TRANSCRIPT OF PROCEEDINGS

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Date: 30 October, 2007

CORONERS COURT

WEBBER, Coroner

IN THE MATTER OF AN INQUEST INTO THE
CAUSE AND CIRCUMSTANCES SURROUNDING
THE DEATH OF VERONICA MARGARET NOFFKE

BEENLEIGH

..DATE 29/08/2007

..DAY 1

FINDINGS

This is a hearing to deliver the findings in relation to the inquest of Veronica Margaret Noffke. Well, what I intend to do this morning, is I intend to read my findings into the record. We will then arrange for transcripts to be made and a copy of the transcript of those findings will be supplied to the family, to the prosecution and also to the medical services who were represented by Crown Law.

This is an inquest into the circumstances of the death of Veronica Margaret Noffke. The purpose of the inquest is to find as far as practical the identity of the deceased person, how the person died, when the person died, where the person died and what caused the person to die. The Coroner must not include in the findings any statement that a person is or may be guilty of an offence or should be liable for something. A Coroner may, where appropriate comment on anything connected with the death that relates to public health or safety, the administration of justice or ways to prevent deaths from happening in similar circumstances in the future.

The Coroner's written findings must be given to the family of the person who died, as well as to each of the parties appearing at the inquest.

Veronica Margaret Noffke was a 73 year old female born on the 19th of November 1931. On the 29th of April 2005 the ambulance services transported her to the Logan Hospital believing she was suffering a severe asthma attack. At the time of admission she had a cardio reparatory arrest and was

resuscitated and was then admitted to the intensive care unit and ventilated. She remained sedated until the 9th of May, when she was transferred from the intensive care unit to the coronary care unit and she then passed away at 5.36 a.m. on the 10th of May.

A total of 14 statements were tendered at the inquest. They included nine medical reports, with eight of the witnesses being called to give evidence. Detective Furlong provided to the inquest a summary of his investigations and the preparation of his report.

The medical evidence was that Dr Katherine Hoonan, who was the medical specialist on duty when Mrs Noffke was admitted on the 29th of April 2005, her initial assessment of Mrs Noffke was that she was very unwell. Her breathing was inadequate and she was in respiratory distress and was unable to talk. Her chest was silent on osculations, indicating little air movement in her lungs. Investigations revealed a respiratory acidosis at levels indicating respiratory failure.

There was also concerns of heart attack as she presented with an acute heart condition. She was then transferred to the intensive care unit for on-going management.

Dr Worsvold was one of the - one of a number of doctors who attended to Mrs Noffke during her stay in the intensive care unit. His assessment was that she was very sick and a very unwell patient, and, during his shifts he would carry out any

instructions from the on-call specialist consultant. These included blood tests, chest X-ray, CT scans, ultra sounds. The CT scans of the chest included dye to look for dots in the lungs and stated that the CT scans showed no bleeding into the brain.

By the 7th of May, her respiratory function had improved to the point where she was excavated and was able to maintain adequate breathing. On the 9th of May, as I stated, she was transferred to the coronary care unit. Dr Barry was the night medical registrar on the 9th of May, and following a discussion with Dr Worsvold, a review of Mrs Noffke found her to be stable and it was safe and appropriate to transfer her from the intensive care unit to the coronary care unit and she outlined that the difference in these units was that in the intensive care unit, the care was a one on one situation, but the coronary care unit, that was a two on one situation. She then familiarised herself with Mrs Noffke's history and carried out an examination. She said there was no complaint of pain by Mrs Noffke and she started her on medication for blood pressure.

Early on the 10th of May, she reviewed Mrs Noffke as her blood pressure had fallen. Steps were taken to address the situation and after 15 minutes her blood pressure normalised and she started to feel better. Some two and a half hours

later, she was again called to review Mrs Noffke, as she was feeling unwell and was cold, clammy and distressed. She was experiencing breathing problems and was given more oxygen. Following advice from the on-call physician, a further medication was administered. After some 45 to 60 minutes her heart rate decreased, she maintained reasonable blood pressure, her breathing rate decreased and her colour improved. She was not distressed, but she said she still felt unwell.

After attending to other admissions, Dr Barry returned and finding a deterioration in her condition, commenced arrangements to return Mrs Noffke to the intensive care unit. It was then noted that Mrs Noffke had cardio respiratory arrested. An arrest code was called and after extensive and unsuccessful attempts to resuscitate, all attempts were ceased at 5.36 a.m.

Dr Barry stated that she could not recall any bruising and it was not unusual for patients coming from the ICU to have bruising. She said clinical bruising - clinical bleeding and bruising was more likely due to the body mass, with the use of wide needles to find their marks and the anti-coagulant on board making the blood thinner.

She stated she had examined her on two occasions and that the low blood pressure and bleeding was something considered during one examination. She stated Mrs Noffke was awake, she made no mention of pain and no masses could be felt or detected. She further stated that there was no indication of any definitive internal bleeding. Her evidence was that the administering of three different types of anti-coagulant and medication all together was quite normal. She stated, "It increases anti-coagulant effect and was appropriate".

Dr Williams was the forensic pathologist who performed the autopsy. She stated that the most remarkable finding was the extensive bruising, with the cause most likely resulting from a tendency to bruise. She stated that bleeding was in the abdominal cavity, but could not discover any cause or reason for the bleeding. She said there were no perforations and nothing obvious. Her assumption was that there was a slow ooze within the body, which could not be detected.

She stated the underlying cause of bleeding related to the anti-coagulant medication and that from the reports attached to her findings, although rare, there can be complications with anti-coagulant treatment. She stated that the loss of blood had contributed to Mrs Noffke's death. She also stated that Mrs Noffke was a lady with a past medical history including hypertension, previous cellula vascular accidents

and chronic obstructive airway disease. These were significant conditions that would have placed an extreme workload and strain on her heart.

Dr Culliford, a forensic medical officer stated that as a result of information received through Dr Malkay, who examined Mrs Noffke and was concerned that the bruising that had not be adequately explained and his concerns that the episode of trauma may have contributed to her death. She carried out an examination and agreed the bruising had not been adequately explained in the cause of death stated or the death certificate, although an autopsy would confirm the cause of death.

Dr Culliford's assessment was that Mrs Noffke was suffering severe heart disease and that the anti-coagulants were seeking to address the situation associated with the person when the person was not moving, and to prevent blood clots on the lungs. She stated the administration of the medication was a juggling game. It had to be high enough to be effective and low enough not to be ineffective. Her assessment was that the administration of the anti-coagulant medication was appropriate. She continued that a person in a generally deteriorated state had no support system and that you may see more bruising in seriously ill patients that had nothing to do with anti-coagulants and that someone with heart failure can

give a higher degree of bruising. She stated that there could be two causes for the bruising. One, local injection sites, she said a lot of bruises were related to injection sites; and two, as a result of the collection of blood.

Dr Culliford also commented on the report of Dr Calloway and thought that her assessment was appropriate as her knowledge was far better than her own. She felt that these treatment was appropriate and after reading through the notes stated that had she had access to the notes, the whole issue may have been resolved and it would have been easier to make a decision at an earlier stage.

Dr Bentley was a clinical haematologist and he viewed and summarised Mrs Noffke's record during her in-patient treatment. His assessment was that she was an extremely unwell lady prior to admission. She was extremely ill and was treated in an intensive care setting over a number of days. He found that the medications employed to counter a potential coronary artery thrombosis were appropriate and that the does administered were appropriate for the patient's weight. His first concerns was suspect bleeding and there was evidence of internal bleeding, which should have been suspected. He stated that the internal bleeding was related to the administration of the anti-coagulant medication. He agreed that to stop the anti-coagulant treatment would have been

hazardous and risky, due to the very unstable condition. The difficulty in detecting such bleeding is born out by Dr Bentley's evidence, that volumes of 500 millilitres of blood may not even be detected on CT scans.

We then have the evidence of Dr Calloway, a specialist in internal medicine, who also reviewed the records and provided a statement. Her opinion was that the haemoglobin readings suggested no significant inter abdominal bleeding had occurred prior to the 9th of May. Her assessment was that Mrs Noffke had probably died of cardiac arrest in the context of multiple medical problems, poor functional status and severe underlying coronary artery disease, which was exacerbated by a new anterial abdominal wall haematoma within a couple of days of death.

She further stated that Mrs Noffke was appropriately treated with anti-coagulants and anti-palliative therapy in all instances and that the medical treatment was adequate, appropriate and proper.

Dr Mulkay became involved when requested by Serenity Funerals to complete a certificate to cremate and was unsatisfied with the stated cause of death. After - after viewing the body in the light of extensive bruising not mentioned on the death

certificate, he referred the matter then to the Coroner and the police.

His evidence was that it was quite likely the bruising on the abdomen was not there when Mrs Noffke died. That bleeding inside the abdomen takes some time to make its way through and would show up two days post mortem. He accepted it would not have been evidence for observance at the time Dr Barry completed the death certificate.

Conclusion: There is no issue with any of the medical evidence that Mr Noffke was extremely ill and unwell and suffered from a number of medical conditions when she was admitted on the 29th of April and, after an initial examination, was treated in the intensive care unit. There is also no issue as to the cause of death set out in the autopsy report of Dr Williams. It is accepted by all the independent medical specialists who have viewed the records, that the anti-coagulant medication and the doses that were administered were appropriate. These opinions support Dr Barry, who stated in her evidence that such treatment was quite normal.

The main concerns of the independent assessments were the suspect bleeding. However, the evidence of Dr Barry that she had, on two occasions, after Mrs Noffke had been transferred to her care, examined her and could not detect any masses and

that during one of these examinations, Mrs Noffke was awake and made no complaint of pain. Confirms Dr Barry's evidence that she was aware of the invasive risk of the anti-coagulant treatment.

The difficulty in detecting any bleeding was addressed by Dr Williams when she stated that she, during the autopsy was unable to discover any cause or reason for the bleeding and she stated further, as I previously said that there was nothing obvious. It was quite difficult and pretty much impossible to detect.

Further, the evidence of Dr Bentley that masses of 500 millimetres of blood may not even be detected on CT scans, also supports Dr Barry.

Although it is accepted that the anti-coagulant medications contributed to the cause of the bleeding, it is also accepted that to stop the treatment would have been extremely risky when considering Mrs Noffke's medical condition. It was also accepted by all specialists that the bruising that became apparent was a result of the abdominal wall haematoma. The evidence of Dr Mulkay that it was quite likely not apparent at the time of death. This would support the assessment of Dr Calloway, that suggests that no significant inter abdominal bleeding had occurred prior to the 9th of May and then the

evidence of Dr Culliford that a lot of bruising would only occur after a period of 18 hours.

I am satisfied that there was no person at fault; that Mrs Noffke was extremely unwell and was in a serious condition when she was admitted to hospital and placed in the intensive care unit; that the care, the medication and the doses that were administered were appropriate; that her condition required aggressive treatment and that any risk of the anti-coagulant therapy were far outweighed by the benefits of such treatment. I am also satisfied that the treating medical personnel were aware of the possible complications associated with the use of anti-coagulants and that they were sufficiently monitored.

I therefore find that Veronica Margaret Noffke died at the Logan Hospital on the 10th of May 2005; that the cause of death was coronary atherosclerosis. Other significant conditions included hypertension, previous cerebrovascular accidents, chronic obstructive airway disease; anterior abdominal wall haematoma and anti-coagulant therapy.

I will make no further comments in relation to this matter and I would extend condolences to the family.
