OFFICE OF THE STATE CORONER

FINDINGS OF INQUEST

CITATION:	**Inquest into the death of David John DUGGAN**
TITLE OF COURT:	Coroners Court
JURISDICTION:	Caloundra
FILE NO:	5/07
DELIVERED ON:	13 August 2009
DELIVERED AT:	Caloundra
HEARING DATE(s):	10, 11, 12, 13 and 14 November 2008
FINDINGS OF:	Coroner – Magistrate D.M. Fingleton
CATCHWORDS:	CORONERS: Inquest – Death in Hospital; possible toxicity from medication; possible "access block"

REPRESENTATION:

Counsel Assisting:	Mr. J. Tate, Barrister-at-Law, Crown Law
Spouse of Deceased:	Ms. Pamela H. Macdonnell
Ms. C. Chapman, R.N.:	Mr. J. Allen, Barrister-at-Law, instructed by Roberts & Kane, Solicitors
State of Queensland, Queensland Health and employees (save Ms. Chapman):	Mr. A. Luchich, instructed by TressCox Lawyers

CORONER'S FINDINGS AND DECISION

1. These are my findings in relation to the death of **David John DUGGAN** who died at the **Caloundra Hospital** on 19 January 2007, while awaiting transfer to the Royal Brisbane Hospital for treatment of a cynovial cyst on his spine. These findings seek to explain how the death occurred and consider whether any changes to policies or practices could reduce the likelihood of deaths occurring in similar circumstances in the future. The *Coroners Act 2003*[1] provides that when an inquest is held into a death, the coroner's written findings must be given to the family of the person who died and to each of the persons or organisations granted leave to appear at the inquest. These findings will be distributed in accordance with the requirements of the Act and also placed on the website of the Office of the State Coroner.

The scope of the Coroner's inquiry and findings

2. A coroner has jurisdiction to inquire into the cause and the circumstances of a reportable death. If possible he/she is required to find:-

   a) whether a death in fact happened;
   b) the identity of the deceased;
   c) when, where and how the death occurred; and
   d) what caused the person to die.

3. There has been considerable litigation concerning the extent of a coroner's jurisdiction to inquire into the circumstances of a death. The authorities clearly establish that the scope of an inquest goes beyond merely establishing the medical cause of death.

4. An inquest is not a trial between opposing parties but an inquiry into the death. In a leading English case it was described in this way:- *"It is an inquisitorial process, a process of investigation quite unlike a criminal trial where the prosecutor accuses and the accused defends… The function of an inquest is to seek out and record as many of the facts concerning the death as the public interest requires."* [2]

5. The focus is on discovering what happened, not on ascribing guilt, attributing blame or apportioning liability. The purpose is to inform the family and the public of how the death occurred with a view to reducing the likelihood of similar deaths. As a result, the Act authorises a coroner to make preventive recommendations concerning public health or safety, the administration of justice or ways to prevent deaths from happening in similar circumstances in future.[3] However, a coroner must not include in the findings or any comments or recommendations, statements that a

[1] *Coroners Act* 2003, s45
[2] *R v South London Coroner; ex parte Thompson* (1982) 126 S.J. 625
[3] s46

person is or maybe guilty of an offence or is or maybe civilly liable for something.[4]

The Admissibility of Evidence and the Standard of Proof

6. Proceedings in a coroner's court are not bound by the rules of evidence because the Act provides that the court "*may inform itself in any way it considers appropriate."*[5] That does not mean that any and every piece of information however unreliable will be admitted into evidence and acted upon. However, it does give a coroner greater scope to receive information that may not be admissible in other proceedings and to have regard to its origin or source when determining what weight should be given to the information.

7. This flexibility has been explained as a consequence of an inquest being a fact-finding exercise rather than a means of apportioning guilt: an inquiry rather than a trial.[6]

8. A coroner should apply the civil standard of proof, namely the balance of probabilities but the approach referred to as the *Briginshaw* sliding scale is applicable.[7] This means that the more significant the issue to be determined, the more serious an allegation or the more inherently unlikely an occurrence, the clearer and more persuasive the evidence needed for the trier of fact to be sufficiently satisfied that it has been proven to the civil standard.[8]

9. It is also clear that a coroner is obliged to comply with the rules of natural justice and to act judicially.[9] This means that no findings adverse to the interest of any party may be made without that party first being given a right to be heard in opposition to that finding. As *Annetts v McCann*[10] makes clear that includes being given an opportunity to make submissions against findings that might be damaging to the reputation of any individual or organisation.

10. If, from information obtained at an inquest or during the investigation, a coroner reasonably believes that the information may cause a disciplinary body for a person's profession or trade to inquire into or take steps in relation to the person's conduct, then the coroner may give that information to that body.[11]

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[4] s45(5) and 46(3)
[5] s35
[6] *R v South London Coroner; ex parte Thompson* per Lord Lane CJ, (1982) 126 S.J. 625
[7] *Anderson v Blashki* [1993] 2 VR 89 at 96 per Gobbo J
[8] *Briginshaw v Briginshaw* (1938) 60 CLR 336 at 361 per Sir Owen Dixon J
[9] *Harmsworth v State Coroner* [1989] VR 989 at 994 and see a useful discussion of the issue in Freckelton I., "Inquest Law" in *The inquest handbook*, Selby H., Federation Press, 1998 at 13
[10] (1990) 65 ALJR 167 at 168
[11] S 48(4)

The Autopsy

11. On 23 January, 2007, Dr Peter Ellis performed an external and full internal autopsy examination and took toxicology and histology samples.

    Dr Ellis concluded that the Cause of Death was:

    1(a) Hypertensive Heart Disease, due to, or as a consequence of

    1(b) Possible Oxycodone and Morphine Toxicity and Chronic Fatty Liver.

The Evidence

12. It is not necessary to repeat or summarise all of the information contained in the exhibits and in the oral evidence given, but I will refer to what I consider to be the more important parts of the evidence.

13. On 19 January 2007, David John Duggan died at Caloundra Hospital situated at West Terrace, Caloundra in the State of Queensland. Mr Duggan had been a patient of the Hospital since 10 January 2007.

14. Mr. Duggan consulted his general practitioner, Dr David Heazlewood on Monday, 8 January 2007. Dr. Heazlewood had been treating Mr Duggan since 2001. He had treated Mr Duggan for a back condition in 2005. Dr Heazlewood said that back condition was sciatica being low back pain but not of the acute nature which subsequently occurred in 2007.

15. When Mr Duggan consulted Dr. Heazlewood on 8 January 2007, he had severe back pain in his lower spine region and was finding it difficult to sleep. The pain was coming down his right thigh with altered sensation and on examination he was tender across the lower spine and had a significant reduction in his range of movements, reduced sensation in the right thigh and no reflexes below his knee.

16. Dr Heazlewood referred Mr Duggan for a CT scan which was carried out on Tuesday, 9 January 2007. That CT scan suggested there were fragments of disc in his right L3/4 vertebrae region.

17. Dr Heazlewood's best recollection was that he contacted the Royal Brisbane Hospital (RBH) and spoke to a neurosurgical registrar and that there was a bed available at the RBH. He later described this as his "impression" that a bed was available. Given that Mr Duggan was in too much pain to travel to Brisbane by car he said he spoke to the Emergency Department at Caloundra Hospital and organised for Mr Duggan to be referred there.

18. Dr Heazlewood prepared a detailed letter (dated 10 January 2007) for Mr Duggan's referral to the Caloundra Hospital. That document is exhibit 3 but also appears as part of exhibit 28, the Hospital records. It recorded the extreme pain that Mr Duggan was experiencing even with the use of narcotic analgesia which had been administered by Dr Heazlewood. It

recorded Mr Duggan's history as an ex-smoker who consumed four glasses of white wine each evening. It also recorded Mr Duggan's history of having an enlarged heart (cardiomegaly) which Dr Heazlewood said in his evidence had been detected by a previous chest x-ray.

19. It recorded Mr Duggan's family history which included ischemic heart disease and myocardial infarction in his father. Dr Heazlewood said in his evidence that Mr Duggan was a large man of approximately 120kg. He also had a history of hypertension which was recorded in the referral letter. Dr Heazlewood could not recall Mr Duggan ever discussing with him, symptoms that might be consistent with sleep apnoea.

20. Mr Duggan attended the Caloundra Hospital emergency department on the morning of 10 January 2007. He was seen by Dr Chakradhar Thota. Dr Thota's statement dated 19 August 2008, is exhibit 4. The clinical picture on Mr Duggan's presentation is recorded in Dr Thota's statement. Dr Thota contacted a neurosurgical registrar at the RBH, Dr Matthew Cockburn, who initially accepted Mr Duggan for transfer for further investigations and management. However, subsequently, Dr Cockburn contacted Dr Thota requesting that the CT scan films which had been taken on 9 January 2007 be sent to the RBH, so that further consideration could be given as to whether to transfer Mr Duggan. Accordingly, Mr Duggan was admitted to the Caloundra Hospital for management of his pain.

21. Following discussion between Dr Thota and Dr Cockburn, it was decided by Dr Cockburn that Mr Duggan's condition was not life threatening or sufficiently emergent to require transfer. Rather, he fell into a category of patient, the standard clinical treatment for which, was to receive symptomatic pain relief and then to be reviewed as an outpatient of the RBH in four to six weeks by the neurosurgical clinic. Exhibits 6 and 7 were tendered as evidence that the standard clinical treatment for patients such as Mr Duggan was not immediate transfer because the situation was not life threatening or threatening significant neurological function.

22. This evidence was opposed to Dr Thota's, who thought it was due to no beds being available. However, the evidence of Dr Cockburn is preferred in this respect. Mr Duggan was admitted to the Caloundra Hospital under the care of Dr John Endacott as the Consultant with Dr John Blenkin as the Senior Medical Officer/Registrar. During the period 10 to 12 January, they were assisted by a residential medical officer, Dr Dave Lutchman.

23. A ward round was conducted on Thursday, 11 January 2007. Mr Duggan was in significant pain. The treating doctors determined to increase his pain relief medication which had been initially prescribed by the emergency department doctors and to liaise with the RBH to determine what management was required. Mr Duggan's Oxycontin (morphine) dosage was therefore increased to 20mgs twice daily.

24. Meanwhile, Dr Cockburn confirmed the non-urgency of Mr Duggan's condition in terms of being transferred to RBH; that he should be provided

with symptomatic pain relief and be reviewed in the outpatients department at the RBH in four weeks time. Dr Cockburn also requested that Mr Duggan have an MRI of his spine prior to the outpatient department appointment. Dr Lutchman made those arrangements for Monday,15 January 2007 at Nambour Hospital and Dr Blenckin wrote up the referral for Mr Duggan to attend the outpatient department at RBH. These documents were part of the hospital records (exhibit 28).

25. From a further ward round on 12 January, by Dr Blenkin and Dr Lutchman, the notes indicated that Mr Duggan was still in significant pain but he did not have any new neurological deficit. Dr Blenkin ordered an increase of Mr Duggan's morphine to 30 mgs twice daily and added Amitriptyline. Mr Duggan was able to provide a report of his condition and his history without any difficulty. He also participated in a neurological examination which involved certain physical activities such as raising his legs in the air and obeying the commands of the doctor conducting the neurological examination. It was not noted that Mr Duggan appeared to have difficulty concentrating or was unable to provide a history, nor that he was excessively sedated or excessively drowsy, issues which would have been noted as significant.

26. Over the course of the weekend 13-14 January, Mr Duggan continued to receive his pain medication. No notes in the hospital records suggested that he was excessively sedated or drowsy or noted any other concerns over his condition. Late on 13 January, Mr Duggan was transferred from the medical ward to Dove Cottage, a facility at some distance from the central nurses' station usually used for palliative purposes but used on this occasion because the other wards were full. This was a nursing decision and not one made by any of the treating doctors.

27. On Monday, 15 January, Mr Duggan went to the Nambour Hospital for an MRI of his spine. He had increasing pain as a result of the transport but the nursing entry made at 10 pm, stated that he settled with regular analgesia and did not require any analgesia for the breakthrough pain. During a ward round on 16 January, Dr Blenkin, Dr Endacott and Dr Christian McGrath were present. Dr McGrath had taken over the position of Dr Lutchman. Mr Duggan's pain was not improving but he was able to mobilise with a walking stick.

28. The pharmacological regime was altered – Mr Duggan was commenced on Gabapentin (300mgs) to treat the neuropathic (nerve) pain, as the opioid medication was not controlling his pain. His Diazepam was weaned down, to limit the side effects of drowsiness, as he had reported feeling dopey. The anti-inflammatory Ibuprofen was ceased.

29. Dr Blenkin, having contacted the RBH neurological team regarding the MRI films spoke with Dr Martin who had taken over from Dr Cockburn, who stated that she had not received the films.

30. During a further ward round on Wednesday, 17 January by Dr Blenkin, Mr Duggan said that the pain in his right leg was constant and never went

away. It was regarded as neuropathic in nature. On examination, Dr Blenkin found him to be without a fever and with normal vital signs. He was sitting up and eating his lunch and was calm and not distressed, notwithstanding his continual pain. No symptoms or clinical observations existed, to suggest that Mr Duggan was excessively sedated. Calls to Dr Martin at RBH about her views on the MRI were unsuccessful as Dr Martin was in operating theatre. A further attempt to contact Dr Martin at 8.00am on 18 January was also unsuccessful, as she was not on duty until 3.30pm that afternoon.

31. During a further ward round on 18 January, Mr Duggan reported that he was not feeling well and complained of lots of pain, with difficulty sleeping. He reported pins and needles along his right leg with the pain flaring up rather than getting progressively worse. He reported as still feeling dopey. However, he was found to be easily rousable and participated in conversation with the doctors. He was able to give a report of his symptoms to them and participate in a neurological examination, which involved physical activity on his part, although the results were difficult to interpret because of his pain. A further reduction in Diazepam to 2.5 mgs twice a day was ordered by Dr Endacott as a continual weaning of the drug, together with an increase in Gabapentin to 600mgs twice daily to try and control his neuropathic pain.

32. In a discussion with Dr Martin at 2.20pm on that day, it was reported that the MRI films were still not with her. Dr Martin received the films following further arrangements were made by Dr Blenkin for them to be sent to her. The delay was not explained but it had been the responsibility of the Radiology Section to transmit the MRI by electronic means and this had not happened. Dr Martin told Dr Blenkin at 3.45pm that she would discuss the case with her consultant and get back to him.

33. During the afternoon/evening of 18 January, Mr Duggan was nursed by RN Probert, a nurse of 30 years' experience, who both administered medications as ordered and checked on Dr Duggan every hour. Mr Duggan was lucid and ate his dinner while watching television and had a shower on his own. At 10.40pm he was administered some morphine as he was in severe pain and so that he could settle for the night. There were no indications that Mr Duggan was excessively sedated or drowsy.

34. Mr Duggan slept through the night. Upon awakening at 6.00am, he declined further pain relief. He was clear eyed, alert, easily conversant with the nurse on duty, Mr Wade and had no signs of drowsiness. He was able to toilet himself. Nurse Chapman (a nurse of some 20 years' experience) took over from 6.15am to 2.45pm on Friday, 19 January 2007. She found him chatty, although he reported as suffering back pain. He was administered his medications at approx. 7.15am and some morphine at 9.00am. He showered himself while his bed was attended to. Observations taken at 9.40am were all within normal limits.

35. At 12 noon, a ward round was taking place and Nurse Chapman heard discussion about changing Mr Duggan's medications. She returned to Mr

Duggan's room at about 1.30pm to retrieve his chart for review of the changes. Mr Duggan was asleep and snoring loudly. At no time during her attendances on the patient that morning, did he appear to be blue or bluish nor did he ever appear disoriented.

36. This was in contrast to the observation of Mr Duggan's *de facto* wife, Ms Macdonnell, who had been visiting him regularly, since his admission to the hospital. She said that he had not been interested in eating his lunch and she thought he was turning blue. Concerned, she went up to the nurses' counter and told them but no one came. She left him but thought she would never see him alive again. She believed Mr Duggan also believed he was dying. Ms Macdonnell did, however, talk forcefully with Dr Blenkin and asked that Mr Duggan's medication be reduced.

37. Prior to the ward round at 12 noon, Dr Blenkin had spoken to Dr Martin at the RBH, who indicated that her consultant neurosurgeon had seen the MRI films and suggested a transfer to Brisbane for surgery be scheduled. Mr Duggan had been told about these arrangements and was pleased. Ms Macdonnell's concerns about Mr Duggan's drowsiness were addressed. It was explained to her that there was a balance between managing his pain and the side effects of the medications. Although not overly concerned with Ms Macdonnell's concerns, Dr Blenkin took them on board and decided to reduce the dosage of Gabapentin and Oxycontin. The Diazepam was also ceased completely. No blueness was observed in Mr Duggan.

38. Further, no adverse effects to the narcotic analgesia he was taking were observed in Mr Duggan, e.g., sweating, vomiting, low blood pressure, pin point pupils or respiratory depression. He did not have any slurred speech. He could answer all the doctors' questions appropriately and was able to converse with them. A tea lady, Pamela Walton stated that at around 1.00pm when she picked up Mr Duggan's lunch tray, he was chatty and no different to what he had been on previous days she had spoken with him.

39. At between 3.00pm and 3.15pm that day, Ms Walton again went into Mr Duggan's room, during the patient's rest period between 1.30pm and 2.30pm. She observed that all was not right with Mr Duggan and informed a male nurse. Subsequently, Dr Alex Dunn came to Mr Duggan's room and pronounced him as deceased.

Medical Evidence:

40. Dr Ellis was the forensic pathologist, who carried out the autopsy of Mr Duggan. His original conclusion as to "Cause of Death" was:

    "1(a) Hypertensive Heath Disease, due to, or as a consequence of

    1(b) Possible Oxycodone and Morphine Toxicity and Chronic Fatty Liver."

Because of an issue with the computer used by Dr Ellis at the time, he said that he would have preferred his original conclusion to have read:

"1. Hypertensive Health Disease;

Other Significant Conditions –

2. Possible Oxycodone and morphine toxicity;
Chronic Fatty Liver."

41. In his "summary and interpretation" section (exhibit 2), Dr Ellis stated that:

> *"death was likely to have been multi-factorial. Cardiac enlargement (and Mr Duggan had a history of high blood pressure) is known to predispose to sudden cardiac failure as is chronic fatty liver disease. It is not possible to exclude the analgesic medication as contribution to death although the measured levels were not within the published fatal ranges. It is apparent that death was due to a hypertensive heart disease with a possible (and non-quantifiable) 'contribution of analgesic medication'. The fatty change in the liver may have been a contributing factor."*

42. Dr Ellis, in his evidence, discussed the fact of Mr Duggan's large heart (a fact which had been included in the referring doctor's letter to the Caloundra Hospital upon Mr Duggan's admission). He said that if a person has a sick heart, the adrenalin which is added from severe pain, can worsen the outcome of heart disease and that a large heart is susceptible to beating irregularly.

43. Dr Ellis commented on the fact that there was a delay of four days in his being able to conduct an autopsy and because there was no blood and a blood test had not been made immediately after death, he was restricted in his ability to comment on the levels of drugs in the deceased's blood at the time of his death. But certainly, at autopsy stage, non-fatal ranges were in the body. Dr Ellis was unable to exclude that reduced consciousness, caused by a drug that caused brain depression, was the cause of death, based on the autopsy alone. However, if he were to conclude that, it would have to be because the drugs were at a higher level than at the time of autopsy or that Mr Duggan had been sensitive to them.

44. Ultimately, Dr Ellis, in his evidence, revised his view of the cause of death to be:

1. Hypertensive heart disease

Other significant conditions:

(a) Possible oxycodone and morphine toxicity
(b) Chronic fatty liver

45. Two other medical experts gave evidence – they were Professor Olatino Drummer, a Forensic Pharmacologist from the Victorian Institute of Forensic Medicine and Dr Paul Kubler, a Clinical Pharmacologist from the RBH.

46. In Professor Drummer's report dated 3 November 2008, he took the view that from a toxicological perspective there was no evidence that any administered drugs contributed significantly to the death of Mr Duggan. Perhaps more importantly, however, Professor Drummer expressed a view that none of the prescribed drugs, in the dosage concentrations administered, were capable of causing serious toxicity or death. Equally, he noted that the toxicology report suggested that the blood concentrations were such that the results did not suggest a possible toxic role for any one, or more, of the drugs, or the drugs in the administered combinations.

47. The Professor's views were further discussed in oral evidence. In particular, Professor Drummer (Transcript day 4 – page 124), said:

> *"Q. From the perspective of your subspecialty, are you able to positively exclude the medication that David was receiving from possible negative sequelae and his death?*
>
> *A. Look, I can't exclude the possibility that his drugs, particularly narcotics, may in some way contributed to his death. I can't exclude that absolutely. All I can say, there's no particular suggestion, based on the – the doses and the toxicology, to suggest that is likely to be the case, although, you know, I have heard that there was some evidence that might be related to a drug effect – the dopiness and also the presentation of Mr Duggan to his wife that morning. But that, by itself, wouldn't convince me that it was a drug effect, necessarily but as I said I can't exclude there was drug involvement in his death absolutely".*

48. Turning to Doctor Kubler, whose report reviewed the clinical facts from the perspective of a clinical pharmacologist. It is important to note, however that Dr Kubler had not had the advantage of reading Professor Drummer's report prior to preparing his report. In oral evidence (Transcript day 4 – page 5), he agreed with Professor Drummer's opinion and ultimately doubted that this case could be appropriately explained by respiratory depression. He made no suggestion that the pain relief medication administered was other than in accordance with normal clinical practice for pain management, stating that the drugs appeared to have been at the appropriate upper limit for the dosing of a patient the age of Mr Duggan.

49. Dr Kubler considered that the cause of death was primary arrhythmia. He had concerns about the frequency of observations which appear to have been taken and considered that the medical file contained insufficient information to allow him to assess the level of sedation of Mr Duggan. He considered that such observations should be regularly taken every 4 hours, as a matter of best practice.

50. Dr Kubler dealt with the issue of the “blueness” noticed by Ms Macdonnell stating that it could have been there because Mr Duggan was overweight and some of the superficial veins were being compressed. He did not have sufficient information on that issue to be more specific.

51. He went on to say that he considered that had Mr Duggan gone to the RBH after he was first admitted to the Caloundra Hospital, that the outcome would have been no different.

52. It would also appear that the combined evidence of RN Wade, RN Chapman, Dr Blenkin, Dr McGrath and also Ms Walton suggests that Mr Duggan did not appear excessively sedated on either Thursday 18 January 2007 or Friday 19 January 2007. Throughout Mr Duggan’s entire period of hospitalisation he was always able to converse appropriately with the doctors, provide reports of his daily symptoms and participate in neurological examinations which involved physical activity on his part. He was able to eat his own meals and on Friday, 19 January 2007 was able to shower independently.

53. Dr. Blenkin gave evidence that he did not notice any bluishness in Mr Duggan on 19 January and that his decision to reduce the level of Mr Duggan’s medication on 19 January was more related to taking note of Ms Macdonnell’s concerns than any concerns he had about Mr Duggan’s treatment.

“Access Block”

54. It appears from the evidence, that it is not possible to identify a difficulty in this case as being the limited number of beds available at the neurosurgical department of the RBH which would have allowed transfer of the deceased for surgical intervention. It is also clear that the neurosurgical registrars and consultants at the RBH did not see Mr Duggan’s case as one that required urgent surgical intervention at first. Rather, and in line with normal clinical practice, a conservative management regime was advised to see if Mr Duggan’s symptoms would settle naturally over some weeks.

55. There was some delay in the receipt by the neurosurgical department at the RBH of the copies of the MRI scans. Upon this happening, it was decided that surgery was required for the treatment of Mr Duggan and that such surgery should be scheduled but no mention of emergency was made. Arrangements had been made by Caloundra Hospital to have Mr Duggan transferred to RBH by ambulance, as soon as possible on or after 20 January, upon receiving information that a bed was available there.

Pain management

56. Dr Kubler was able to offer advice in relation to pain management procedures. He suggested that:

(a) Adequate documentation of a patient's response to narcotic analgesics (in a non palliative setting) noting effectiveness and side effects;
(b) The need for a clinical action plan if the desired parameters are not met.

57. A Root Cause Analysis Report was tendered as an exhibit (exhibit 23) and commented upon in the evidence of Ms McArdle, of Queensland Health. Such a report is raised when a "sentinel event" – such as the unexpected death of a patient in a Queensland Hospital occurs.

58. As a result of this Report, several changes have occurred at the Caloundra Hospital. These include:

The Hospital now functions almost entirely as a geriatric ward. However, the emergency ward still functions. Now, the admission of someone in Mr Duggan's condition – suffering acute pain, would be considered "inappropriate" and the patient would be moved to Nambour Hospital as soon as possible. Clause 10 of the Report - "Lessons Learnt" states:

> *"On investigating this incident, the prominent barrier was the inappropriate admission of this patient to Caloundra Hospital. Had this been addressed, the other contributing factors that have been identified may not have occurred. However, it is important to note the other factors that have been addressed and subsequent recommendations will improve the service that is provided at Caloundra and aid patient safety."*

In the area of pain management, the report was critical of staff not adhering to correct procedures when ordering/ceasing and administering medication and incomplete record keeping. Whether or not as a result of this, there is now information available about the acute pain service at Nambour Hospital and the ability for staff to consult with those pain doctors for specialist pain advice, should that be required.

Again, Clause 10 of the Report states:

> *"Nambour now has been granted funding for guidelines on the management of patients to formalise and raise awareness of a referral management system for patients in ongoing acute pain."*

The Report did go on to explain that the management of the Caloundra Hospital has implemented the various recommendations described in the report.

Dove Cottage

59. Another issue which was raised was the placement of Mr Duggan in Dove Cottage, a ward located at some distance from the nurses' station. The outlying of patients in Dove Cottage (which has since been demolished and the area subsequently reconstructed as a dedicated palliative care unit), was a process which occurred at peak times of service use. Mr

Duggan had access in Dove Cottage to a buzzer to summon nursing assistance if he required it and a telephone with outside lines for communication. He was still subject to the same observations and reviews as ordered by the medical practitioners in charge of his treatment.

Relationships with relatives of patients

60. The *de facto* partner of the deceased expressed her concerns that there was insufficient communication between treating doctors and nurses and herself. She was of the opinion that if a Nurse Advocate System was available to her, as is the case in New South Wales and Victorian hospitals, that she would have had less trouble in conveying her concerns to the medical staff at the hospital.

Queensland Police Service Investigation

61. Evidence given by the police officer who investigated the death of Mr Duggan suggested an inadequacy in the training of himself and others to successfully complete coronial enquiries. These shortcomings included–

    (a) The lack of seniority of officers given the investigation of a complex hospital death and lack of adequate supervision by more senior officers throughout the investigation;
    (b) No pictures were taken of the death scene;
    (c) No blood sample was taken within four hours of death;
    (d) Death by natural causes was assumed even though an autopsy would be taking place;
    (e) No statements taken from hospital staff or the *de facto* partner of the deceased.

Findings required by s45

62. I am required to find, as far as is possible, who the deceased was, when and where he died, what caused the death and how he came by his death. I have already dealt with the last of these issues, being the circumstances of David John Duggan's death. As a result of considering all of the material contained in the exhibits and the evidence given by the witnesses I am able to make the following findings in relation to the other aspects of the death. In doing so, I note that, for various reasons, no medical expert was able to rule out entirely the possible drug toxicity as a cause of death. However, on the balance of probabilities I find that:

    (a) The identity of the deceased was David John Duggan

    (b) The place of death was Caloundra Hospital, Caloundra, Queensland

    (c) The date of death was 19 January 2007

    (d) The formal cause of death was:

        1 Hypertensive Heart Disease;

Other Significant Conditions:

Chronic Fatty Liver.

Concerns, Comments and Recommendations

63. There were a series of events which built upon each other in relation to the death of Mr Duggan.

64. Section 46 of the Act provides that a coroner may comment on anything connected with a 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.

Referral of Information

65. The facts in this case do not warrant the referral of information to prosecuting authority or a professional disciplinary body.

Recommendations

66. It is clear the management of the Caloundra Hospital has implemented the various recommendations described in the sentinel review report and there is no point in repeating those administrative recommendations in these findings.

67. It is appropriate, given the facts of this case, for Queensland Health to review its pain management and risk protocols generally but, in particular, the protocols applicable to primary care Level 1 hospitals.

68. That Queensland Health investigates the introduction of Nurse Advocates into the hospital system to assist communication between patients' relatives and medical staff.

69. The Queensland Police Service should review the adequacy of the investigations police undertake in relation to hospital deaths for coroners and the training for officers who carry them out.

I close this inquest. The sympathies of the court are once again extended to Ms Macdonnell for her sad loss of Mr Duggan.

D.M. Fingleton
Caloundra Coroner

13 August 2009