alerted Dr Channo to any pathology or possible pathology recorded by the x-rays other than the rib fracture. Apart from noting the rib fracture, Dr Channo noted that there was no other abnormality detected. There is also no suggestion that Dr Williams saw Dr Spedding's letter that spoke of breathing difficulty.

6.5. I accept that a diagnosis of lung pathology underlying broken ribs is in the main based upon the overall clinical assessment of the patient, not merely upon the examination of x-rays. But the x-ray report suggested possible underlying pathology and recommended clinical correlation. My view is that because the x-ray report was not seen by Dr Channo, nor by anyone else for that matter, no such clinical correlation ever took place. This in my view was an unsatisfactory state of affairs. Not only was there no clinical correlation, no such correlation was even considered.

6.6. Dr Finnis was of the view that the x-rays revealed changes in the left base which were clearly abnormal for a young male and were consistent with likely pathology, a collapse or infection with loss of air space that had been developing for a number of days. For him, that would have meant that he would have been obliged to look further. He would have wanted to examine the deceased's blood count to determine if infection was present and to see if it looked as though he did have a developing pneumonia. He said he would have treated the deceased with antibiotics, albeit possibly as an outpatient.

6.7. Associate Professor Fitzgerald told me that in his view the unseen x-ray report involved a *"key-finding"* (T298). He said:

> 'The chest X-ray shows at least one fractured rib and a consolidated left lung base with some fluid in the lung, which would be of concern and would certainly explain why he couldn't breathe properly because his lung wasn't working properly, because of the overlying injury and the interference with ventilation. So I guess one, you need to have the X-ray reported correctly, and secondly, you need to investigate whether the patient has got any breathing difficulties.' (T294)

His view was that most people would have been admitted to hospital with x-ray report results of this nature and with clinically observed difficulty in breathing (T297). He said that you would expect that if the deceased had presented with fractured ribs, with some consolidation of the lungs, and with presumed underlying infection, that this pathology would progress and develop into subsequent and worsening lung infection (T299). Indeed, that is precisely what transpired in this case. Associate Professor Fitzgerald also believed that arterial blood gas tests and a full blood examination should have been conducted to check oxygenation and infection respectively, but that in any event the x-ray results in contribution with clinically observed difficulty in breathing were significant and worrying signs in themselves, largely rendering other tests as irrelevant unless abnormal.

6.8. Dr Williams told me that she would not have performed arterial blood gas tests or a full blood examination. My view is that Associate Professor Fitzgerald's approach is to be preferred. I accept the observations of both Dr Finnis and Associate Professor Fitzgerald. The evidence that the x-rays contained significant diagnostic information is overwhelming in my view. It is difficult to resist the conclusion that the unavailability of the x-ray report on 5 March 2002 meant that a significant diagnostic opportunity was missed. It was already known, or should have been known from Dr Spedding's referral letter that the deceased had a broken rib or ribs. In the eyes of Drs Channo and Williams, the x-rays merely confirmed the presence of a rib cage injury and excluded an existing pneumothorax at that time. I am satisfied that the x-rays contained more diagnostic information than simply that. The x-ray report, or a more careful clinical assessment of the x-rays themselves while the deceased was in the Emergency Department, would have completed the picture. I have little doubt that a proper and timely evaluation of the x-rays should have dictated a different and more timely course of treatment. All that took place in reality on 5 March 2002 was that the deceased had a rib cage injury confirmed, that he was given stronger pain relief and was referred back to his local GP with the hospital notes. Even then, Dr Spedding was evidently misled by Dr Channo's writing in relation to the existence or otherwise of a rib fracture. The point is, however, that the deceased's underlying suspected lung pathology was never adequately addressed on that day by RAH staff because, in the main, the x-ray report was not available. As to whether this affected the eventual fatal outcome I will deal with presently.

6.9. I turn to the deceased's presentation to the RAH Emergency Department on 6 March 2002. The first observation to be made is that the x-ray report of 5 March 2002 does not appear to have been seen on this occasion either. There is no evidence that it had made its way onto the deceased's clinical record at any stage. Although dated 5 March 2002, there is no evidence that it was seen by Dr Woolven who examined the deceased on 6 March 2002. Dr Woolven had no recollection of looking through any records of prior attendances. However, as observed earlier, in my view he must have at least seen Dr Channo's UR9 form from the previous attendance, given the striking similarity between the manner in which both practitioners recorded the deceased's medical history and recent medication. Dr Woolven conceded, in the light of that coincidence, that it was highly probable that he did see Dr Channo's form. It also seems from the evidence that Dr Woolven on this occasion also had a discussion with Drs Channo and Grove about the deceased. There is also the fact that there was a computerised reference to the previous day's diagnosis of fractured ribs on Dr Woolven's own UR9 form relating to the presentation on 6 March 2002. Although Dr Woolven stated that he could not recall being aware of the deceased's fractured rib or ribs, in my view, it is inconceivable that Dr Woolven was not aware of the previous day's diagnosis of a fractured rib at the time he personally examined the deceased on 6 March 2002. I am satisfied that he was so aware.

6.10. I find, however, that Dr Woolven did not see the x-rays themselves nor the x-ray report, nor was given any documented information that was suggestive of underlying lung pathology.

6.11. In the event, Dr Woolven diagnosed the deceased as having urinary retention/constipation. However, in his evidence, Dr Woolven made certain concessions about his approach had he been made aware of the x-ray report. He said at T266 that the suspected pathology described in the report was to use his expression, *"certainly significant"*, although his own examination suggested his lungs were clear. Dr Woolven also stated that if at the time he had been aware of the very recent diagnosis of a broken rib, he thought he would have chased up an x-ray report if it was in existence. He did not recall doing that (T280). Given the fact, as I find, that Dr Woolven must have known about the recent diagnosis of a fractured rib, his failure to enquire as to whether the report was in existence is perplexing, particularly when it is borne in mind that the diagnosis was made only the night before and that the

deceased was presenting with abdominal pain that Dr Woolven knew had worsened since then. In Dr Woolven's favour, although he did not lay claim to this, I do not overlook the possibility that having seen Dr Channo's UR9 form he was wrong footed by its reference to no abnormality having been detected except the fractured rib.

6.12. It is to be remembered that the deceased at that time had a spleen injury. Dr Woolven conceded that fractured ribs on the left side, together with a low urinary output and other signs, made the diagnosis of a ruptured spleen the more likely presentation (T272). Those other signs included tachycardia which is a rapid heart beat. It was recorded by the ambulance officers as 138 beats per minute and by the nursing staff as 121 beats per minute. Those signs were very abnormal and somewhat alarming in Associate Professor Fitzgerald's assessment. Dr Woolven sought to deflect the significance of that abnormality by pointing out that prior to the deceased's discharge his heart rate had reduced to 80 beats per minute, within the normal range. In this regard, I prefer the approach of Associate Professor Fitzgerald who said in effect that the reduced heart rate has to be examined against the incontrovertible fact that he had originally presented with significant tachycardia, a much more telling observation than the lower rate recorded later (T324-326).

6.13. The deceased may have been suffering from constipation and urinary retention, or at least a low urinary output, as well on 6 March 2002. But there was clearly information within the four walls of the RAH on this occasion that was available, or should have been available, to Dr Woolven, upon which an informed diagnosis of a ruptured spleen and suspected lung pathology could have been made and acted upon in the deceased's interests. Without being wise after the event, there were classic signs of what was wrong with the deceased in Associate Professor Fitzgerald's view. The deceased had severe pain, described as 15/10 where 10 represents the worst pain the patient can imagine. He had shoulder pain, consistent with pain reflected from the splenic injury. He was tachycardic, had little urinary output and had previously been diagnosed with a broken ribcage on the left side, an injury that frequently goes hand in hand with a splenic injury. If anything, Dr Finnis was even more forthright about the significance of the deceased's symptomatology on 6 March 2002. He said at T227 and T238 that the x-ray report and other symptoms gave rise to a *"constellation of signs which we would teach medical students should be taken very seriously indeed"*. At T239 Dr Finnis went so far as to say that the lung changes, rib fractures,

abdominal pain travelling to the left shoulder were signs, taught to even junior doctors, to be treated with great respect such that they amounted to a *"red flag"*. In the light of all that there was, I find, another missed opportunity to diagnose correctly.

7. **Did the failure to properly diagnose on 5 and 6 March 2002 affect the fatal outcome?**

7.1. I am not satisfied that the ruptured spleen played a role of significance in the death of the deceased. Although this discrete injury was not diagnosed until the 7 March 2002 presentation at the RAH, it is clear to me that the undiagnosed pathology of major significance was the lung infection consequent upon broken ribs. The development of the fatal pneumothorax reflected the natural progression of that infective process, and of the consequent lung tissue deterioration. No attempt was made to arrest that progression until the deceased's admission on 7 March 2002.

7.2. Associate Professor Fitzgerald expressed the view that with earlier diagnosis:

> 'Whether his death, with confidence you could say absolutely, could have been avoided, I can't say that. I think it would have been likely that he would have survived. I think he would have had 50% survival if he had been diagnosed on the 5th.' (T312)

He also said at T313 that he had no doubt that an earlier diagnosis and intervention on 6 March 2002 would also have improved the deceased's chances of a non-fatal outcome.

7.3. Associate Professor Fitzgerald explained that when the deceased presented on 5 March 2002 his vital signs were reasonably good, he was maintaining reasonable oxygen saturation and that he had a reasonable physiological response for a young person to the developing infection and respiratory failure. On that basis he believed that if the deceased had been treated earlier, he most likely would have survived (T316). For example, he stated that one of the things that could have been commenced was intravenous antibiotics to counter the lung infection.

7.4. Dr Finnis also expressed a view about this issue. At T231 he stated that the findings from the 5 March 2002 x-rays almost certainly represented the beginning of the pneumonia which became widespread in the deceased's lung and that the development of that pneumonia had a significant bearing on the ultimate outcome. However, Dr Finnis stated that in his view the delay in diagnosis and intervention of twenty-four to forty-eight hours was on balance unlikely to have made an enormous

difference in terms of preventing the fatal outcome. He explained that antibiotics alone do not cure infections and that the deceased bore a number of risk factors which would have rendered him less likely to have responded well to treatment for infection (T240).

7.5. Associate Professor Fitzgerald strongly disagreed with Dr Finnis' view. He said:

> 'Yes. I don't believe it. It is absolutely contrary to how people practise medicine. They want people to present early so they can intervene early to prevent subsequent complications. You have a look at the referring doctor's examination on 7 March where he indicates that the patient, clinically, now has a consolidated lung - he has drawn that as a diagram on his referring letter - and two days previously that didn't exist. So, he has had significant progress of the underlying diseased state. So, I can't honestly say, even though I'd like to, but I can't honestly that earlier treatment wouldn't have made any difference. I honestly believe it would have made a significant difference.' (T344)

In addition, Associate Professor Fitzgerald pointed to the deterioration in the deceased's appearance and of his vital signs that had taken place between 5 March and 7 March 2002, the day on which he was diagnosed accurately. There were significant differences in presentation, temperature and pulse rate and air entry to the lungs (T346). Associate Professor Fitzgerald was particularly persuasive in this regard and I accept his analysis of the situation.

7.6. In my view, the deceased's chances of successful treatment and survival would have been significantly enhanced had he been properly evaluated and his lung infection been detected on 5 March 2002. The matter is less clear in relation to 6 March 2002 given the passage of time, but I accept Associate Professor Fitzgerald's evidence at T313 that earlier diagnosis and intervention on that date might have made some difference to the outcome.

8. <u>The availability of the 5 March 2002 x-ray report to doctors on 5 and 6 March 2002</u>

8.1. Dr Finnis told me that it was not surprising to him that the x-ray report was not seen by the practitioners who were involved in the deceased's presentation 5 March 2002. Dr Finnis spoke of the overburdening of Emergency Departments and the queuing of the review of radiological reports such that he would have been astounded if it had been made available within a few hours. On the other hand, he thought that the report would have been available on 6 March 2002 which raises in my view a very serious question mark as to why its contents were not evaluated on that occasion.

8.2. I heard evidence from a Dr Michael Davey, who is the Acting Director of the RAH Emergency Department. In March 2002 he was a staff specialist in that department. He told me that at that time the x-ray processing system was such that there was often a significant delay between the availability of the x-ray for the clinician in the Emergency Department and the availability of the formal report from the radiology specialist. In after hours and weekend situations, the availability of the report could be delayed for several days, often longer. I am told that the situation has improved since then, but one would have to wonder what the utility of an x-ray report actually was in the circumstances that prevailed in March 2002, particularly where a patient is very likely to deteriorate significantly over a short period of time. Dr Davey told me that if after an x-ray report became available it was assessed that a diagnosis had been missed, then the patient could be recalled or a letter sent to the GP. One has to observe, however, that in situations where a report was not available for some days, it might be too late to provide the patient with any meaningful assistance. How such a state of affairs could have existed is a matter that this Court finds difficult to comprehend. This is no personal reflection on Dr Davey. There were obviously systemic difficulties in existence that were not of his making. The point in this case, however, is that the report was dated 5 March 2002, the date of the deceased's first presentation. It may not have been available on 5 March 2002 to Dr Channo, but there seems to be no reason why, to echo Dr Finnis' thoughts on the matter, it should not have been available to Dr Woolven on 6 March 2002.

8.3. That the important x-ray revelations were not taken into account on 5 March and 6 March 2002 seems to me to be the product of a number of factors:

A. Dr Channo's inexperience in assessing x-ray films;

B. Dr Williams' failure to detect the signs of underlying pathology from the x-rays themselves or her failure to fully appreciate their true significance;

C. The unavailability of the x-ray report to practitioners on 5 March 2002;

D. Dr Woolven's failure to recognise the significance of the previous day's diagnosis of fractured ribs and his failure to chase up the x-ray report.

8.4. That the x-ray report was of significance on 5 March 2002 is highlighted by the fact that Dr Channo testified that if its contents had come to his attention on that day, they would have raised sufficient concern such that he would possibly have spoken to the

emergency consultant. Alternatively, he may have raised the matter with the deceased's GP. His view was that the x-ray report revelations meant that the deceased possibly had an infection in his lung. However, the only person he consulted was Dr Williams, and that was simply in relation to the films themselves. As seen, Dr Williams does not seem to be unduly concerned by what she sees in the x-rays even now. I can only infer that she thought likewise then, and the result of that seems to have been the entry in the clinical record that there was no abnormality detected other than a fractured rib.

8.5. On 6 March 2002, Dr Woolven without having seen the x-ray report, was so confident about his diagnosis that he only spoke briefly to a more senior practitioner about the possibility of performing an abdominal ultrasound. However, the more senior practitioner was busy and in any event the deceased seemed to have experienced some relief of his symptoms by then. Without having seen the x-ray report, the conclusion that Dr Woolven's confidence in his diagnosis was largely misplaced is one I feel compelled to draw.

8.6. Dr Davey now believes that the current turnaround time for x-ray reports for the Emergency Department is about 4 to 4.5 hours, although films performed after hours are not reported until the following morning. In addition, there is now interim reporting prepared by a trainee radiology specialist, which is later reviewed by a consultant radiologist.

8.7. I was also told by Dr Davey that the review of radiology reporting systems is on-going. For example, a difficulty that Dr Davey is attempting to address is the fact that radiologists usually have little or no knowledge of the clinical assessment made by the emergency practitioner and so the degree of urgency is something that the radiologists may have no appreciation of. There are measures being considered in an effort to remedy that situation.

8.8. Lack of human resources is also recognised as a difficulty. It is said to be numerically impractical to have consultant radiologists present at the RAH twenty-four hours a day, seven days a week. Dr Davey expressed the view that Registrars in emergency departments are sufficiently trained and experienced to examine x-rays in any event. I must say that from the facts of this case I have some reservations about that statement having universal application. Whether a Registrar is capable of accurately detecting

underlying pathology upon a reading of an x-ray obviously depends on the skill, competence and experience of the individual doctor concerned. It seems to me that the answer lies in the speed at which x-rays can be examined by practitioners who have some specialised skill in interpreting them, be they Registrars or qualified radiologists, so that if any abnormality is ultimately detected on specialist review, it is done in time to ensure that the patient can be appropriately treated.

9. Recommendations

9.1. By virtue of Section 25(2) of the Coroners Act, 2003 the Court may make recommendations that might in the opinion of the Court prevent or reduce the likelihood of a recurrence of an event similar to the event that was the subject of the Inquest.

9.2. On 5 and 6 March 2002 the deceased was examined by practitioners who were then working as Resident Medical Officers at the RAH Emergency Department. It does not appear that the deceased was actually seen and examined by any other more senior medical practitioner. Both examinations have to be scrutinised against the background that there had been a previous presentation or presentations by the deceased. I did not hear any evidence as to whether, in circumstances of re-presentations, patients are actually examined by practitioners senior to the rank of Resident Medical Officer or whether any protocol exists at the RAH in this regard. If there is no such protocol in place, I recommend that the RAH consider implementing measures whereby patients re-presenting to the RAH Emergency Department are personally examined or reviewed by practitioners of the rank of Registrar or above before they are discharged.

9.3. I also recommend that the RAH consider implementing measures to ensure that x-ray films are examined within the Emergency Department by practitioners who are identifiably competent in so doing.

9.4. I also recommend that the RAH continue to develop and implement measures to ensure that x-ray reports, prepared by radiological registrars and specialists, are prepared and made available in a timely manner so as to ensure that any abnormality detected is acted upon before the health of the patient is compromised.

9.5. I also recommend that the RAH implement measures to ensure that x-ray films and reports are always made available to Emergency Department practitioners whenever a patient re-presents to the Emergency Department.

Key Words: Abdominal injuries; Emergency Departments; Hospital treatment; Misdiagnosis; Pneumothorax;

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

Seal the 10th day of November, 2005.

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Deputy State Coroner

Inquest Number 20/2005 (0809/02)