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 8th and 9th days of December 2008 and the 25th day of November 2009, by the Coroner's Court of the said State, constituted of Anthony Ernest Schapel, Deputy State Coroner, into the death of Joyce Millicent Wilman (aka Bracegirdle).

The said Court finds that Joyce Millicent Wilman (aka Bracegirdle) aged 62 years, late of 2 Marcian Avenue, Elizabeth Downs, South Australia died at the Queen Elizabeth Hospital, South Australia on the 9th day of February 2007 as a result of gastric necrosis and perforation due to strangulated diaphragmatic hernia. The said Court finds that the circumstances of her death were as follows:

1. Introduction and reason for Inquest

1.1. Ms Joyce Millicent Wilman, 62 years of age, died on 9 February 2007 while a patient at the Queen Elizabeth Hospital (QEH). Ms Wilman had undergone a laparotomy during the previous day in which it had been discovered that she had a necrotic and non-viable stomach that also had a tear along the greater curve. Repair of the stomach was not performed during the course of this surgery in view of the non-viability of the stomach and the poor prognosis. The abdominal wound was closed following the surgery and the Ms Wilman was admitted to the Intensive Care Unit for comfort care only.

1.2. Dr John Gilbert, a Forensic Pathologist at Forensic Science South Australia, performed an autopsy in respect of Ms Wilman. The examination confirmed the presence of severe ischaemic and gangrenous changes of the stomach. These appear

to have resulted from herniation of the distal part of the stomach into the left chest cavity via a diaphragmatic hernia. It appeared that the hernia had become strangulated with compromise of the blood supply to both the herniated and the intra-abdominal portions of the stomach resulting in perforation of the intra-abdominal portion. In his post-mortem report[1] Dr Gilbert states that the cause of Ms Wilman's death was gastric necrosis and perforation due to strangulated diaphragmatic hernia. I find that to have been the cause of Ms Wilman's death.

1.3. During the course of the Inquest I heard a great deal of evidence about hernias that involve the stomach. The hernia is referred to interchangeably as a diaphragmatic hernia or an hiatus hernia. It usually involves the protrusion of part of the stomach through the diaphragmatic hiatus. This hiatus is the opening through which the oesophagus normally passes from the thoracic cavity into the abdominal cavity and then the stomach. There are a number of different types of hiatus hernia. An ordinary hiatus hernia may be asymptomatic. Ms Wilman's hernia became more complicated than that. During the course of the evidence there was some uncertainty expressed as to the precise nature of Ms Wilman's hernia, in particular whether it was a para-hiatal hernia or para-oesophageal hernia. The difference was immaterial to the issues with which the inquest was concerned. In any event, after consultation with Dr Gilbert it was agreed by all entities represented in the Inquest that the kind of hernia involved in Ms Wilman's case was a para-oesophageal hernia that involves a significant portion of the stomach entering the thoracic cavity through the diaphragmatic hiatus. While this kind of hiatus hernia is relatively uncommon, such a hernia can be the subject of serious complications when the part of the stomach that protrudes through the hiatus into the thoracic cavity becomes strangulated or twisted. This may result in a further complication whereby blood supply to that part of the stomach is cut off. As a result of this, the stomach becomes ischaemic and necrotic and effectively dies. This is what happened in Ms Wilman's case. Once that happens, the condition becomes irreversible and inevitably the non-viability of the stomach will lead to death. However, the evidence would suggest that at one point in time prior to Ms Wilman's laparotomy on 8 February 2007, the situation may not have reached that irretrievable stage had timely intervention occurred. I return to that aspect of the matter later in these findings.

[1] Exhibit C3a

1.4. Ms Wilman had a long history of mental illness. She suffered from schizophrenia. I do not need to recount the entire history of that illness in her case. Ms Wilman's admission to hospital prior to her death was in fact as the result of her having been detained under the Mental Health Act 1993 (MHA) in respect of an acute exacerbation of her psychosis. She had been detained by Dr Catherine Ye on 29 January 2007. Dr Ye had attended at Ms Wilman's home at Elizabeth Downs as a result of information obtained during home visits conducted by the Northern Acute Crisis Intervention Service. Dr Ye's statement[2] makes it quite clear that Ms Wilman presented that day with persecutory delusions and thinking as well as profound formal thought disorders. Dr Ye believed that Ms Wilman was acutely psychotic and was suffering a relapse of her schizophrenia. She was also dehydrated. She detained Ms Wilman on the basis that she was floridly psychotic, had poor self care, was irritable and had poor judgment with no insight. Following her detention Ms Wilman was originally conveyed to the Lyell McEwin Hospital (LMH). On 31 January 2007 Ms Wilman was transferred to the QEH where she remained until the day of her death. She was admitted to the Cramond Clinic at the QEH which is the acute psychiatric ward of that hospital. It was while Ms Wilman was confined to the Cramond Clinic that she became physically unwell as a result of the hernia that I have described. Ms Wilman's detention under the MHA was only revoked when it became obvious that she was dying. Notwithstanding the revocation of the detention, in my view this was a death in custody and for that reason it was mandatory for an Inquest to be held pursuant to the Coroners Act 2003. I set out relevantly the definition of death in custody as set out in that Act.

> '***death in custody*** means the death of a person where there is reason to believe that the death occurred, or the cause of death, or a possible cause of death, arose, or may have arisen, while the person:
>
> (a) was being detained in any place within the State under any Act or law, including any Act or law providing for home detention (and, for the purposes of this paragraph, a detainee who is absent from the place of his or her detention but is in the custody of an escort will be regarded as being in detention, but not otherwise)'

It will be seen that the definition applies in a scenario where the cause of the death 'arose' whilst the person was being detained. Thus, although when Ms Wilman died she was not the subject of a detention order because of its revocation, the cause of her

[2] Exhibit C10a

death had nevertheless arisen while she had been detained pursuant to such an order. Therefore her death is to be viewed as a death in custody.

1.5. Aside from the fact that the Inquest was mandatory, an issue arose in the course of the investigation that ensued after Ms Wilman's death as to whether or not she had been accorded appropriate medical treatment during her admission in the QEH and, in particular, whether more timely diagnostic and surgical intervention should have taken place prior to the laparotomy that eventually occurred on 8 February 2007.

2. The relevant provisions of the Mental Health Act 1993

2.1. Before discussing the circumstances of Ms Wilman's hospitalisation and death, I should briefly explain the regime of detention that the MHA provides for. Section 12(1) of the MHA enables a medical practitioner to make an order for the immediate admission and detention of a person in an approved treatment centre where the medical practitioner is satisfied of a number of matters: firstly that a person has a mental illness that requires immediate treatment, secondly that such treatment is available in an approved treatment centre and thirdly that the person should be admitted as a patient and detained in an approved treatment centre in the interests of his or her own health and safety or for the protection of other persons. Section 12(2) of the Act provides that such a detention order expires 3 days after the day it is made unless it is earlier revoked. A person so detained must be examined by a psychiatrist within 24 hours of the patient's admission to the approved treatment centre or, where that is not practicable, as soon as is practicable after that admission. The examining psychiatrist must consider whether the continued detention of the patient is justified or not. If the psychiatrist is not satisfied that the continued detention of the patient is justified, the psychiatrist must revoke the order. Otherwise, the psychiatrist will confirm the order. If the psychiatrist confirms the order, this has the effect of continuing the 3 day period that had been activated by the original detention order. Before the expiry of that 3 day period, a further order for detention for a further period up to 21 days may be imposed. A second 21 day order may be imposed upon the expiry of the first such order. A 21 day order may be revoked at any time during the currency of the order. Ms Wilman had been subjected to the regime of detention that I have just described and had been detained under a first 21 day order. It was this order that was revoked shortly before her death.

3. Background

3.1. It appears that Ms Wilman was first diagnosed with an hiatus hernia in July 2006. On 21 July 2006 she was conveyed to the Emergency Department of the LMH by ambulance. On that occasion Ms Wilman complained of generalised, continued abdominal pain over a period of 2 days. The pain had been accompanied by nausea and vomiting. However, when examined by medical staff at the LMH she was in fact pain free and her vital signs were all within normal limits. She had normal bowel sounds. In spite of what appeared to be a reassuring examination, the doctors ordered a chest and abdominal X-ray both of which revealed the existence of an hiatus hernia with no signs of an obstruction. The hiatus hernia was considered on this occasion to be an incidental finding only and was thought not to explain her symptoms. Given the fact that Ms Wilman was pain free and displayed no further symptoms, she was discharged with a letter for her general practitioner.

3.2. Ms Wilman was again brought into the Emergency Department of the LMH by ambulance on 27 July 2006. She presented with a history of nausea and vomiting over a period of about two hours. An ECG examination revealed an irregular heartbeat. Ms Wilman was given some intravenous fluids and antiemetics. She had no ongoing symptoms of abdominal pain, nausea or vomiting and by the time Dr John Ceely examined her that evening, her symptoms had resolved. She was again discharged with a plan that she would be followed up by her usual doctor if any further investigations were required. There were no further X-rays conducted on this occasion.

3.3. Ms Wilman's treatment both in July 2006 and January and February 2007 was examined by Professor Glyn Jamieson who is the Dorothy Mortlock Professor of Surgery in the discipline of surgery at the University of Adelaide. Professor Jamieson at one time was also the Head of the Oesophago-Gastric Unit of the Royal Adelaide Hospital having retired from that position in 2004. Professor Jamieson remains a Senior Consultant on that Unit. He has had wide experience in upper gastro intestinal surgery in general and in oesophagic and gastric surgery in particular. I regarded Professor Jamieson as an expert in his field. He provided a report to the Inquest[3] and also gave oral evidence. The main focus of Professor Jamieson's examination of Ms

[3] Exhibit C22

Wilman's treatment was upon the events of January and February 2007, but he was also asked to comment upon Ms Wilman's presentations in July 2006.

3.4. I did not understand Professor Jamieson to be critical of medical staff at the LMH in respect of Ms Wilman's discharge on either occasion in July 2006. The most significant feature of Professor Jamieson's evidence in this regard, however, is the fact that the hernia that was detected in July 2006 was in his opinion that which claimed her life in due course. The presence of the hernia in July 2006 is a matter that is naturally relevant to her presentation and diagnosis in the following year. That said, there is no or no sufficient evidence that Ms Wilman experienced any symptoms specifically attributable to the hernia until a point in time well into her period of admission at the QEH in February 2007.

4. Ms Wilman's deterioration in February 2007

4.1. As alluded to earlier, Ms Wilman was detained on 29 January 2007 and she was in the first instance conveyed to the LMH. There Ms Wilman was subjected to a physical examination which included examinations of her abdomen and chest both of which were normal. The only issue as far as Ms Wilman's physical health was concerned was the fact that she appeared to be dehydrated for which she was given intravenous fluids. Investigations were also conducted to ascertain whether Ms Wilman was experiencing anaemia and also in order to obtain a white cell count to determine whether there were any signs of infection or inflammation. Everything was normal in that regard. As far as Ms Wilman's abdominal investigation was concerned, this was conducted by Dr Kyaw[4] and upon examination Ms Wilman's abdomen was found to be soft and non-tender with no evidence of a serious infection or peritonitis. There was no feature suggestive of organ perforation or organ enlargement. Bowel sounds were present and there was no sign of bowel obstruction. There was no feature of inflammation of internal organs including the stomach. The abdominal examination was '*absolutely normal at the time*'[5]. A Dr Busuttil, who was a consultant within the Emergency Department at the LMH, says in her statement[6] that in effect there was no need to check Ms Wilman's past medical history because there was no concern about her physical wellbeing at the time of her presentation. The presentations of July 2006

[4] Exhibit C11b
[5] Exhibit C11b, page 2
[6] Exhibit C6a

do not appear to have been considered and one can understand that there was no perceived need for consideration of the same as of 29 January 2007.

4.2. On 30 January 2007 Ms Wilman's detention was confirmed which meant that the original detention by Dr Ye would continue for 3 days.

4.3. On 31 January 2007 Ms Wilman was transferred by ambulance to the Cramond Clinic at the QEH for further investigation as to her acopia and schizophrenia. It was felt that the QEH was better equipped to provide for Ms Wilman's care and treatment as it provided open bed management.

4.4. On 1 February 2007 Dr Susan Waite, a consultant psychiatrist at Cramond Clinic, made an order under Section 12(5) of the MHA detaining Ms Wilman for a period of 21 days. This order was to remain in force until its revocation shortly before Ms Wilman's death.

4.5. I do not need to discuss in any detail the reasons for the detention orders except to say that at all material times Ms Wilman was floridly psychotic with disorganised thinking and behaviour and with poor self care. There is no question but that the detention orders were appropriate.

4.6. Dr Angela Okungu was in her first year of the psychiatry training program in 2007. She was working at the Cramond Clinic as a trainee psychiatrist at the time of Ms Wilman's admission. Her duties involved the day to day care of patients within Cramond Clinic including clinical evaluation and discharge planning under supervision of a psychiatric consultant such as Dr Waite. As it happened, Dr Okungu also worked two afternoons per week, Tuesdays and Thursdays, at the Port Adelaide Continuing Care Clinic. As well, on Wednesday afternoons she was involved in a lecture series with the South Australian psychiatry training program at Glenside. Dr Okungu received her medical degrees from the University of Adelaide in 2004.

4.7. Dr Okungu reviewed Ms Wilman for the first time on 31 January 2007, the day of Ms Wilman's arrival at the Cramond Clinic. From that day until the night of 5 and 6 February no clinical signs arose that would have suggested any difficulties with Ms Wilman's physical health.

4.8. Dr Okungu reviewed Ms Wilman again on Monday 5 February 2007. There was a slight improvement in Ms Wilman's mental state, although she was still floridly psychotic. Upon Dr Okungu's examination, which took place that morning, there was no suggestion of any physical illness. In Dr Okungu's statement[7] she asserts that she would routinely have asked Ms Wilman if she had any problems with her health or wellbeing and Ms Wilman told her that she did not. Blood test results showed no abnormalities except for high fasting glucose. A nursing note of the afternoon of the same day reveals that Ms Wilman was at that time eating and drinking well. However, a nursing note covering the evening of 5 and 6 February 2007 makes reference to the fact that Ms Wilman was heard to be vomiting in the toilet after her meal.

4.9. Dr Okungu again reviewed Ms Wilman on the morning of 6 February 2007. On this occasion Dr Okungu noted that Ms Wilman complained of stomach discomfort and stated that acid came up when she vomited. Ms Wilman stated that she had had this trouble at home. She admitted to Dr Okungu that she sometimes induced vomiting. She also revealed that her bowels had not been open for more than 4 days. Upon examination she was uncomfortable and distressed. An examination of her abdomen revealed that her abdomen was soft and non-tender with no masses or enlarged organs. There was no focal abdominal tenderness. Dr Okungu has recorded a differential diagnosis that included possible dyspepsia or gastroesophageal reflux. She prescribed an antacid, antiemetic and Coloxil for constipation. A nursing note timed at midday on 6 February 2007 states that Ms Wilman was noted to be vomiting into the toilet bowel. The vomiting appeared spontaneous and Ms Wilman denied having induced it. She was given Maxalon for nausea. A further nursing note made in the late afternoon also records loud vomiting at approximately 8:30am and 10:05am. It is recorded that at lunch time she only ate a small ice cream. There was further vomiting recorded during the course of the afternoon. Ms Wilman was X-rayed that day. I refer to the X-ray results in due course.

4.10. The nursing note timed at 6am on 7 February 2007 records that Ms Wilman had been drinking excessive amounts of water, was holding her stomach and was making regurgitating type noises. Later that morning the nursing note timed at 9:45am

[7] Exhibit C20a

records that Ms Wilman was inducing vomiting and was reporting abdominal discomfort.

4.11. Dr Okungu examined Ms Wilman that morning and made a note at 10:30am. Dr Okungu recorded that Ms Wilman was complaining of a stomach ache and had epigastric discomfort as well. By then the X-ray results and some blood results were available. The X-ray results were reported verbally from the Radiology Department. Dr Okungu has recorded that the X-rays had revealed faecal loading with a soft tissue mass in the left upper quadrant. There is no record of any mention of the existence of an hiatus hernia. Dr Okungu discussed Ms Wilman's presentation with Dr Waite, the consultant psychiatrist. It is common ground that Dr Waite suggested that Dr Okungu arrange for a review by the gastroenterology team that day. Dr Okungu noted the suggestion in these terms:

> 'Gastro review to be requested.'

Dr Okungu noted, as part of the note of 10:30am, that she attempted to contact the gastroenterology registrar with a view to arranging a gastroenterological review. Dr Okungu did this by paging the registrar through the switchboard. The note concerning her attempt to contact the gastroenterology registrar is couched in these terms:

> '- Dr. Basil (Gastro Reg) #21042 contacted re:
> Referral.'

There is no note one way or the other about the registrar responding to any attempt to contact that person, but it is clear that no response to Dr Okungu's request for the gastroenterology registrar to contact her was ever made. Dr Okungu gave evidence at the Inquest and was to tell this Court that she had made three paging attempts to contact the gastroenterology registrar. She also believed that she had also faxed a written request for review to the relevant department. However, such a document was not produced in the Inquest and it is not within Ms Wilman's clinical casenotes. As it happened, 7 February 2007 was a Wednesday and so Dr Okungu was off the unit for the afternoon attending to her psychiatry lectures. She left sometime between midday and 1pm. Dr Okungu had nothing further to do with Ms Wilman that day. Dr Okungu accepts, I think it fair to say only in hindsight, that she should have made greater efforts to contact the registrar that day about Ms Wilman. She said that she

agreed with that proposition '*Retrospectively given that she then went on to deteriorate, looking back, that would have been a good option*'[8].

4.12. Ms Wilman was seen by a Dr Greasley on the afternoon of 7 February 2007. Dr Greasley made a note of his examination. The note is timed at 4:30pm and the note suggests that his examination was by way of a psychiatric review. During the Inquest, Dr Greasley was variously described as a psychiatric resident medical officer or a GP trainee doing psychiatric rotation. It appears that he was a relatively junior doctor. Dr Greasley's note, which consists of one page of the clinical record, describes Ms Wilman's physical condition for the most part. His note includes reference to her complaint of stomach ache and vomiting for the last 2 or 3 days and the fact that Ms Wilman had been given an enema. There is reference to frank blood covering the bowl and rectal prolapse when straining. There is further reference in this note to a verbal report of the X-ray results in terms similar to those recorded earlier in the day by Dr Okungu, namely the faecal loading and query mass with the suggestion that her bowel be cleared out followed by a repeat X-ray. This time, however, Dr Greasley has made apparent reference in the notes to an 'interim' X-ray report in which a normal gas pattern and a large hiatus hernia was described. Dr Greasley's plan is recorded as having been to observe for further blood loss, await the 'formal' X-ray report and to await the gastroenterological review. Any deterioration was to be dealt with by contacting the doctor on call. The existence of an hiatus hernia was thus recognised within Cramond Clinic at that time. The formal X-ray report that was to become exhibit c19 did not come into being until the following day. That report would have had some added significance as it specifically recommends a clinical correlation between the hernia and Ms Wilman's symptoms. It also suggested that the hernia *'may relate to the patient's symptoms'*. There is no evidence that this suggested clinical correlation, nor the pointed suggestion that Ms Wilman's hernia may have accounted for her acute presentation, was actually conveyed to Crammed Clinic in any so-called interim X-ray report. In any event, as will be seen, there does not appear to have been any such clinical correlation undertaken when, in the opinion of the expert Professor Jamieson, it is evident that Ms Wilman's symptoms as they existed on 7 February were reflective of the hernia and its evolving complications.

[8] Transcript, page 56

4.13. Nursing notes relating to Ms Wilman and her presentation later on 7 February 2007 suggest that Ms Wilman continued to complain of abdominal pain and she continued to bring up fluids, at times being seen to induce vomiting herself. There is a note to the effect that Ms Wilman was extremely distressed and tired from her day. In the evening she was still complaining of abdominal pain and still bringing up fluids.

4.14. It is clear that on 7 February 2007 the gastroenterological review did not take place and that the paging requests for the registrar to contact Cramond Clinic were simply not responded to.

4.15. On the morning of 8 February 2007 it was noted by nursing staff at 6:10am that Ms Wilman had been up and down to the toilet overnight on a number of occasions. She complained of abdominal pain. Similarly, a nursing note timed at 7:45am suggests that she continued to complain of abdominal pain. There is a note that she had vomited. Her abdomen was noted to be '*very distended where yesterday abdomen was very soft*'.

4.16. An intern medical officer, Dr Hsieh, was called to see Ms Wilman. This doctor made a note of the examination timed at 8:25am. The note made by Dr Hsieh suggests that she was called to review Ms Wilman in respect of the abdominal pain and distension. Upon examination Ms Wilman was in obvious discomfort with a '*largely distended abdomen that was tender on light palpation*'. She had an inverted umbilicus. Bowel sounds were absent, but with no guarding or rigidity. Dr Hsieh diagnosed Ms Wilman with severe constipation, amongst other things, with a plan to encourage bowel motions. There is no reference in this note to the X-rays of 6 February 2007, nor of the possibility of an hiatus hernia or of its possible complications, nor of the existence of an acute abdomen.

4.17. Dr Okungu examined Ms Wilman during the course of the ward round that day. It was obvious at that point in time that Ms Wilman had undergone a significant deterioration physically. Dr Okungu told me in evidence that during the course of this examination she stepped out of the meeting to attempt to organise a review either by a medical or surgical team. However, the surgical registrar on-call was in theatre at that time. She contacted the gastroenterology registrar, Dr Basil, who suggested that Dr Okungu call the surgical registrar as the case sounded more of a surgical nature, but she had already done that. The calls that she made, she suggested, occurred at about

9:10am which was nearly 24 hours after she had paged Dr Basil in the first instance. By 11:20am that morning there had still been no response forthcoming from either a medical or surgical team. At that stage Dr Okungu made a call to another surgical registrar but he was also in theatre and unable to take the call. An attempt was made to contact a third surgical registrar who was also in theatre. There was a further communication which did not result in any immediate attendance by a reviewing medical officer. At midday Dr Okungu again examined Ms Wilman who was complaining of abdominal tenderness, was uncomfortable and was distressed. She was diaphoretic, which means that she was sweating profusely, her abdomen was distended and her bowel sounds were still absent. She was peripherally shut down. Professor Jamieson was to tell me in evidence that Ms Wilman's presentation and level of deterioration at that time was probably reflective of the existence of the stomach perforation.

4.18. Dr Waite told me in evidence that on the morning of 8 February 2007 she had been present at the ward round. She told me that she recalled the nursing staff being very concerned about Ms Wilman's overnight deterioration. During the course of the ward round Dr Waite was aware of Dr Okungu's attempts to contact the various registrars and her not being able to do so because they had been in theatre. A note made by Dr Okungu timed at midday suggests that the patient was still awaiting a surgical review. It is not clear to me whether any firm contact had been made by that stage or whether any firm arrangement had been made for a review. My doubt about that issue was compounded by the fact that it was not until 1pm that day that Dr Waite, having again seen the patient herself, directly contacted a surgeon by the name of Dr Walsh. Suffice it to say, no-one apart from Dr Hsieh, an intern, Dr Okungu, a trainee psychiatrist, and Dr Waite, a consultant psychiatrist, had seen Ms Wilman at any time during the course of that morning when it was clear to all that a surgical review was not only indicated but indicated as a matter of urgency. At 1pm Dr Waite noted herself in the clinical record that Ms Wilman had suffered a deterioration over the last 3 days and that on this particular occasion she had a distended abdomen with tenderness and no bowel sounds. She recorded as a possible diagnosis a bowel obstruction. It was at that time that she contacted the surgeon, Dr Walsh. Dr Waite herself had not drawn any connection between the hiatus hernia and the severity of Ms Wilman's symptoms. As indicated in her note, Dr Waite was more concerned about a bowel obstruction. In any event whether Dr Waite, a psychiatrist, drew any

such connection, or whether any other medical officer drew such a connection either on 7 or 8 February 2007, one thing is certain and that is that the correct and appropriate level of expertise was not brought to bear on Ms Wilman's presentation. That expertise could only have been provided by a gastroenterology registrar in the first instance and surgical registrar in the second and neither area of expertise was at any stage made available on 7 February or the first half of 8 February by which stage Ms Wilman's situation was probably irretrievable. Dr Waite told me that on 7 February 2007 she had told Dr Okungu that she should obtain a gastroenterology consultation because it was unclear as to what was causing Ms Wilman's symptoms. Although Dr Waite told me that at that particular time, in her experience, the obtaining of a medical review to occur at Cramond Clinic did not occur as quickly as would be desired, she had expected a gastroenterology review to have been conducted on the afternoon of that day. She did say, however, that she would not have been surprised if they were not able to obtain the review until the following day, but she would nevertheless have expected that some discussion would have occurred with a gastroenterology registrar and a consultation at least organised. In any event, she would have hoped that if initial paging attempts had not been fruitful, that the doctor who was making such attempts would persist in those attempts. Dr Waite told me that on 8 February 2007 when she discovered that nothing had happened as far as any review was concerned, that she was disappointed. One can imagine Dr Waite's disappointment because even if her suggestion to Dr Okungu had been couched in terms of a recommendation perhaps rather than an order, in either case nothing had happened whatsoever. The fact that there was this large element of uncertainty about how long it might take to secure within the psychiatric ward of a public hospital a specialist medical review of an acute presentation such as Ms Wilman's, and the fact that it never materialised in any event on 7 February or the first part of the following day, is something that this Court finds difficult to comprehend.

4.19. After Dr Waite contacted the surgeon, Dr Walsh, Ms Wilman was transferred to the High Dependency Unit in the afternoon. That evening when Ms Wilman was seen by a surgical registrar, it was determined that she needed an urgent laparotomy which is a procedure designed to diagnose the cause of an acute abdomen. The surgery took place and it revealed that Ms Wilman had a necrotic, non-viable stomach with the tear that I have already described. The result was that Ms Wilman's prognosis was

regarded as extremely poor. I have already referred to the fact that the detention order was revoked. Ms Wilman was declared life extinct on 9 February 2007 at 1:50pm.

5. X-ray reports

5.1. As seen earlier, Dr Okungu had received a verbal report in respect of the X-ray that was taken on 6 February 2007. She recorded no reference to the existence of an hiatus hernia. That verbal report was given to her on the morning of 7 February 2007. That afternoon Dr Greasley has himself recorded a verbal X-ray report in the same terms, but recorded also what appeared to be at that time the existence of an interim report that suggested that Ms Wilman had a large hiatus hernia.

5.2. I did not see any written interim report during the course of the Inquest as it is believed that interim reports are superseded by the final report which is delivered by way of computer. The final report was Exhibit C19 and is dated 8 February 2007. The report describes clinical details including complaints of stomach pain, vomiting and constipation. The report goes on to say:

> 'There is an air fluid level seen in the lower chest in keeping with a large size hiatus hernia. This may relate to the patient's symptoms. Please correlate clinically.'

5.3. It is not clear to me whether the interim report that was evidently seen by Dr Greasley would have suggested the need for a clinical correlation between the hiatus hernia and Ms Wilman's symptoms. Suffice it to say, there was no such clinical correlation on 7 February 2007 and no connection appears to have been drawn, or even considered, between the existence of the hiatus hernia and Ms Wilman's symptoms by any clinician on 7 February 2007. Indeed, on 8 February 2007 the most senior and experienced clinician, Dr Waite, did not draw any such correlation as she believed that the symptomatology of Ms Wilman was more in keeping with a bowel obstruction.

5.4. Whatever was conveyed to Cramond staff in the interim report, it was evident, or should have been evident, that Ms Wilman was deteriorating before their eyes. That was clearly a matter for gastroenterological expertise and especially so if indeed the interim report suggested clinical correlation between the hernia and symptoms as they existed. But the necessary expertise was not chased up. It will again be emphasized in this context that the gastroenterology review that was contemplated on 7 February

2007 did not take place, either then or the following day, and attempts to obtain surgical review on 8 February 2007 were also fruitless.

6. The evidence of Professor Jamieson

6.1. The salient feature of Professor Jamieson's evidence is that earlier diagnosis of Ms Wilman's gastric volvulus, being the strangulation or the twisting of the hernia, may have resulted in a more favourable outcome for Ms Wilman. Professor Jamieson was of the view that on 7 February 2007, even though the stomach may have been ischaemic in the sense that its blood supply was jeopardised but not completely absent, the stomach may still have been recoverable at that stage if the blood supply had been restored to normal by untwisting the stomach. If an operation had been carried out that day which had corrected the hernia, the stomach may still have been viable. Even if the stomach was ischaemic to the point where restoration of the blood supply would have allowed it to survive in part, that part of the stomach that was adversely affected could have been removed. Professor Jamieson also believed that by that stage Ms Wilman had not developed the perforation of the stomach which was to lead to her final and rapid deterioration. By midday on 8 February 2007 it was clear that by then Ms Wilman was diaphoretic and acutely physically unwell. Professor Jamieson believes that sometime between 7 and 8 February 2007 the stomach perforation had occurred and had occurred by midday of 8 February 2007.

6.2. Professor Jamieson also told me that on 7 February 2007 an even simpler intervention not requiring surgery may also have assisted Ms Wilman. The passage of nasogastric tube might have been able to decompress the stomach to a significant degree. He said that much of the problem associated with a strangulated hernia stems from the resulting distension that occurs and that if the stomach is able to be decompressed, the acuteness of the problem might be overcome[9]. If that was unsuccessful then surgery would have been indicated. Professor Jamieson also suggested that Ms Wilman may have had a chance in that regard even up to a point on 8 February 2007.

6.3. Professor Jamieson was of the opinion that Ms Wilman's symptomatology was reflective of the hiatus hernia, even before her eventual significant deterioration. That would include of course her abdominal discomfort and her vomiting. Professor Jamieson did not suggest that either a psychiatric registrar or psychiatrist would have

[9] Transcript, page 116

made a diagnosis of a complication that had as its origin an hiatus hernia, but the point to be made was that there was an opinion entertained by the Radiology Department that there should have been a clinical correlation between her symptoms and the hiatus hernia and that the clinical correlation should have been made well before 8 February 2007 when it was too late. Professor Jamieson told me that he would have expected gastroenterological experts probably to have ultimately made a diagnosis at a time prior to death of the stomach which had taken place in this case[10]. He said:

> 'It comes from investigation of a patient I guess and a patient comes in with an acute problem, various diagnoses are suspected and probably a volvulus or twist of the parahiatal would be very low down the list and only thought of often when other things have been excluded but nevertheless still thought of eventually.'[11]

Professor Jamieson also said that the previous presentations at the LMH may well have assisted in a diagnosis. I make no further comment about that in the light of the fact that in his view there was in existence on 7 February 2007 material upon which an appropriate diagnosis could have been made in any case. Professor Jamieson made the following points which I accept:

- The final radiological reported[12] dated 8 February 2007 should have been available earlier[13];
- That if the X-ray report had been available earlier, and properly understood earlier, a gastroenterologist or gastrointestinal surgeon should have been obtained to see Ms Wilman[14];
- That the psychiatric registrar, Dr Okungu, should in any case have persisted in her attempts to page the gastroenterology registrar on 7 February 2007 and that specialist assistance should not have been left for 24 hours[15];
- That a gastroenterology review on 7 February 2007 would have been expected to entertain a proper diagnosis of Ms Wilman's condition notwithstanding the rarity of the condition[16].

[10] Transcript, page 129
[11] Transcript, page 129
[12] Exhibit C19
[13] Transcript, page 107
[14] Transcript, page 107
[15] Transcript, page 110
[16] Transcript, page 106

7. Conclusions

7.1. Ms Wilman was detained under the MHA as a result of which she was hospitalised, firstly in the LMH and then the QEH. There is no suggestion other than that her detention was lawful and appropriate.

7.2. At the QEH Ms Wilman developed symptoms that were reflective of the existence of complications of an hiatus hernia. An X-ray was performed which revealed the existence of an hiatus hernia and suggested clinical correlation with her symptomatology. I am uncertain whether the suggestion of such a correlation was conveyed to Cramond Clinic staff at any material time. This is due to the fact that the X-ray report was conveyed verbally to Dr Okungu in the first instance and there is in my view no reliable record of what was conveyed in this verbal exchange. Secondly, the interim report that Dr Greasley saw is not available. In any event, what is clear is that clinical correlation was never really properly considered or implemented within Cramond Clinic. This occurred for the most part because attempts to gain a gastroenterological review of Ms Wilman on 7 February 2007 were fruitless. To my mind insufficient vigour was brought to bear upon the attempts to obtain that review. It is difficult to escape the conclusion that gastroenterological expertise would necessarily have involved a clinical consideration of whether or not Ms Wilman's symptoms were the product of a complication of her hiatus hernia.

7.3. If Ms Wilman had been the subject of a gastroenterological review on 7 February 2007 I find that it is likely that the strangulating hiatus hernia would have been diagnosed in time for her to have received meaningful intervention.

7.4. To my mind none of the staff at Cramond Clinic can be criticised for failing themselves to diagnose Ms Wilman's condition. However, as I say, there was insufficient effort made to obtain the necessary expertise in order to make a proper diagnosis of her condition.

7.5. On 8 February 2007, again, attempts to obtain specialist evaluation of Ms Wilman were fruitless and the proper expertise was not brought to bear on her situation until very late in the day, by which time it was too late for any meaningful surgical intervention.

7.6. By the time Ms Wilman's strangulated hiatus hernia was diagnosed by way of a laparotomy, her stomach had become non-viable and her death was therefore inevitable.

7.7. Ms Wilman's death in my view probably could have been avoided had the proper specialist intervention occurred on 7 February 2007.

8. Recommendations

8.1. Pursuant to section 25(2) of the Coroner's Act 2003 I am empowered to make recommendations that in the opinion of the Court might prevent, or reduce the likelihood of, a recurrence of an event similar to the event that was the subject of the Inquest.

8.2. This Court has previously commented upon the highly undesirable situation whereby final X-ray reports are not delivered in a timely manner. I refer here to the Inquest into the death of Christopher Lazopolous[17] in respect of which findings were delivered by the Court, as constituted by me, on 10 November 2005. That Inquest involved procedures regarding provision of X-ray reports at the Royal Adelaide Hospital. In that Inquest I made the following recommendation:

> '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.'

It appears that this recommendation could have been more universally directed as far as the public hospital system is concerned. The provision of final X-ray reports two days after the X-ray is performed is, in my opinion, simply not good enough, especially when no record is kept of interim reports. I recommend that the Queen Elizabeth Hospital 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. I also recommend that the Minister for Health cause a review of X-ray report delivery in all public hospitals to ensure that final X-ray reports are delivered in a timely manner. I also recommend that written interim X-ray reports are kept as part of a patient's clinical file in order to provide a record of

[17] Inquest Number 20/2005

what was known about the results of the X-ray at a time before delivery of the final report.

8.3. The other area of concern revealed in this Inquest is the lack of urgency by which specialist medical and surgical intervention was provided and the seemingly unreliable means by which it was sought. On my calculations the interval between Dr Waite's recommendation at approximately 10:30am on 7 February 2007 that a gastroenterology review be obtained and the obtaining of the first review by specialist expertise was significantly greater than 24 hours. The attempts to obtain that expertise was sought for the most part by way of paging. In this case this method proved itself to be highly unreliable. One would like to think that the obvious lessons that this case provides in this regard would have been addressed long before this Inquest. Nevertheless, I recommend that the Queen Elizabeth Hospital take the necessary steps to ensure that when specialist medical or surgical review is directed or recommended, that it be sought and provided with the necessary degree of urgency and by the most efficient means of communication available.

Key Words: Death in Custody; Hospital Treatment; Inadequate Examination

In witness whereof the said Coroner has hereunto set and subscribed his hand and Seal the 25th day of November, 2009.

Deputy State Coroner