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 11th and 12th days of February 2009 and the 3rd of June 2010, by the Coroner's Court of the said State, constituted of Mark Frederick Johns, State Coroner, into the death of Aileen Dawn Promnitz.

The said Court finds that Aileen Dawn Promnitz aged 79 years, late of 4 Fidock Street, Seaton, South Australia died at the Queen Elizabeth Hospital, Woodville Road, Woodville, South Australia on the 6th day of March 2006 as a result of sepsis due to urinary tract infection with Group B streptococci. The said Court finds that the circumstances of her death were as follows:

1. Introduction

1.1. Mrs Promnitz was 79 years of age when she died on 6 March 2006. She was at that time a resident at St Hilarion Nursing Home at Lockleys. On the evening of 5 March 2006 Mrs Promnitz was conveyed by ambulance to the Queen Elizabeth Hospital because of dehydration resulting from a deterioration in her health over the course of that day. On her arrival at the hospital she was triaged in the Emergency Department at approximately 8pm. She was triaged at Priority 4 and, according to the Australian Triage Scale, should have been seen by a doctor within one hour. Although observations were taken by a nurse on two occasions between Mrs Promnitz's arrival and midnight, she was not seen by a doctor. For the whole of this period she was in a corner of the waiting room at the Queen Elizabeth Hospital Emergency Department. At 2am on 6 March 2006 she was found by a member of the public to be deceased in the waiting area.

2. Cause of death

2.1. An autopsy was conducted by Dr Karen Heath, Forensic Pathologist. In a report dated 17 May 2006[1] Dr Heath[2] gave the cause of death as sepsis due to urinary tract infection with Group B streptococci and I so find.

3. Issues arising at the Inquest

3.1. The primary issue for consideration at this Inquest was the question of how Mrs Promnitz came to be left for 6 hours without being seen by a medical practitioner and, worse still, how she came to die in those circumstances. I heard from three witnesses: Dr Anthony Hoby, the acting Director of the Emergency Department at the Queen Elizabeth Hospital, Dr Sally Tideman, the Director of Medical Services at the Queen Elizabeth Hospital and Professor Anne-Maree Kelly, Emergency Physician, who was requested by counsel assisting me to provide an expert overview.

3.2. Professor Kelly prepared two reports for the Court's assistance[3]. She summarised her understanding of events as follows - Ms Promnitz was transferred to the Queen Elizabeth Hospital after a deterioration in her health and arrived at the hospital around 8pm. She was triaged in a timely manner but, as a bed was not available, was placed on a waiting room trolley where she remained until her death some five to six hours later. Professor Kelly said:

> 'This is an unacceptable delay for somebody who is elderly and unwell and reflective of some of the issues related to lack of access to departments for emergency services.' [4]

3.3. In my opinion, Professor Kelly is absolutely correct. There was an unacceptable delay in this case. It is wrong that a 79 year old lady should be left for 5 to 6 hours only to die alone in the waiting room of the Emergency Department of one of the State's leading public hospitals.

3.4. Professor Kelly agreed with the opinion of Dr Heath that the most likely cause of Mrs Promnitz's condition was a urinary tract infection that had spread to affect the rest of her system. Professor Kelly commented, and I find, that if the urinary tract infection had been treated earlier it is quite possible that Mrs Promnitz would not have died. There was available a method of treatment for such a condition, namely aggressive

[1] Exhibit C2a
[2] Then Dr Riches
[3] Exhibit C12
[4] Transcript, page 59

intravenous fluids to rehydrate her and maintain her blood pressure, and the early use of antibiotics to treat her infection.

3.5. The evidence showed that Mrs Promnitz was seen twice by a nurse in the 6 hours between her triaging and her death. On both of these occasions and at the time of her arrival at the hospital, her vital signs were normal. The difficulty with this is that normal vital signs are, according to Professor Kelly:

> '… not uncommon with what is effectively a septicaemia and that sudden and potentially fatal deterioration could have happened some time thereafter …' [5]

Professor Kelly said that the vital signs are often the last things to change so the fact that they are normal is not necessarily a reassurance in itself[6].

3.6. Professor Kelly said that a patient assigned a triage category of 4 should, according to Australian Triage Scale standards, be seen within one hour. She said that this is a target time, but in a well functioning Emergency Department most people would be treated within that time[7]. Professor Kelly said that in a busy Emergency Department somewhere around 60% to 80% of people with triage category 4 would be expected to be treated within one hour[8].

3.7. Professor Kelly gave evidence that Emergency Department overcrowding increases the mortality for patients who present to Emergency Departments during times of overcrowding in the order of 20% to 30%. She said that this would equate to as many as 1500 people per year in Australia[9].

3.8. Clearly Mrs Promnitz's case supports this statistic. Had Mrs Promnitz arrived in the Emergency Department when it was less busy, one could confidently expect that she would have been seen sooner and her death may have been avoided.

3.9. Professor Kelly did not criticise the appropriateness of Mrs Promnitz's triaging at category 4[10].

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[5] Transcript, page 60
[6] Transcript, page 61
[7] Transcript, page 62
[8] Transcript, page 62
[9] Transcript, pages 67-68
[10] Transcript, page 73

3.10. The evidence of Drs Hoby and Tideman give some cause for one to hope that the circumstances of this case are unlikely to recur today. The following circumstances have changed:

1) There is now a nurse in the Emergency Department whose role it is to assist the triage nurse and the assistant is assigned solely to maintaining contact with patients in the waiting room and ensuring that they are observed[11];

2) There is now a formalised over-capacity policy which means that at a particular point the Emergency Department can call a Code E across the Queen Elizabeth Hospital which is a signal to other parts of the hospital that the Emergency Department requires assistance. At this call all senior medical staff and consultants within the hospital are required to assess existing patients for discharge, and critically determine whether any capacity exists for the transfer of patients from within the Emergency Department to medical wards. Dr Tideman explained that there are several triggers for a Code E. One such trigger is where there are more than 45 patients within the Emergency Department, another, where there are 35 patients within the Department but also 10 awaiting admission to the Department. Another is where there is a patient in category 2 who has been waiting for more than 30 minutes[12];

3) A new ward has been added to the hospital which is called the Diagnostic and Planning Unit. It is a 16 bed ward. A patient such as Mrs Promnitz would have been admitted to the Diagnostic and Planning Unit where the object is for the patient to be seen swiftly by a consultant and diagnosed so they it can be determined from that Unit whether the person can return to the nursing home, or be admitted to a general ward within the hospital[13].

4. Conclusions

4.1. Mrs Promnitz's death in the waiting area of the Emergency Department of the Queen Elizabeth Hospital on 6 March 2006 was avoidable.

[11] Transcript, page 27
[12] Transcript, page 44
[13] Transcript, pages 46-48

4.2. The circumstances have changed in the Emergency Department of the Queen Elizabeth Hospital which gives some cause for hope that this event is unlikely to be repeated.

5. Recommendations

5.1. I make no recommendations in relation to the Queen Elizabeth Hospital. However, Dr Tideman in particular made the point, in the course of her evidence, that the support for nursing home patients by general practitioners in South Australia is simply not adequate. She expressed the view that:

> 'It's deplorable, in my view; absolutely deplorable that we are not in this State able to provide good general practitioner services that don't rely on locum services to our residential aged care. And therefore the acute setting - the acute hospitals, like my hospital - then becomes the first line for sick elderly patients who do not need to be in a hospital and, in fact, care can be compromised by them coming into a hospital. ' [14]

5.2. I should add that I acknowledge that Professor Kelly's opinion was that it was entirely appropriate that Mrs Promnitz be admitted to the Queen Elizabeth Hospital, as she was. However, Dr Tideman's remarks are very concerning and, in my opinion, her concerns need to be referred to the Commonwealth Minister for Health and Ageing, the Commonwealth being the relevant tier of Government that deals with the number and funding of general practitioners in Australia. I therefore direct that a copy of this finding be forwarded to the Commonwealth Minister for Health and Ageing to note the strong criticisms of Dr Tideman in relation to the deplorable inadequacy of general practitioner services to aged care facilities in the State of South Australia.

[14] Transcript, page 53

Key Words: Group B Streptococcus; Emergency Departments

In witness whereof the said Coroner has hereunto set and subscribed his hand and Seal the 3rd day of June, 2010.

State Coroner

Inquest Number 2/2009 (0321/2006)