OFFICE OF THE STATE CORONER

FINDINGS OF INQUEST

CITATION:	**Inquest into the death of Elise Susannah Neville**
TITLE OF COURT:	Coroner's Court
JURISDICTION:	Brisbane
FILE NO:	COR/02 2463
DELIVERED ON:	12 September 2008
DELIVERED AT:	Brisbane
HEARING DATE(s):	8 April 2008, 25 & 26 June 2008
FINDINGS OF:	Coroner Lock
CATCHWORDS:	CORONERS: Inquest – Head Injuries, Bunk Beds, doctors working hours, emergency department care in regional hospital, emergency retrieval, open disclosure of adverse health events.

REPRESENTATION:

Ms J Rosengren, Counsel assisting the Coroner

Mr DK Boddice representing the State of Queensland

Ms B Betts representing the Department of Emergency Services

Mr Shields of Ryan & Bosscher representing Dr Doneman

Dr Neville representing himself and Mrs Neville

CORONERS FINDINGS AND DECISION

1. These are my findings in relation to the death of **Elise Susannah Neville** who died at the Royal Brisbane Hospital on 9 January 2002. 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 date of death means that my findings are made pursuant to the *Coroner's Act 1958* (the Act) as distinct from the *Coroner's Act 2003* which came into force after 1 December 2003. Any references to legislation will be to the *Coroners Act 1958.*

2. As such the scope of the inquest and my findings are bound by ss 24 and 43 of the *Coroners Act 1958.* This limits my findings to identifying who the deceased was; when, where and how the person came to die; and (relevantly in this case) whether any person should be charged with her murder or manslaughter. I am not otherwise permitted to express any opinion on any matter which is outside the scope of this inquest, except in the form of a rider or recommendation which, in my opinion, is designed to prevent the occurrence of similar circumstances. I am not permitted to frame my findings in such a way as to appear to determine or influence any question or issue of civil or criminal liability.

The scope of the Coroner's inquiry and findings

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

    (i) whether a death in fact happened;
    (ii) the identity of the deceased; and
    (iii) when, where and how the death occurred.

4. 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. With the introduction of the Coroners Act 2003 there has no doubt been a change in emphasis and there has been the removal from consideration under the 1958 Act towards establishing in appropriate cases whether a prima facie case of criminal liability for the major offences of murder or manslaughter existed and for the person should be committed to trial.

5. Notwithstanding the difference in approaches between the two Acts many of the common law principles which apply in other coronial jurisdictions apply in inquests conducted under either piece of legislation. 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."* [1]

6. 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.

The Admissibility of Evidence and the Standard of Proof

7. Proceedings in a coroner's court are not bound by the rules of evidence because the Act provides that the court "may admit any evidence that the coroner thinks fit."[2] 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.

8. This flexibility has been explained as a consequence of an inquest being a fact-finding exercise rather than a means of apportioning guilt. As already stated, it is an inquiry rather than a trial.

9. 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.[3] 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.[4]

10. It is also clear that a Coroner is obliged to comply with the rules of natural justice and to act judicially.[5] 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*[6] 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.

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[1] *R v South London Coroner; ex parte Thompson* (1982) 126 S.J. 625
[2] s34
[3] *Anderson v Blashki* [1993] 2 VR 89 at 96 per Gobbo J
[4] Briginshaw v Briginshaw (1938) 60 CLR 336 at 361 per Sir Owen Dixon J
[5] *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
[6] (1990) 65 ALJR 167 at 168

11. As this inquest is being held under the provisions of the 1958 Act, if, from the evidence received the coroner is of the opinion that there is sufficient evidence to put that person on trial for murder or manslaughter, the coroner may order that person to be committed before a court of competent jurisdiction.[7]

The Evidence

12. It is not necessary to repeat or summarise all of the information contained in the exhibits and from the oral evidence given, but I will refer to what I consider to be the more important parts of the evidence. It is also important to understand that many significant failings in the medical care provided to Elise that morning were directly responsible for her death. Dr and Mrs Neville have tirelessly pursued on a number of fronts many issues which contributed towards their daughter's death and in an effort to address some of the systemic deficiencies so that a similar tragedy is not repeated. Their grief is still palpable and they continue to have very significant concerns.

Over view of the Hospital Presentations of 6 January 2002

13. On 05 January 2005, Dr and Mrs Neville took Elise, aged 10 and their two other children, Laura aged 14 and Michael, aged 9 on holiday to Kings Beach, Caloundra for holiday. Dr Neville was medically qualified but he had not practiced clinically for some time and worked for Queensland Health in the public health area. What ever may have been his medical knowledge, the Neville family were entitled to receive and to rely upon medical advice and care as would any other member of the public.

14. The Neville family stayed in a two bedroom unit, with the three children staying in the one room. The bed arrangement included a bunk bed and a trundle bed. Elise was on the top bunk, Michael was on the bottom bunk and Laura was on a trundle bed. The bunk bed had no guard rails around it and would not have complied with then current, but non-mandatory Australian standard for bunk beds.[8]

15. On the night of 06 January 2002, Elise retired to bed at approximately 9:30pm. At 11:45pm, Mrs Neville entered their children's bedroom and placed the quilts from the beds on the floor because Mrs Neville was concerned that Michael might stumble out of bed in the dark.

16. At approximately 1:50am, Dr and Mrs Neville awoke to a loud crashing noise and crying. They entered the children's bedroom and found Elise on the floor below the bunk bed. It was apparent that Elise had fallen from the top bunk which was from a height of some 1.435

[7] S 41
[8] AS/NZS 4220:1994

metres. Elise was conscious, crying and complained that the left side of her head was hurting.

17. Dr Neville decided to remove Elise's mattress from the top bunk and position it in his bedroom at the foot of his and his wife's bed so that he could keep an eye on Elise. By 3am, it was apparent to Dr Neville that Elise had become increasingly agitated. Whilst on the mattress, Elise was restless, talking a little but mostly moaning. At about 3:10am, Elise vomited.

18. Dr Neville thought a CT scan or some other investigation was required. Dr and Mrs Neville took Elise to the Caloundra Hospital to see whether she required treatment. They arrived at the Caloundra Hospital at approximately 3:25am. There were no other patients in the emergency department at this time. The registered nurses (RN) on duty were RN Diane Forbes and RN Beverly Duncan. RN Forbes was the more senior of the two registered nurses and had worked at the Caloundra Hospital since 1990. RN Duncan provided the direct nursing care to Elise whilst RN Forbes attended to administrative duties.

19. The Doctor on duty was Dr Andrew Robert Doneman. Dr Doneman had obtained bachelor degrees in medicine and surgery in 1999 and had since graduation been employed as a junior house doctor at the Nambour Hospital. He was due to be appointed a senior House Officer in one week. Dr Doneman had been doing an emergency medicine rotation term of six (6) months at the Caloundra Hospital, at the time of Elise's presentation and was due to complete that rotation on 09 July 2002.

20. Dr Doneman was the only Doctor on duty and was rostered on a 24 hour shift which had commenced at 8am the previous day. Dr Doneman was 19 hours into the 24 hour shift. There was only one other patient in the ED at the time. Dr and Mrs Neville describe a delay in receiving attention with a plea from them for Elise to be looked at. There then follows a period of between 45 minutes to an hour where they entered into discussions with him about what treatment should be provided to Elise.

21. Neither a CT scan nor any other radiological investigations were undertaken. Elise was not held for observation. Dr Doneman did not consider that Elise's condition warranted that Elise be observed in a hospital setting and therefore did not recommend to Dr and Mrs Neville that Elise be taken to the Nambour Hospital or any other hospital. There was some discussion about keeping Elsie there for observation and it seems that Dr Doneman had come to a reluctant agreement to do just that. However, Dr Doneman was of the opinion that it was not the policy of Caloundra Hospital to admit children for observation. After checking and confirming with nursing staff that this was the case he told her parents that Elise could not be admitted for that purpose.

22. Elise was discharged back into the care of her parents at some time between 4:10 and 4:30am. When Elise arrived back at the holiday unit, she was placed in her parents' bed and Mrs Neville slept on the mattress on the floor. Elise kept complaining about her sore head but eventually settled at about 6am. Dr Neville dozed off and woke up at about 7am to find that Elise had a rash over the left side of her body and her back. Elise's jaw had a rigid appearance and the pupils were fixed and dilated.

23. An ambulance was called and arrived at 7:20am. Elise's rash had disappeared by this time. The initial plan was to transport Elise to the Nambour Hospital but whilst being transported, Elise turned blue. The ambulance proceeded straight to the Caloundra Hospital. The ambulance arrived at the Caloundra Hospital at 7:40am. Dr Doneman was still on duty at this time. Elise's Glasgow Coma Score (GCS) was 3. Dr Doneman expressed shock that Elise's condition had deteriorated so radically.

24. Dr and Mrs Neville had relied upon what they were told by Dr Doneman. They were frightened and anxious when they took her to Caloundra Hospital on the first occasion. They were distraught and full of anguish by the time they ended up at Caloundra Hospital the second time.

25. Dr Doneman telephoned Dr Tilleard, an Emergency Physician at the Nambour Hospital and discussed Elise's condition with him. It was decided that Elise should be air lifted to the Royal Children's Hospital in Brisbane. The medical retrieval team was requested at 8am. With the assistance of an anaesthetist, Dr Richard Young, Dr Doneman inserted an endotracheal tube into Elise. Mannitol was administered.

26. The medical retrieval team arrived at 8:50am. Elise was prepared for evacuation and was air lifted by heli-ambulance with a medical retrieval team at approximately 9:40am. There was insufficient room for either of Elise's parents to accompany her in the heli-ambulance. Dr and Mrs Neville were driven to Brisbane by a staff member from Caloundra Hospital.

27. Elise arrived at the Royal Children's Hospital just after 10:00am. She received a CT scan of her head. The results of this scan showed an extensive left sided extradural haematoma and a skull fracture. She was immediately taken to the operating theatre to have the haematoma evacuated.

28. Elise's neurological condition continued to deteriorate following the surgery. Tests conducted on 09 January 2002 confirmed that brain death had occurred and her parents were advised of this at about midday. A decision was made at approximately 5:30pm to cease life support. Elise passed away without regaining consciousness.

29. Dr Michael Redmond, a prominent Brisbane neurosurgeon was asked to provide a second neurosurgical opinion to Elise's parents. He later considered the medical file from Caloundra Hospital and provided a report to investigating police as part of the coronial investigation.[9]He opined that her clinical features on the first presentation were not clearly those of an extradural haematoma but her poor compliance and sleepiness did indicate she had sustained a head injury and a degree of suspicion was warranted as to possible complications. He said that the very least of what should have been offered was for her to be admitted for observation or referred to the Nambour or the Royal Childrens' Hospital.

30. He noted that at her second presentation the presence of fixed and dilated pupils which he considered was a grave prognostic feature. Dr Redmond opined that from that time on she was unlikely to have survived, or if she had survived she was likely to have suffered severe neurological deficits. He considered that there were significant delays in obtaining emergency treatment. There was approximately a one hour delay in intubation and commencement of hyperventilation and the administration of Mannitol. He said that the delay of 2.5 hours for her to be received at Royal Childrens' Hospital was unacceptable and warranted inquiry.

31. Dr Redmond stated that: *It is considered unacceptable for a patient, following head injury, to "talk and die". Elise Neville is one who "talked and died". In a sophisticated medical system, such as we enjoy, with ready access to hospitals of ascending levels of sophistication, it is tragic and unacceptable that an event such as this should occur.*

The Autopsy

32. An autopsy examination was not carried out after considering the wishes of Elise's family. Her injuries and the cause of death were well documented in the medical files and an autopsy would have added very little.

Investigations by other bodies

33. Preceding this inquest, a number of other investigative bodies have conducted enquiries and made findings. These included Queensland Health, The Health Rights Commission, the Medical Board of Queensland, the Queensland Nursing Council and the Office of Fair Trading. The Queensland Ombudsman investigated complaints made by Dr and Mrs Neville in relation to the outcome of those investigations. The Ombudsman made numerous recommendations with respect to a number of systemic deficiencies it found in the investigation process and in findings made in the course of those investigations. The Health Practitioners Tribunal also finalised disciplinary proceedings taken out against Dr Doneman.

[9] Exhibit B4, report dated 30/8/2002

34. While the purpose of this inquest is not to review those findings or go behind those findings, it is appropriate to summarise the findings by those various investigative bodies, the findings of the Ombudsman and the responses by those bodies to recommendations made by the Ombudsman. What is set out in this decision is not an exhaustive exposition of what occurred in the course of those investigations. That is more than adequately set out in the very comprehensive report of the Queensland Ombudsman of June 2006.[10] Nor does my summary give any specific endorsement of the investigations or findings of those investigations. It is important however to give a proper overview to the investigations that did take place and the results.

35. Many of the recommendations made by the Ombudsman relate to the health complaints framework and to administrative decisions made. It is not for this inquiry to comment on the administrative functions and decisions made by the Ombudsman, particularly as where they relate to administrative decisions made after the death of Elise and I do not intend to repeat or refer to each and every one. That report should stand on its own. I note that the Ombudsman decided not to table the report in Parliament until after the completion of the coronial proceedings. The tabling of the report should be undertaken as soon as is practical. It is a significant and important document. To the extent that it is necessary for me to make that recommendation I do so.

Issues for Consideration at the Inquest

36. In light of the recommendations made by the Ombudsman, the Office of the State Coroner determined that the appropriate manner to approach the inquest was to examine the recommendations made by the Ombudsman which were more directly related to the medical cause of death and the events immediately following the fall from the bunk. The Deputy State Coroner then requested an update from those bodies as to the implementation of those recommendations and examined their responses.

37. I held a pre-inquest hearing on 8 April 2008. A decision was made by me to not hear any direct evidence from Dr Doneman and the nurses directly involved in treating Elise that morning. Although there were factual issues identified by Dr and Mrs Neville with which they had some considerable dispute, I took the view that the essential factual issues had been thoroughly addressed in the various investigations; findings had been made as a result; and disciplinary proceedings had been finalised.

38. Dr and Mrs Neville have advocated and submitted that I should be considering committing Dr Doneman for trial for manslaughter on the

[10] The Neville Report, *An investigation into the adequacy of the health complaint mechanisms in Queensland, and other systemic issues identified as a result of the death of Elise Neville, aged 10 years.*

basis the evidence established criminal negligence. I made it clear at the pre-inquest hearing that having considered the evidence contained in my investigation file that there was insufficient evidence to commit any person to a trial on criminal charges of murder or manslaughter. Further I considered that there was no potential that the airing of those issues again would bring about a different conclusion. I understand that Dr and Mrs Neville have many points of contention regarding what happened that morning. However the essential facts were known and have been determined in other venues. Variations and conflicts in the versions of events, even if the conflicts could be determined by me, would not change the findings of fact already made in the matter by other bodies. Nor would it impact on any decision I could make concerning whether any person should be committed for trial.

39. On that basis I determined that the focus of the inquest would be to hear evidence from the various authorities who had given responses to the Office of State Coroners request for further information with a view to looking to the future. This involved the hearing of 2 days of oral evidence. However it is important to understand that I would also be considering all of the evidence contained in the 8 volumes of exhibits which had already been tendered at the inquest.

40. Apart from reviewing all of that material and the responses from various witnesses, four other issues of major concern were identified by counsel assisting this enquiry, which were to be addressed in the hearing.

    These were as follows:

    (i) Safe working hours of doctors and any changes that have been made;
    (ii) Any changes made to the emergency department at Caloundra Hospital particularly as it relates to care for children;
    (iii) The deficiencies in the retrieval process as found by the Health Rights Commission and any changes that have been made;
    (iv) Whether changes made to the safety of bunk beds are sufficient and what steps have been taken to raise public awareness of those changes.

41. For convenience I will endeavour to refer to those issues as they arise in the course of my review of the investigations carried out by other bodies as follows.

Medical Board of Queensland ("MBQ") investigation summary

42. The Medical Board of Queensland completed its investigation and provided a report dated 11 November 2003.[11] The MBQ found that at the first presentation to Caloundra Hospital Dr Doneman failed to:

[11] Exhibit L174

(i) properly examine Elise;
(ii) suspect that Elise's symptoms were a possible sign of significant head injury and
(iii) refer Elise for specialist treatment.

43. As a result the MBQ concluded that Dr Doneman's management of Elise at this time constituted unsatisfactory professional conduct as defined in the *Health Practitioners (Professional Standards) Act 1999.* The MBQ resolved to refer the disciplinary matter to the Health Practitioners Tribunal.

44. The MBQ concluded that there was no evidence of unsatisfactory professional conduct in relation to Dr Doneman's treatment of Elise at the time of her second presentation.

45. In the course of its report the MBQ analysed the evidence and made a number of findings, which are summarised below.

Issues Raised	**Findings Made**
First attendance	
Dr Doneman failed to carry out a complete GCS test.	Dr Doneman did not assess Elise's GCS properly. Further, his observation that Elises's eyes were closed when he entered the room should have alerted an experienced practitioner to the possibility of a decrease in conscious state warranting further observations.
Dr Doneman failed to palpate Elise's skull to ascertain any possible fracture.	Dr Doneman did not adequately examine Elise's head and did not perform a comprehensive neurological examination and therefore was not in a position to make a decision as to whether Elise had suffered a significant head injury. The indicators of a possible significant injury were present and Elise should have at the very least, been admitted for neurological observation.
Dr Doneman failed to examine Elise's ears.	Dr Doneman's belief that Elise did not have any CSF fluid behind her ear was unreasonable in circumstances where he had not examined her. It is standard practice to examine the ears of a patient who has suffered a head injury. However, it is not possible to determine the likelihood of blood being present in Elise's ear at the time of her first presentation at Caloundra Hospital.
Level of consciousness.	Dr Doneman placed too much emphasis on

	the fact that Elise had not lost consciousness when considering the possibility of an extradural haematoma. At the very least, he should have taken into account his relative inexperience and consulted with a more senior colleague. It is accepted that diagnosing an extradural haematoma it is very difficult.
Entry in medical records that "*sleepy and poorly compliant*".	Poor compliance and sleepiness are an early manifestation of the effects of an extradural haematoma and at least the possibility of this diagnosis should have been contemplated by Dr Doneman and it was unreasonable for him not to have been suspicious.
Entry in medical records that "*unable to fully assess because of non compliance*".	It was unreasonable for Dr Doneman not to contact a more senior colleague, such as Dr Tilleard, about Elise's condition. Dr Tilleard indicated that if Dr Doneman had telephoned him and presented these symptoms to him over the telephone, he would not have advised Dr Doneman to send Elise home and would have recommended a CT scan. It was unreasonable that Dr Doneman did not contact a more senior colleague to confirm his own thoughts on the matter or to get a second opinion.
Mrs Neville said she told Dr Doneman that Elise's behaviour during the examination was not normal for her and Dr Doneman admitted that he may have said something like "*it's late, she's had a disturbed night*".	Elise fulfilled all the criteria that Dr Doneman himself stated he would view as suspicious in relation to head injury protocols.
Dr Doneman's comment that he did not consider admitting Elise.	Dr Doneman's comment is not supported by the nurses who both stated that he asked them whether children were admitted to Caloundra Hospital. The fact that he asked this question of the nurses would indicate that Elise's parents were pushing for him to do so and therefore were not happy to take Elise home as Dr Doneman stated.
Second presentation	
Delay in administration of	The reason for this is unclear. Dr Doneman

Mannitol.	spoke to Dr Tilleard at about 8am and the Mannitol was not administered until 8.50am. It is not possible to attribute this delay to Dr Doneman as other medical staff had come on duty and Dr Doneman was finishing his shift.

40. Dr and Mrs Neville complained to the Queensland Ombudsman Office about Dr Doneman's treatment of Elise and the subsequent investigation conducted by the Medical Board of Queensland.

The Ombudsman found that:

(i) In the original letter of complaint by Dr and Mrs Neville to the MBQ, they sought that Dr Doneman be immediately suspended and that the MBQ seek to have him deregistered. The MBQ did not take interim action to suspend or impose conditions on Dr Doneman's registration as it did not reasonably believe the doctor posed "an imminent threat to the well-being of vulnerable persons …". The Ombudsman formed the opinion that the reasons of the MBQ for not taking immediate action focussed on the decision not to suspend but did not satisfactorily address why it did not impose conditions. The Ombudsman concluded that the MBQ should have taken action to impose conditions on the registration of Dr Doneman at its meeting on 11 March 2003;[12]

(ii) There was a 10 month delay between the appointment of the initial investigator, on 27 August 2002 and the appointment of the second investigator, on 24 June 2003, during which time very few active steps were taken to advance the investigation. The factors which resulted in the delay included the referral of the complaint to the Health Rights Commission, the untimely resignation of the investigator on 06 June 2003 and the backlog of complaints as there were some 295 investigations on hand. Dr and Mrs Neville had been informed that the investigation would take approximately 6 months to complete.

(iii) Dr and Mrs Neville also sought the deregistration of the Executive Director of Medical Services for the Sunshine Coast Health Service District. In an early report to the Director General, the Executive Director opined that the early management of Elise by Dr Doneman was reasonable.[13] The MBQ formed the view that the Executive Director's report was not the result of a substantial investigation and that any flaws demonstrated would not amount to unsatisfactory professional conduct. The Ombudsman expressed the opinion that the MBQ took a fairly narrow interpretation of its

[12] *The Neville Report*, p107
[13] Part of exhibit L67

investigative powers. The Ombudsman's main concern was that no agency investigated the "erroneous statements and opinions" in the Executive Director's report. The Ombudsman noted that amendments to the definition of "health service" in the legislation that will enable the Health Quality and Complaints Commission to investigate a complaint about a report of the kind prepared by the Executive Director.[14]

Findings of the Health Practitioner's Tribunal ("HPT")

41. The MBQ referred the disciplinary proceedings relating to Dr Doneman to the Health Practitioners Tribunal (HPT) for hearing. The Tribunal was constituted by Her Honour Judge Richards, Dr Comerford, Dr Hirschfeld and Ms J Felton. On 08 November 2004 the HPT accepted a guilty plea by Dr Doneman and imposed an order that Dr Doneman was to work only in a supervised position for a total period of 12 months.

42. In reaching its decision[15], the HPT found that Dr Doneman's treatment of Elise was deficient in a number of respects and considered the following facts:-

(i) Dr Doneman failed to:

(a) properly assess Elise's GCS;
(b) examine the external auditory canals and ear drums;
(c) ask Elise basic questions to ascertain her level of consciousness and understanding;
(d) conduct a full physical examination including a proper neurological and spinal assessment;
(e) assess the severity of Elise's headache;
(f) understand the signals that he observed and noted in his written notes as *very poor compliance, difficult to fully assess, not overly compliant and a reluctance to comply* as pointing to a potentially worsening head condition and
(g) did not give particular weight to the comments of Elise's parents as to her poor compliance and unusual behaviour.

(ii) the fact that Elise only opened her eyes after being spoken to and rocked on her chest, should have resulted in her GCS score being reduced and alerted an experienced practitioner to the possibility of a decreasing conscious state warranting further observation;

(iii) Dr Doneman should have at very least observed her in the Emergency Department for four hours or discussed her with a more senior practitioner and Dr Atkinson points out that she

[14] The *Health Quality and Complaints Commission Act 2006* was subsequently enacted and s37 provides for this.
[15] Exhibit L198

should have been sent to the Nambour Hospital for a CT scan;

(iv) the poor documentation and incomplete examination of Elise were of a lesser standard than might reasonably be expected from Dr Doneman as a Junior House Officer;

(v) Dr Doneman's interpretation of the history and physical findings were based on limited examination and his lack of appreciation of Elise's parents concerns were wrong;

(vi) the expert reports of Drs Atkinson and Cameron show that Elise's injury was not a common one and the fact that Dr Doneman was inexperienced was likely to have contributed to his decision to send her home; and

(vii) Dr Doneman must have been fatigued by the hours he was working and must have had a reduced capacity to assess the situation when it presented itself.

(viii) The Tribunal stated *"that it seems extraordinary in this day that anyone, let alone someone in a position of such responsibility should be asked to work such long hours and that if this tragedy leads to nothing else, it should lead to the abolition of such brutally long shift hours."*

(ix) That it was a matter of concern that it was the policy not to allow children to be observed in the emergency department at Caloundra Hospital. It was understood this practice had been abandoned but this also contributed to the actions of Dr Doneman.

Queensland Nursing Council ("QNC") investigation summary

43. RN Beverly Duncan

A complaint was made by Dr and Mrs Neville about RN Duncan. The complaint was concerned with her competence and conduct, namely that RN Duncan:

(i) displayed an uncaring attitude and unprofessional manner;
(ii) failed to complete an appropriate triage assessment and
(iii) fabricated her observations and recorded incorrect and misleading information on triage documentation.

44. In November 2003 an investigator for the QNC found sufficient evidence to warrant a finding that there were concerns regarding RN Duncan's competence.

In March 2004, the QNC resolved to:

(i) await an investigation by the Coroner before making a determination as to what action, if any, should be taken against RN Duncan and;
(ii) initiate an investigation in relation to RN Forbes.

45. At its monthly meeting in September 2004, the QNC decided that it held concerns regarding RN Duncan's triage assessment and her functioning as a member of a multidisciplinary team and decided that before preferring a charge against RN Duncan, it would convene a meeting to attempt to resolve the concerns raised by Dr and Mrs Neville. This meeting took place on 18 November 2005. RN Duncan entered into undertakings for re-education in triage assessment and functioning as a member of a multidisciplinary team. The re-education was to include a formative assessment component and RN Duncan was required to sit an oral exam before an expert panel. If a satisfactory outcome was not reached, a charge would be preferred against RN Duncan.

46. At its meeting of 02 November 2007, the QNC determined that RN Duncan's limited registration be cancelled and that she be granted a full and active licence. She had completed approved courses of education and an oral examination on 26 September 2007. The Coroner's office was subsequently advised by the QNC on 31 January 2008 that no charges were to be preferred against RN Duncan to the Nursing Tribunal because RN Duncan had met all of the conditions imposed upon her by her licence.

47. <u>RN Diane Forbes</u>

48. In July 2004, the investigator completed her report in relation to the conduct of RN Forbes.

47. The QNC decided there was insufficient evidence to warrant taking disciplinary action against RN Forbes. In arriving at this decision, the QNC noted that the decision to investigate RN Forbes had been based on the understanding that she was in charge of the shift. However, the investigation revealed that the Caloundra Hospital had a policy which did not designate which nurse was in charge of the shift. In those circumstances and given that RN Forbes did not assess the patient, the QNC considered that there was no basis to question her competency.

48. Part of the complaint was that RN Forbes totally lacked empathy. The QNC was of the opinion that even if proven, this was not conduct that could give rise to any disciplinary action.

49. Dr and Mrs Neville made a complaint to the Queensland Ombudsman's Office that:

(i) there was a lengthy delay in the QNC finalising its investigation;
(ii) the QNC failed to properly consider all relevant considerations when determining whether disciplinary action should be taken against the two Registered Nurses.

50. The Ombudsman found that:

(i) the QNC's investigation eventually dealt with both of the Neville's complaints that RN Duncan lacked competence and that she had deliberately fabricated records of Elise's presentation;
(ii) RN Duncan's statutory declaration was provided to the QNC in May 2005, more than 3 years after the incident and therefore, there was a real risk that RN Duncan's recollection of the events could have been impaired by such a lengthy delay;
(iii) the QNC did not refer the matter to the Nursing Tribunal for determination and therefore the Tribunal did not make findings of fact in relation to the different versions of RN Duncan and the Nevilles;
(iv) the only evidence to support QNC's decision that the Caloundra Hospital had a practice that did not designate which nurse was in charge of a shift, was a letter from Queensland Health's lawyers dated 21 May 2004 stating that RN Forbes had informed them that this was the case and
(v) QNC's investigator should have sought corroboration from Queensland Health for RN Forbes' assertion that she was not the nurse in charge.
(vi) Recommended that QNC cease its practice of delaying consideration of disciplinary action pending the completion of criminal or other proceedings (such as coronial proceedings).

51. In relation to the last finding it is the view of the Office of the State Coroner that disciplinary and investigatory bodies such as the Medical Board and the Queensland Nursing Council should carry out their statutory functions as quickly as possible and should not postpone taking action until other authorities have completed their investigations.[16]

Health Rights Commission investigation summary

[16] Findings of the State Coroner in the matter of Sabadina p31. See also the comments of the Honourable Geoffrey Davies at p314 in the *Queensland Public Hospitals Commission of Enquiry Report*

52. Complaints from Dr and Mrs Neville were received by the HRC on 09 April 2002.The HRC provided a 3 page letter on 4 September 2003 This found there was no “non-admission of children policy” in existence at Caloundra Hospital and it did not include any adverse findings or recommendations. After numerous concerns were raised by Dr and Mrs Neville about the investigation and findings, the Commission agreed to conduct a review.

53. The HRC second investigation report was issued on 28 June 2004 [17]. The Ombudsman noted that the second report bore little resemblance to the earlier report and that the HRC now considered that ”*Elise Neville’s tragic death has highlighted significant systemic issues at Caloundra Hospital”.*[18]

54. A number of issues were raised by the HRC and a summary of the findings follows.

Non - Care of Children

55. At the time of Elise’s admission, Dr and Mrs Neville were informed that a policy existed preventing the admission of children. The Commission initially found that in fact no such policy existed and that no consideration other than clinical should have prevented staff from keeping Elise from observation. On further consideration the Commission accepted that, even though there was no formal policy, there was a culture in existence of “non care for children” at Caloundra Hospital. For example, in their subsequent statements Dr Doneman, RN Forbes and RN Duncan appeared to be in no doubt that children generally were not kept for observation at Caloundra Hospital, let alone admitted.

56. The available data showed that in the seven months before 07 January 2002, only six children were admitted. Of these, five were admitted for inter-hospital transfer purposes after an average stay of three hours. Significantly, only one child was kept for observation, that child being sent home after one and a half hours in the Emergency Department.

57. There has been a dramatic change in practice following 15 January 2002. The low number of admissions prior to January 2002 suggests that, formal policies aside, it simply was not common or accepted practice to admit or keep children with a head injury at Caloundra Hospital. There was a lack of awareness, among at least some staff, of the Caloundra Hospital’s capacity and obligation to provide an appropriate level of care for children who presented. The recommendations of the HRC investigation were:

[17] Exhibit G
[18] Exhibit G at p.5

(i) the District Manager initiate appropriate action to bring about sustainable change, so that there is no doubt in anyone's mind as to the level of care that can and should be afforded to children at Caloundra Hospital;

(ii) Queensland Health investigate the introduction of an accredited course that would assist staff in smaller hospitals to be proficient in the current practices of emergency care of children and

(iii) Queensland Health undertake periodic auditing to monitor the effectiveness of the changes already introduced at Caloundra Hospital to ensure that changes are both effective and sustainable.

57. The Ombudsman considered that a practice had been allowed to develop among clinical staff at the Caloundra Hospital Emergency Department of refusing admission to children on the basis that Nambour Hospital was better resourced to deal with those patients. The management at Caloundra Hospital had not taken sufficient steps to make clear to clinical staff that there was no such policy.

58. The Ombudsman recommended that Queensland Health ensure formal admission policies existed in all public hospital Emergency Department and that all Emergency Department staff were adequately trained in the application of these policies prior to commencing in these departments. It has been noted that Caloundra Hospital has now developed a paediatric admission policy which will be referred to later.

59. One issue raised by Dr and Mrs Neville in submissions to me was that, on the basis that there existed no policy of non-admission of children at Caloundra Hospital, this was further evidence which would support the bringing of criminal charges against Dr Doneman and nursing staff on the basis this was simply a fabrication by nursing staff acceded to meekly by Dr Doneman so that they could have a peaceful night.

60. I think it can be accepted that there was no official QH policy of not admitting children. However the evidence does clearly point to a practice/culture of non-admission of children. From a staff perspective it was tantamount to a policy. In an early document which forms part of the extensive paper trail in this case, the District Manager in a facsimile of 15 January 2002 referred to the fact that "it is currently not the District's policy to admit children at Caloundra for observation." In my view there is ample evidence that allows me to conclude and agree with the findings of the Commission and the Ombudsman on this point.

Head Injury forms

61. Dr and Mrs Neville were not given a “head injury information form”. A copy of the current form was provided to the then Commissioner to check its adequacy. There were concerns raised about the adequacy of that form. This form was compared with a number of similar forms from other Emergency Departments that see children. The other forms all advised parents to check every one to two hours if the child can be aroused. No such advice appeared on Caloundra Hospital’s head injury form.

62. A new form has since been developed and it includes appropriate information consistent with the standard of other health services forms. The Commission stated that the Caloundra Hospital should ensure that all staff are familiar with the form and that they are readily available and provided.

Limited Medical notes

63. Limited medical notes were made of Elise’s second presentation at the Caloundra Hospital. The Commission found that documentation for clinical staff is now covered in continuing medical education sessions. The district’s *Handbook for Medical Officers* was revised in December 2003, to include a section on documentation and is provided to all commencing medical staff as part of their orientation.

64. A nursing documentation project was also instigated to increase staff awareness of documentation standards and procedures. The education sessions are undertaken twice per year. Regular documentation audits are carried out on a 6 monthly basis. The Ombudsman found that the documentation relating to both of Elise’s presentation was inadequate but did not make any additional recommendations about this issue. The efforts made by QH and the hospital to address that issue is considered by me to be appropriate.

Intubation and Administration of Mannitol

65. There were concerns raised about the length of time it took to intubate Elise and to administer mannitol. A resolution of those issues was made more difficult by the limited medical notes.

66. The Commission stated that the intubation of children can be problematic in itself and can require a higher level of medical skill than would be expected of a relatively junior doctor.

67. This raised the question as to whether the Caloundra Hospital should have available a doctor on a 24 hour roster, who is suitably skilled in the intubation of children. The Commission was advised that the district has at all times a medical superintendent on call. The medical staff who participate in the medical superintendent on call roster are senior medical officers who are suitably skilled in the intubation of children.

68. Concerns were also raised about the delay in the administration of Mannitol. This is a medication given to reduce brain swelling and elevated intracranial pressure. The Hospital records, limited as they are, indicate that QAS were with Elise at 07.32, departed at 07.40 and presented at Caloundra Hospital at 7.45am. Her Glasgow Coma Score, as recorded by the QAS officers and then on admission was 3 (the lowest possible). Intubation was completed by 8.20am and mannitol was not commenced until 8.45am.

69. The HRC found that there are no notes in the clinical record relevant to the decisions made other than noting the timelines as such. The Commission investigation found that the medical staff involved in the decision to administer mannitol could not recall the details of any discussion held and therefore the Commission determined that it is was not possible to take that matter any further. The Commission found that it was unable to say whether the administration of mannitol took place within a reasonable timeframe or not.

70. The Commission was able to confirm that Dr Bryant, a neuro-surgical registrar at Royal Children's Hospital was contacted by Caloundra Hospital and spoke to staff on 2 occasions after Elise arrived. Dr Bryant does not make any reference to those conversations in his statement dated 1 May 2002.[19]

71. However there is the evidence of Dr Neville which says that it took 60 minutes from the time of the second presentation for mannitol to be administered. That is supported by the documented timeline referred to above,

72. Elise's neurological condition at the second presentation was clearly very serious. In the Neurological Guidelines it is stated that where there is a deteriorating head injury in a country hospital, and after consulting with a neurosurgeon the next step is to administer mannitol and frusemide. If there is to be a transfer to a neurosurgery unit within 2 hours then this should be adminsistered along with intubation. If the transfer is to take longer than 2 hours and a burrhole exploration or craniectomy is to take place, again mannitol and frusemide should be administered whilst that was all being prepared for.

73. Clinically it is plainly obvious that the sooner these agents are administered the better. Even if it can be said that intubation of children can be problematic for junior doctors and they did the best they could that day, there still was a delay in commencing the intubation. There clearly was an unacceptable delay in the introduction of mannitol and there seems to be no explanation provided as to why that may be. One possibility surmised by the Commission was that it was simply overlooked in the heat of the

[19] Exhibit C3

moment. The alternative was there was a conscious decision to delay mannitol until after intubation, but even then a delay in an essential component of emergency treatment has an unexplained delay of a further 25 minutes.

74. I find that for whatever reason the delay to administer mannitol was unreasonable.

Burr Hole procedures

75. Elise's parents have questioned why doctors at Caloundra Hospital did not perform a "Burr Holes" procedure on Elise to relieve her intra-cranial pressure. Dr Michael Bryant, a neurosurgical registrar at Royal Children's Hospital was contacted by staff at Caloundra Hospital at least twice following Elise's second presentation and he was asked whether a burr holes procedure should be attempted at Caloundra Hospital. He advised that Elise should be transferred as soon as possible for "definitive treatment".The Commission found that, the decision not to proceed with a Burr Holes procedure at Caloundra Hospital was appropriate.

76. In relation to this issue I considered further evidence from Dr Marianne Vonau, the Director of Neurosurgery at Royal Children's Hospital, Brisbane who provided a statement[20] and gave evidence. Dr Neville also provided the court with some further medical literature on the subject.[21]

77. Queensland has neurosurgical centres situated in Townsville, the Gold Coast and two units in Brisbane. In a state the size of Queensland, QH's position is that it is not possible to have general surgeons capable of undertaking complex neurosurgery routinely available in other regional centres.

78. The guidelines produced by the Neurosurgical Society of Australasia provide that for management of intracranial haemorrhage it is recommended that there be either rapid transfer under intensive care to a neurosurgical centre, or should the transfer time be greater than two hours there should be an on the spot operation with neurosurgical support.

79. Although a burr hole procedure may in many cases be an appropriate procedure, Dr Vonau's opinion is that it has limitations and in some cases a craniotomy (which is a much more complex procedure) may be the preferred option. Dr Vonau said that there is a paucity of general surgeons being able to perform emergency neurosurgery. She said that some of these issues have been

[20] Exhibit M4

[21] Treatment of extradural haemorrhage in Queensland, *Emergency Medicine Australasia (2007) 19, 325-332* and *The Management of Acute Neurotrauma in rural and remote locations,* a set of guidelines by the Royal Australasian College of Surgeons.

reviewed by the Rural Surgeons Group to try and train general surgeons to cover such areas as emergency neurosurgery and vascular surgery. There were issues concerning a reluctance to perform such procedures because of the skill set required; maintaining the skills where the procedures may be infrequently required; litigation fears; the transient nature of the population of rural surgeons amongst the main concerns. To assist, Dr Vonau has offered to and has run Neurotrauma Workshops to teach emergency neurosurgery to general surgeons.

80. Ultimately treatment at a neurosurgical unit in a timely manner is optimal. She stated that part of the issue is identifying a diagnosis and identifying when a person is deteriorating neurologically. In a case such as Caloundra it would be viable to transport to Brisbane provided there was the diagnosis, and the communication and getting transport organised efficiently to avoid delays.

81. Of course those very issues were critical in Elise's case. There was a failure to properly assess her and ultimately to observe her. There was a failure to diagnose the cause of her deteriorating neurological condition. This was the principal cause of her death. Then there were delays that occurred at the second presentation in intubation and the administering of mannitol, compounded even further by delays in the retrieval process. It is clear that Elise was given very little chance of survival because of all of these factors and there were failures at many levels.

82. Dr Vonau agreed that putting resources into training staff to make the diagnosis was important but the better option was to get definitive care in a neurosurgical centre rather than embarking on emergency procedures. She said there were some plans to set up a major hospital on the Sunshine Coast which may include a neurosurgical unit and which would resolve some of those issues for the Sunshine Coast area. The problems of course would still apply if a similar situation occurred in other rural and remote areas so what more can be done to provide a better service still needs to be looked at.

83. There were other methods of giving assistance to regional centres faced with a similar scenario which involved the use of technology to link emergency surgeons to neurosurgeons or for that matter other specialist surgeons which Dr Vonau also considered would be the next best option.

84. Dr Vonau also noted the benefit of a CT Scan to assist in a diagnosis and I will refer to that issue when discussing the Caloundra Hospital in particular. She also said, and this is confirmed in the Guidelines, that in the absence of a CT scan an x-ray of the skull could be taken and if there is a fracture in the tempo parietal region there is a good chance there would be an underlying haematoma. In Elise's case this is specifically what was found at the

Royal Brisbane Hospital.[22] An x-ray was not conducted on Elise and there was, and still is no CT scanner at Caloundra Hospital.

85. I also heard from Dr Priestly and Dr Rashford on this issue. They both agree with Dr Vonau that there would not be any role for burr hole procedures at Caloundra Hospital and an expedient transfer to Brisbane is the best option.

86. The decision to perform a burr hole procedure is clearly a complex one. There are difficult clinical decisions to be made. General surgeons who may be more readily found at larger provincial hospitals are not necessarily trained in the procedure. A CT scan would be necessary. A burr hole procedure may not be the most effective procedure and more complex neurosurgery may be required. Whilst all those decisions are being made time may be lost in the transfer of the patient to a neurosurgical unit. In any event it is unlikely that a patient will be able to access a neurosurgical unit in the recommended two hourswindow of opportunity. Of course the sooner the patient can be treated the better. At best it is a procedure that would need to be performed by a surgeon as distinct from a registrar or senior medical officer who is stationed in some other remoter area.

87. I find that it would not be reasonable to expect that Caloundra or for that matter Nambour Hospital as it was then set up in 2002 had the capacity to perform such a complex emergency procedure.

88. However more can be done. For cases where it simply is not possible to transfer patients to major hospitals in time for emergency neurosurgery or vascular surgery then if possible that surgery should be performed on the spot. The issue is what needs to be done to allow for that to occur. The type of work being done by Dr Vonau in training general surgeons in such procedures should be given some appropriate resources. A range of options and processes needs to be evaluated. The use of the telemedicine links may also prove useful.

89. I will recommend that Queensland Health conduct a review of the capacity of rural or remote hospital facilities or regions to perform such procedures, and to identify what would be required to allow such medical procedures to take place. I am not saying that all remote, rural or even larger regional facilities should have the capacity to perform such procedures but there does appear to be some potential for a better service to be provided and rather than this being reviewed in an ad hoc fashion it should be more comprehensively investigated and reported upon.

Retrieval Issues

[22] Exhibit C3, statement of Dr Bryant

90. Concerns were raised with the time taken to transport Elise to the Royal Children's Hospital. It took approximately two and a quarter hours from the time Elise presented at Caloundra Hospital the second time, until her arrival at Royal Children's Hospital.

91. It was considered by the HRC that the medical consultant responsible for the decision to air vac Elise to the Royal Children's Hospital was well experienced in retrievals and based the decision on individual experience and local knowledge.

92. An independent opinion regarding Elise's retrieval was obtained from Dr Manning, Director, Medical Retrieval Unit, New South Wales' Ambulance Service and he was neither critical of the decision to use air transport over road transport nor the time taken to transport Elise to the Royal Caloundra Hospital. However, Dr Manning did believe that there was potential to save time with a different "parallel" system of coordination. There appeared to have been a linear and sequential system when ideally the systems in place should enable those responsible for providing treatment to focus solely on clinical needs, leaving decisions regarding the components of the retrieval process to be made simultaneously by another agent. The Ombudsman pointed out that Dr Manning had opined that this different system could afford significant time savings.

93. Dr Manning also commented that at the time of the assessment by the ambulance officers, Elise was in urgent need of onward retrieval and transfer to a tertiary centre. Onward retrieval and transport coordination could have been commenced at this time. Therefore, the Health Rights Commission found that clearly the system of retrieval afforded to Elise was not optimal. This perhaps is an understatement. It was simply unacceptable.

94. The Commission found that if there had been a better retrieval system, there may have been a better response. It found that the helicopter service should have been on line sooner. While helicopter retrieval was available on a 24 hour basis, the pilot commenced his shift at 9am, and another pilot was available on an "on call" basis from 5pm until 9am. Since Elise's retrieval, the helicopter service has changed its shifts to ensure that a pilot is on site from 8am.

95. The Health Rights Commission also found that there should have been more formal processes for decision making and coordination of the retrieval. A conclusion was drawn that the retrieval process could have taken less time under a system similar to that of New South Wales.

96. The Health Rights Commission recommended that Dr Manning's advice and recommendations be taken into account in the current review of Queensland's retrieval/transfer system, namely:-

(i) an evidence based process be undertaken to objectively determine the most appropriate transport vehicle and retrieval team to undertake missions between various hospitals matched against clinical urgency and time of day;
(ii) consideration be given to the applicability and suitability of the NSW protocols and procedures
(iii) and that a State or regionalized retrieval coordination system be instituted.

97. In relation to recommendation (i), Queensland Health provided the following information to the Ombudsman. In July 2003, the Qld Emergency Medical System Advisory Committee (QEMSAC), which involves Queensland Health and the Department of Emergency Services commenced a review of the system of clinical coordination and operational aspects of aeromedical services in Queensland. The aim was to provide a more coordinated and consistent approach to clinical coordination for aeromedical services in Queensland. There have been 3 separate independent reviews which have impacted on the aeromedical retrieval system in Queensland (the Elcock Review, the Cornish Review and the Wilson Review) and have made wide-ranging recommendations.

98. Further, Queensland now has a joint-agency (Queensland Health & Queensland Ambulance Service) single point clinical coordination centre in Brisbane (known as the QCC:QEMS Coordination Centre). This commenced on 02 August 2004 and is co-located with the Queensland Ambulance Service with the responsibility of providing coordination of patient transport needs across the southern and central health zones. The effect of this is to separate the role of clinical coordination from the provision of direct patient care.

99. A similar QCC was established in Townsville on 16 January 2006 and provides for similar arrangements for northern Queensland from Mackay to the Torres Strait. The functions of the QCCs are to improve advice on clinical care; coordinate the transfer of patients between facilities; and to determine the transport needs on clinical grounds.

100. The abovementioned system provides that if an initial assessment by the medical officer responsible for the care of the patient is made to transport the critically ill patient by air, then the responsible medical officer activates the Clinical Coordination Network. Contact is made with the clinical coordinator at the QCC for clinical coordination.

101. The clinical coordinators at the QCC in Brisbane are senior Queensland Health medical consultants experienced in retrievals and their role is to provide clinical advice and to assess individual clinical needs against total resource availability and demand in

collaboration with the responsible medical officer, the QAS desk and the Aeromedical desk both co-located with the clinical coordinator at the QCC. The Queensland Ambulance Service has the capacity to know where all transport (road and aeromedical aircraft) is at any one time and its availability and capability.

102. The Ombudsman concluded that the system changes implemented have provided Queensland with a more efficient and better coordinated clinical transport service. A recommendation was made that Queensland Health conduct periodic systems evaluations of retrieval services as planned. Queensland Health has responded that a formal review will be undertaken at 6 monthly intervals and that the Clinical Coordination and Retrieval Oversight Committee has been established.

103. In relation to recommendation (ii), Queensland Health informed the Ombudsman that the principles of the New South Wales protocol were reviewed during the development of the QCCs and are being further evaluated in the current Queensland Trauma Plan Project.

104. In relation to recommendation (iii), Queensland Health informed the Ombudsman that an ongoing quality system review process is provided through a Clinical Coordination and Patient Retrieval System Oversight Committee which meets quarterly under the Chairmanship of the Chief Health Officer.

105. There was a delay in dispatching a retrieval team from Nambour Hospital to Caloundra Hospital. Concern was expressed by Nambour Hospital at the time it took Queensland Ambulance Service to collect the retrieval team. There was a conflict between the Queensland Ambulance Service and Nambour Hospital as to how many requests were made for retrieval. The Nambour Hospital staff members advised that two separate calls were made to Queensland Ambulance Service whilst the Queensland Ambulance Service records one call having been made at 8.13am. Queensland Ambulance Service audio tapes, which may have shed some light on the issue, are no longer available. The usual procedure is to keep audio tapes of all incoming calls for six months. The Ombudsman was unable to obtain sufficient evidence to explain the discrepancy in recorded times. The Ombudsman considered that one thing that was clear was that an error occurred in one organization or the other. The Ombudsman therefore recommended that the QAS prepare a set of indicators to prompt staff when to archive audio tapes. These might include complaints or inquiries about time delays and general inquiries by investigation organisations.

106. Dr Stephen Rashford is a specialist emergency physician and the Medical Director for Queensland Ambulance Service (QAS). He is also the Senior Staff Specialist and Principal Medical Coordinator with the Queensland Emergency Medical System (QEMS) Coordination Centre in Brisbane. He was asked by the Office of the State Coroner to address two issues;

(i) the procedures that are in place for storing, archiving and destruction of audio-data;
(ii) the enhancements to QEMS aeromedical and patient retrieval services since Elise's death.

107. I do not intend to repeat all that Dr Rashford has said in his response[23] or in his evidence. It reflects the systems and reforms which were considered by the Ombudsman and I agree that the changes have provided Queensland with a more efficient and coordinated clinical retrieval and transport operation. Dr Rashford impressed me with his knowledge and practical dedication to the system in place and efforts to further improve the system so that better clinical outcomes for patients may occur. I was impressed with the benefits of the Telemedicine trial conducted between Townsville and Palm Island which has been rolled out to a number of other sites and which he hopes to roll out to up to 50 sites over the next 12 months.

108. On the issue of the use of burr holes procedures he explained it can be a difficult decision to make and the decision to decide to retrieve back to a major centre or perform the operation has to be made on a case by case basis. In relation to the neurosurgical Guidelines he stated that unless someone was near one of the major centres it would be difficult to meet the 2 hour window of opportunity suggested in the guidelines wherever in the state you might be.

109. On the issue of what would be the preferred option if a similar event occurred in Caloundra he would think that there would not be any role for burr hole procedures and the best option would be an expedient transfer. Burr holes can provide some limited relief, as was explained by Dr Vonau, but valuable time may be wasted in intensive care performing such a procedure when retrieval to a major centre could have been taking place.

110. His description of the retrieval process and advice given whilst that was occurring is clearly a much better coordinated system than what existed at the time of Elise's death. It was noted that at the present time there is no Queensland Health funding for medical crewing of retrieval teams for aircraft. Intensive care paramedics staff the helicopter and he is satisfied with the tremendous work his staff provides, however he would prefer that a medical officer was

[23] Exhibit 14A

available. I would agree and will recommend that QH proceed with that proposal in the next 12 months as indicated was now being discussed within QH.

111. On the Sunshine Coast there was a problem with the pilot not being immediately available to proceed to fly as he was on call and was an hour away from his base. A new base has been built with crew quarters and whilst they were not truly available 24 for hours of the day he said they were heading towards that quickly and were taking delivery of a new helicopter in a few weeks. That helicopter had single pilot Instrument Flight Rules thereby freeing a pilot to roster more properly and allowing a 24 hour coverage. He said it was very likely that this would occur within months. To put that beyond any doubt one of my recommendations will be that this occur.

112. One issue which arose in evidence was that of the retention of voice data with the most recent Standard Operating Procedure providing for this to be stored for a period of 2 years or longer in exceptional circumstances, such as sentinel events, coronial or other investigations. Dr Rashford was asked if that period could be lengthened. He undertook to reply to the Coroner.

113. I have since received advice that at the present time the quality of data does deteriorate over time and QAS is examining alternative means of storing audio-data. However if circumstances necessitate the storage for a longer period the data can be transferred to a WAV file and stored electronically. All clinical cases are now subject to a clinical audit and/or review and in that manner QAS is better able to identify such cases and attend to transfer to such electronic storage. I am satisfied that this process adequately addresses the voice data retention issue.

Doctors' working hours-findings by the Ombudsman

114. Dr Doneman had been working his 20th hour of a 24 hour shift when he initially examined Elise. The Ombudsman looked into the history of the issue concerning the culture of excessive hours worked by doctors, particularly junior doctors.

115. In late 1997, the Australian Medical Association engaged consultants to conduct studies in a number of public hospitals to identify the underlying cultural and organisational systems that contributed to junior doctors' work practices, current rostering practices and hours of work. The case studies were conducted in 7 public hospitals in 4 States, namely Queensland, New South Wales, Victoria & South Australia. The case studies revealed that 70% of junior doctors had worked in excess of 50 hrs/week, 40% had

worked in excess of 60 hrs/week, just over 15% worked in excess of 70 hrs/week and 5% worked more than 80 hrs/week.

116. Following on from this study, in March 1999, the Federal Council of the AMA adopted the *National Code of Practice - Hours of Work, Shiftwork and Rostering for Hospital Doctors* to provide guidance on how to eliminate or minimise risks arising from the hazards associated with shift work and extended working hours. This Code was never endorsed or applied by Queensland Health. The Australian Council for Safety and Quality in Health Care (ACSQHC) was established in January 2000 by Health Ministers to lead national efforts to improve the safety and quality of health care. The Council set up the Safe Staffing Taskforce to lead its work on safe staffing. In addressing the problem, the biggest issue for the health system will be the available supply of health professionals to fill additional shifts, given the chronic under-supply of doctors.

117. Dr Buckland, the then Director-General of Queensland Health advised the Queensland Ombudsman that he considered the issue of safe working hours for doctors to be a professional standards issue as opposed to an industrial relations issue. The Medical Board of Queensland agreed that the issue was consistent with both its legislative functions and strategic direction and that it was appropriate for it to establish a standard, rather than a standard being developed by any one employer, professional association or college. The Executive Director of the Medical Board of Queensland had informed the Ombudsman that work is underway on a draft Discussion Paper and that would invite submissions from interested persons and organizations.

118. The Ombudsman found that the issue of fixing a maximum number of hours for clinicians is fraught with difficulty at a time when a shortage of qualified practitioners is forcing temporary closures of hospital Emergency Departments. A ceiling on hours may exacerbate those difficulties. Nevertheless, he considered that the risk to public health and safety of taking no action to mitigate the dangers of unsafe working hours to be unacceptable. He recommended that Queensland Health:

(i) determine, as quickly as possible, an interim standard on safe working hours for doctors in public hospitals pending finalisation and implementation of any standard being developed by the Medical Board of Queensland; and
(ii) progressively implement the management practices aimed at alleviating the ill-effects of excessive working hours, recommended in the Australian Medical Association Safe Hours Campaign and Risk Management Strategies.

119. Queensland Health responded that the Medical Board of Queensland was preparing a discussion paper in relation to doctor's hours of work and managing fatigue risks. Further, Queensland Health is developing an Alert Doctors Strategy which is a multi-project work program that aims to address the risks associated with medical officer fatigue in Queensland Health. The Director General has approved that the University of South Australia's Centre for Sleep Research be given sole provider status to tender to partner with Queensland Health in the implementation of the Strategy. It will be guided by the Centre's latest research in relation to managing fatigue risks in a health care environment.

Response to the Coroner

120. The Office of the State Coroner requested that the AMA, the MBQ and QH provide a response on the issue of doctors' hours and what has happened since those recommendations were made by the Ombudsman.

121. There is no question that the question of doctors working hours is complex and not simply a matter of presenting a fixed set number of hours beyond which a doctor should not work. At the same time, it is absolutely clear that if there are still doctors working the type of hours and in similar circumstances as happened on this particular morning then this is unacceptable and could not meet with community expectations. There is a growing body of research literature which reveals the negative impacts of work-related fatigue of employee and public safety.[24] Common sense would support a similar conclusion. It would seem that until this tragic death it was not a matter high on the agenda within QH despite the concerns expressed by such bodies as the AMA back in 1999 for a start.

122. In submissions received from Dr Neville he stressed that although he accepted that reasonable working hours are a very important issue for doctors and their patients, there was no real evidence that fatigue in fact played a part in the decision making of Dr Doneman. In deed, as Dr Neville points out, Dr Doneman specifically clarified with the investigator from the MBQ that he "*did not believe at the time of the consultation that he was tired."*[25]

123. I accept that this may be the case and that the extent to which fatigue played a part has not been assessed or tested in a rigorous and objective sense. Realistically it would be almost impossible to do so now.

124. The Health Practitioner's Tribunal considered that Dr Doneman must have been fatigued by the hours he was working and this must have

[24] See Safe Hours report 205 p17
[25] Exhibit L168 top of page 17

contributed to his ability to manage Elise's condition and in his lack of attention to detail. The Tribunal also said that this, amongst other mitigating factors, still did not excuse his behaviour. That is a conclusion which has a firm scientific basis. Fatigue must have played some part.

125. The issue was properly given some attention by the Ombudsman and it is a matter of significant public interest. It needs to be addressed.

126. I do not intend to set out in any detail why long hours and fatigue have an adverse impact on patient care. This is well set out in the various reports and studies that have been relied upon in the Ombudsman's report and by the AMA. Nor is it possible for this inquest to adopt a particular solution. This inquest was not about finding the appropriate solution. That really is for the key players to determine. What this inquest can examine is what progress has been made by the key players on this issue and what more needs to be done.

127. Dr Ross Cartmill was the immediate past president of the AMAQ and he provided a statement and gave evidence. After the comments made by the Health Practitioners Tribunal, the AMAQ and the Salaried Doctors Queensland initiated a Safe Hours of Work Campaign. In 2005 a Risk Assessment Audit was conducted. There was a very low response from the respondents to the survey and it was accepted by him that this did place some limitations on the validity of the data collected. There was some conjecture that the low response was somewhat connected to the culture of junior doctors (and senior doctors) to work long hours and the possible risk to their professional life from trainers and colleges and hospital administrators. There is no evidence that there was direct discouragement to not reply but I accept that the culture which exists is part of the impediment to reform. Subsequently the Safe Hours Report 2005 was published.[26]

128. What the survey and report suggested was that there has been and continued to be a concern that junior staff were working hours which put them in the significant or high risk categories.The basic premise of the report adopted the AMA National Code of Practice that;

(i) No doctor should be required to work when fatigued
(ii) A doctor who is fatigued should be relieved immediately
(iii) No doctor should work a shift of more than 12 hours and in emergent situations up to 16 hours

[26] See Exhibit C3, ASMOF?AMA Qld- Safe Hours Report 2005

(iv) That a period of on call should be followed by a non clinical shift

(v) That each District have a fatigue relief management mechanism which does not place additional pressures on other staff.

129. The report followed the familiar risk assessment methods adopted by workplace health and safety legislation to identify risks and implement control measures to minimise, control or eliminate the risks. It identified that hospital medical practice sometimes required extended hours to be worked for service provision and continuity of care. Unpredictable surges in demand also contribute to longer shifts being worked. On call arrangements also can lead to fatigue.

130. The Safe Hours report recommended that QH develops a Safe Hours Work policy in accordance with the AMA Code of Practice. The report noted that QH approached the MBQ to address the issue.

131. Since 2005, Dr Cartmill was of the view that QH have worked quite hard in recent years to address the issue of doctor fatigue and safe hours. By July 2008 hospitals were expected to have developed a policy to address the issue. He stated that there has been a completely different attitude since 2002 to the issue by QH.

132. He agreed that there had to be some flexibility. He also noted the pressures that the colleges of specialties have in balancing the demands for shorter training programs to bring specialists through earlier and the reduced time for training that would occur in the event of inflexible working hours and consequent shorter shifts.

133. Susan Maree Le Boutillier is the Acting Director of the Medical Workforce Advice and Coordination Unit of QH. She provided a response[27] on behalf of QH and gave evidence. I think that it can be said her enthusiasm for her project is and will be of considerable assistance to the furthering of fatigue and safe work hours issues within QH. I was impressed with her personal commitment and I can only hope that this is reciprocated organisationally. There are still reports being expressed anecdotally in the media which suggest there is still some way to go.[28]

134. Ms Le Boutillier stated that QH was committed to implementing an Alert Doctor's Strategy as part of the negotiations that took place in

[27] Exhibits C10 & C10A

[28] I here refer to comments made to ABC talkback radio ABC 612 the day after the closing of evidence and incorporating an interview with Dr Wakefield on the issue. A number of comments were made which indicated long hours were still occurring. Source: Media Monitors

the *Medical Officers'(Queensland Health Certified Agreement (No 1) 2005*. She reported that interim arrangements had been made to address the issues in the Interim Cumulative Hours Procedures-Medical Officers to manage fatigue risks from doctors working long hours, including when recalled to work or providing telephone advice whilst on call.

135. She stated that there is a whole range of activities and strategies being adopted to deliver a risk management program. The program looks at beyond long working hours, recognising that fatigue can arise in a number of situations, including long hours, on call arrangements and shift breaks. The interim policy which was set up by QH specifically wished to address the circumstances where a doctor was engaged in 16 hours of work, continuous or cumulative within a 24 hour period. However she said that focusing solely on hours of work does not make patients safe because there may be a whole range of factors that can contribute to fatigue.

136. She said that from 1 July 2008 a Medical Fatigue Risk Management policy is in place. This policy will have districts develop local fatigue risk management systems and local workplace protocols which are adopted by each district taking into account district issues. The intent is for this to be far more sophisticated than the original interim continuous hours policy, which will continue to be a guide. A review was to take place six months later (that is by the end of 2008) with a view that every health district is to have a fatigue risk management system in place by 1 July 2009.

137. In relation to reporting of fatigue related adverse events she said that the work force at QH is being educated on the whole issue of fatigue and to report incidents.

138. Ms Le Boutillier also expressed the view that there had been a significant degree of cooperation with the AMAQ and the AMA Council and Doctors in Training nationally. This was confirmed by Dr Cartmill. The policy has been introduced with the assistance of the Centre for Sleep Research.

139. She agreed there whilst there is a culture amongst some doctors to not be involved there is also a strong group of champions within the profession who are challenging that culture, and that has seen considerable success.

140. I asked her if the intent of the policy was that it would no longer be possible for a doctor such as Dr Doneman to be on call or active duty for a 24 hour period. She stated that the intent was to prevent it occurring as much as they possibly can but in certain circumstances

it could occur. However with the policy in place she felt that there would have been other triggers that looked at whether someone higher up at the hospital facility could look at a replacement. Further there would be procedures in place around needing to check with more senior colleagues at other centres as to a proposed course of treatment and to control as much as possible the risk of fatigue related errors occurring.

141. The Medical Board of Queensland was also requested to respond and Kaye Denise Pulsford, the Executive Director provided a short report and gave evidence. In 2004 the MBQ had agreed to a request from the Director General of QH to develop a standard relating to safe working hours for doctors. The development of a standard by the MBQ was of importance, not just in relation to QH medical staff, but more generally across the private hospital and private doctors sectors where it was known that there were similar problems.

142. In February 2007 a discussion paper was finally released by the MBQ requesting submissions. Thirteen (13) submissions were received in July 2007 and a committee was formed to analyse the submissions and evaluate relevant literature. Ms Pulsford said that the next step was to be the development of a position paper for further consultation with stakeholders later in 2008.

143. It is clear that the Medical Board has, for whatever reason, not addressed in an expedient or comprehensive manner the important challenge that this very significant public health issue has raised. There has apparently been some resource issues within the MBQ which impacted on it. Apparently some of those issues have been addressed through a restructure but very much more needs to be done across the various sectors both private and public to debate this issue and to come to a resolution. It is understood that this is not a simple issue. There are varying issues identified by the Board which need consideration although it would seem those issues would not have caught anyone by surprise as they are common features in the issues identified within QH and the AMA.

144. There does seem to be some confusion as to which body is to take the lead role. To date it has been the AMA and QH but if the MBQ has the overriding function to address this issue in a meaningful way then it should do so with much more expediency than has been shown to date. I will recommend accordingly.

Issues concerning Caloundra Hospital/Sunshine Health District- overview of the Ombudsman's Report and response by Queensland Health

145. In 2001, a report entitled *Review of the Emergency Services (DEM), Sunshine Coast Health Service District* (the DEM report) was prepared by the former medical superintendent at the Nambour Hospital as a result of concerns raised that the Service was not meeting reasonable and accepted performance standards. The Ombudsman reported that the existence of this report came to light in December 2005 as a result of an article published in the *Sunday Mail.* The report recommended that:

(i) Caloundra Hospital appoint 5 Principal House Officers (PHOs) to staff the Emergency Department at all times; and
(ii) the Emergency Department PHOs not have responsibility for inpatients at Caloundra Hospital during normal working hours.

146. The Ombudsman sought a response from QH as to what action had been taken.QH stated that recruitment processes commenced in October 2001 and the medical officers had all commenced by 11 March 2002. All 5 appointments were made at the level of PHO and the current coverage for the Caloundra Hospital Emergency Department provided for two specialists, two senior medical Officers and the 5 PHOs.

147. QH stated that while there may not be ideal staffing levels in all Queensland Health's Emergency Departments there is support available through the following initiatives:

(i) The Clinical Coordination Centres which are manned 24 hrs a day, 7 days a week by a specialist in emergency medicine, who are able to give telephone advice regarding patient management as well as coordinate patient movement if required;
(ii) The Clinicians Knowledge Network (CKN) which was introduced in 2001 and is accessible in every Emergency Department and provides on-line access to a system of data bases, including clinical protocols for hundreds of emergency conditions, as well as dozens or emergency texts and journals;
(iii) Improvements in the orientation of medical staff and standards of supervision and monitoring of junior medical staff through the accreditations processes of the Medical Board of Queensland and the Colleges and
(iv) 6 monthly strategic meetings attended by representatives from the Queensland Health hospitals where problems can be aired and possible strategies discussed.

148. In December 2001 the Australian College of Emergency Medicine (ACEM) published a policy document which aimed to establish standards for the provision of services to children who attend EDs in Australia. The Ombudsman recommended Queensland Health adopt and implement the following aspects of the December 2001 policy document:

(i) written protocols regarding the treatment of the specific conditions listed in the ACEM policy be available in all Queensland Health Emergency Departments at all times;
(i) the protocols stipulate the kinds of medical condition where consultation must occur with a senior doctor;
(ii) an audit be undertaken of the CKN accessibility and the ease of use for clinicians in Emergency Departments;
(iii) all junior medical staff be involved in an ongoing learning program in paediatric emergency medicine.

149. In response to an enquiry by the Ombudsman as to what changes had been made to ensure 24 hour experienced medical coverage, Queensland Health advised that a Fellow of the ACEM commenced full time at the Caloundra Hospital in June 2005 and PHOs are now rostered for a series of overlapping shifts to provide continuous coverage. SMO coverage was provided by a rostered and rostered on-call combination. The Ombudsman noted that while the Emergency Department now appears to be staffed by more experienced medical officers the new rostering regime does not address the inherent dangers associated with extended working hours.

150. On the issue raised as to whether nurses at Caloundra Hospital had been provided with an accredited emergency care for children course QH replied that of the 16.8 nursing FTE currently employed in the Caloundra Hospital Emergency Department, 13 have completed a recognised paediatric program within the last 12 months. A number of staff have also received other qualifications that contain a paediatric component.

151. The Ombudsman was unsure whether the training provided to the Caloundra Hospital Emergency Department nursing staff was commensurate with the standard of training provided to Emergency Department nursing staff in comparable hospitals. Queensland Health responded that the Director of Nursing of the Sunshine Coast District was undertaking a review of education and staff development services being provided for nurses. The review was to include an assessment of the paediatric qualifications and training provided to nursing staff in the Emergency Department. Further, a position of Director Education, Staff Development and Research had recently been created in the district to promote and maintain education and staff development standards for nurses. Recruitment was under way for a District Director of EM to coordinate the provision of emergency services across the District. The Ombudsman had no further recommendations to make.

152. Dr Priestley is now the Director of Emergency Medicine for the Sunshine Coast district. He provided a statement addressing 13 issues identified by and set out in a letter to Queensland Health at

the request of the Office of the State Coroner.[29] He also gave evidence at the inquest and elaborated on what was considered the more important in so far as this inquest was concerned.

153. In relation to the admission of children a *Paediatric Admission-Caloundra Health Service* was introduced in July 2002 and revised in July 2007. Processes were put in place to ensure existing and new staff are aware of them. Essentially the policy is to restrict paediatric patients to short term observation only and no paediatric patients are admitted to the Emergency ward. Any particularly concerning cases are referred to Nambour or Royal Brisbane Hospitals. For an admission for observation it is one which involves four to six hours non-interventional observation. An 8 bed observation ward was under construction which may provide some further capacity but it was not expected to substantially alter the criteria for children.

154. Dr Priestly stated that there is a greater consistency of senior staff and an improvement in the qualifications of nursing staff in dealing with emergency paediatric cases.

155. On the issue of policies and procedures in dealing with paediatric head injuries there is a state policy. This involves the seeking of advice from neurological staff in Brisbane or paediatric staff in Nambour. Staff have access to a software which provides useful information as to the assessment and management of paediatric head injuries.

156. Paediatric Life Support courses have been conducted targeting junior medical officers and nursing staff who may become involved in the care of very unwell children and it would appear there has been appropriate uptake in training opportunities. The courses available in 2008 were set out in his statement and again they appear comprehensive enough.

157. Dr Priestley considered that his appointment as a District Director and the appointment of a District Senior Emergency Nurse was evidence of an organisational intention to foster important links between Caloundra Hospital and Nambour so that junior doctors can seek assistance with more senior Nambour staff including the Nambour Emergency Department Clinical Coordinator.

158. Although Dr Rashford spoke enthusiastically about the trial of telemedicine links on various sites throughout the state, Dr Priestley was not aware of any planning to provide a telemedicine link to

[29] Exhibit C14.

assist in real time emergency care of children at Caloundra Hospital. This had been a recommendation of the Health Rights Commission. Dr Priestly said he personally believed that they were better off in investing in highly qualified staff. He said that there was always a senior medical officer available at Caloundra and one available by telephone in Nambour.

159. Although it would have to be said that having highly qualified staff on the ground must be the best option, the telemedicine project does have some obvious benefits for a whole range of reasons. It would be my recommendation that the telemedicine project be expanded to cover the areas of the state where it could provide real benefits. I would expect that as part of any implementation program there would be a review of which Hospitals have perceived gaps in their treatment options so that they can be included. If that review establishes that there would be benefits to Caloundra then it should be included. I agree with Dr Priestley that this should not negate the need to have qualified medical staff on the ground but I note his comments that Caloundra Hospital, as shared by many other EDs around the state has trouble in recruiting best quality junior medical officers. If that is the case then the telemedicine link may be used as a backup when there are problems.

160. I consider that many of the deficiencies existing in 2002 have been addressed. Dr Priestley said that his experience with the QCC retrieval service over the last 2 years had been effective in moving acutely unwell patients which exceeded the capabilities of Caloundra Hospital.

161. Dr Priestley was continuing to give his attention to ensuring that investigations could take place on site including having sufficient numbers of senior medical staff and specialist emergency physicians available and he has made a request for a half to one FTE senior medical officer to fill the gap. I will recommend that his request be approved.

162. Dr Priestley also saw the need for CT Scanner. Approval has been given for one to be in place by August 2009 and he was reasonably confident. To be abundantly clear I will also make a recommendation that this be progressed.

Open Disclosure issues

163. At the time of Elise's death, Queensland Health did not have any policies, practice or procedure describing how to progress open disclosure of adverse clinical events. The Ombudsman concluded

that Queensland Health failed to engage in a process of open disclosure with the Dr and Mrs Neville following Elise's death.

164. In July 2003, the ACSQHC introduced a national *Open Disclosure Standard* which promotes a clear and consistent approach by Australian hospitals to open communication with patients and their nominated support person following an adverse event.

165. Queensland Health advised the Ombudsman that a structured piloting plan of the *Open Disclosure Standard was* currently under development by the Safety Improvement Unit, Patient Safety Centre. Seven of Queensland Health's health service districts were pilot sites participating in the national pilot. The Patient Safety Centre commenced its open disclosure training program in March 2006 with training offered to a number of clinicians (medical, nursing and allied health) in the pilot sites for open disclosure.

166. The Ombudsman recommended that Queensland Health expedite the implementation of the national pilot program on open disclosure in Queensland's public hospitals.

167. In January 2002 there was no State-wide endorsed approach to incident management and to root cause analysis in Queensland Hospitals. In June 2004, Queensland Health introduced an *Incident Management Policy* which defines incidents and outlines the processes and management of incidents and identifies ten sentinel events types as requiring investigation.

168. The final report of the QHSR noted that the effectiveness of the policy had been hindered by the lack of a comprehensive information system for incident reporting; the lack of tools for incident analysis; limited training for staff in analysis techniques and limited resources in the districts to set up training and maintain systems. Queensland Health's Patient Safety Centre took upon addressing these issues.

169. Queensland Health developed a web-based electronic incident reporting system (PRIME) which aims to facilitate the reporting and management of clinical incidents including sentinel events and near misses and enables the analysis of incident trends. Implementation and use of PRIME by the Queensland Health Districts was not mandatory and the Ombudsman was informed that only 64% of the State had fully completed implementation of the system at that time.

170. The Queensland Health PSC has developed a 2 day root cause analysis training program that was rolled out across Health Service Districts in mid 2005. The Ombudsman was informed that it was

expected that all 37 Health Service Districts would have a broad base of staff trained in root cause analysis by August 2006 and that a formal training package and resource material had been developed.

171. The Sunshine Coast district (SCHSD) implemented its Clinical Incidents Policy in May 2005. A Caloundra Health Service Mortality and Review Committed has been established to review, investigate and follow-up serious adverse events for adults and children.

172. Dr John Wakefield is the Senior Director of the Patient Safety Centre. He advised that the first Queensland Health report on critical incidents and sentinel events was published in April 2007.[30] He further advised that since 2005 PRIME had been implemented across 19 of the 20 health districts. The exception was The Prince Charles Hospital which used PRIME for sentinel event reporting and another reporting system for incident reporting.

173. Dr Wakefield was asked what would be the likely response now if Elise's tragic circumstances occurred again. There are two initial decisions to be made. If there was a suspicion that it came within the definition of a "blameworthy act"[31]then the matter would be referred to police or disciplinary authorities. On the basis that it was not considered in that category then a Root Cause Analysis would be commence that would pick up the wide range of system issues that came to light. In addition open disclosure would occur very early with the family, expressing sorrow for what happened and committing to a process of finding out why it happened. There would still be other external investigations including coronial and the Medical Board.

174. It was also noted that the Sentinel Event list applicable in Queensland included "death or permanent loss of function unrelated to the natural course of the underlying condition." This is a category which is not a national sentinel event definition and he said would represent some 90% of the reported sentinel events. An updated version of the Incident management Standard had just been published to commence from 1 July 2008.[32] The standard looks at not just the expectation of the health care provider or clinician but also incorporates the expectation of the family and patient.

[30] Part of Exhibit C 20: *Patient Safety: From Learning to Action, First Queensland Health Report on Clinical Incidents and Sentinel Events.*
[31] This is defined as a purposefully unsafe act, an act involving alcohol or illicit substance abuse by provider, patient abuse or criminal act
[32] Exhibit M5

175. There has been extensive training of staff and employment of patient safety officers in all the districts which he says has brought about a significant shift in the understanding and managing such events. He stated that open disclosure occurred at the earliest opportunity and required senior staff and the treating doctor to sit down with the family and have a discussion about the adverse outcome. The Root Cause Analysis commenced some days later and may involve further discussions with the family or it may include the information already obtained in earlier discussions. Contact with the family was an important component.

176. Dr Neville asked a few questions about reporting these events and the extent to which they are reliant on decisions by clinicians and any bias they may have in deciding whether an event was an unexpected outcome. Dr Wakefield referred to a number of backup mechanisms that may capture such events but conceded that the system was not without risk. It was to be noted that it was not just doctors involved in the reporting process but all clinicians treating the patient who can include nurses, pharmacists, therapists or other health professionals.

177. It has to be said that from the perspective and experience of coroners that there has been a very significant improvement in the reporting and disclosure of adverse events. It is important that we do not simply accept the progress that has been made and stop there. Further improvements can be made but there is evidence of considerable progress and it would seem that at a policy level and at a resource level there is a commitment to the open disclosure process within Queensland Health. I have no recommendations to make on this issue.

Office of Fair Trading investigation summary

178. Elise's death resulted from injuries sustained in a fall from a bunk bed, whilst sleeping. The top bunk did not have a railing around it and it did not comply with the then non-mandatory Australian Standard. The Ombudsman stated that to his knowledge it would appear to be the only reported death of this kind in Australia. The Ombudsman had knowledge of two other deaths but both of these children died as a result of being trapped by the head. The Office of Fair Trading was able to find 4 fatalities in the period 1 July 2000 to 1 August 2007, all of which were strangulation deaths.

179. The Queensland Injury Surveillance Unit recently provided the Coroner with updated figures for the 9 years from 1999 to 2007. QISU data is collected from hospital Emergency Departments representing approximately one quarter of the state population. The

data is indicative only and as Dr Neville pointed out may not have captured Elise's death (Caloundra not being a reporting hospital and Elise was admitted to the neurosurgical ward at Royal Children not the ED). The data also does not capture hospitals in the South and North Coast holiday areas where there is likely to be a greater number of bunk beds.

180. The data showed there were 1020 bunk bed related injuries representing 113 injury presentations per year. By applying a simple mathematical reasoning the QISU estimated that there are 450 bunk bed related injury presentations to ED's annually in Queensland.

181. Their figures showed that 98% were for children 14 years or younger and the peak age brackets being from 1-9. This data is similar to other data and gives explanation to the reason why warning labels limited the age to children under the age of 9.The predominant injury mechanism was from high falls from the top bunk. In relation to serious injuries there were 10 skull fractures, 3 intracranial bleeds, 5 nerve/spinal injuries and 1 abdominal injury. This of course only relates to the data captured by the unit and is representational of only a quarter of the state.

182. There are many limitations in the data collection for injuries. At best the QISU data captures between 20 and 25 %. As the Gold Coast and Sunshine Coast districts are not captured, Dr Neville may very well be right when he says this data may underestimate the true picture in the commercial holiday rental market. More comprehensive data does need to be collected.

183. AS/NZS 4220(the Standard) covering bunk beds was introduced in August 1994 but was not mandatory. The Ministerial Council for Consumer Affairs (MCCA) agreed to make the standard mandatory on 2 May 2002 but due to procedural difficulties this occurred on 1 November 2002. The decision to make the standard mandatory was made before Elise's death.

184. The standard provides that bunk beds must have a guard rail fitted to all four sides of the upper bunk with the top rail at least 160mm above the top of the mattress and the guardrail was to have safe gaps so it does not present as a head entrapment hazard. A review of the standard was completed in 2003 and it was relevantly updated to:

(i) provide for a warning that children under the age of 9 should not use an upper bunk; and
(ii) require the warning to be visible on all bunk beds.

184. Dr and Mrs Neville remain concerned with this as Elise was 10 years and three months of age, and they feel that the reference to 9 years of age wrongly reassures parents that it is safe for children over 9 years of age to use an upper bunk.

185. Mr David Alexander Strachan is the head of Product Safety at the Office of Fair Trading and is the chair of the Australian Standards Committee for nursery furniture. He has been the person principally involved in the issues surrounding the bunk bed standard. He provided the response to the Coroner as to the implementation and progress of the OFT to the Ombudsman's recommendations[33] and gave evidence at the inquest. He stated that bunk bed safety was a very important issue for the OFT and other departments of a similar nature in other states, hence the introduction of the mandatory standard.

186. Mr Strachan advised the court that warning labels are a second best safety intervention and the best option is to design safety into the product. He agrees that placing an age warning label on the product may give some users a false sense of security. The standard was under review. He suggested that if a warning label is to be used then it should provide a warning that it may be not suitable for any age or not for children. The data still shows a significant proportion of injuries in the age 10 to14 categories. I recommend that the warning label issue be reviewed by the relevant authorities as soon as possible and consider whether there should be changes in the warning label stating that top bunk beds are dangerous and are not suitable for any age group or at the very least increasing the age categories to up to age 14.

187. Since the introduction of the mandatory safety standards in November 2002, the following initiatives were reported to the Ombudsman as having been undertaken by the Office of Fair Trading to raise awareness about bunk bed safety:

    (i) a consumer guide and industry compliance guide was published about bunk bed safety;

    (ii) the industry compliance guide was mailed out to 60 manufacturers and retailers;

    (iii) press releases were issued prior to peak holiday periods urging consumers to check with unit managers that any bunk beds used are safe;

    (iv) contact had been made with the Unit Owners Association, Queensland Resident Accommodation Managers Association, Insurance Council of Australia, REIQ and

[33] ExhibitC15

restricted letting agents with information on the mandatory standards;

(v) compliance checks in the retail sector have been carried out at least every 12 months to ensure suppliers remain aware of their obligations;

(vi) information re bunk bed safety has been provided on the OFT website and

(vii) An article was published in Trade Smart which has an audience of over 40,000 traders.

189. The Ombudsman's Office recommended that further strategies be implemented to raise awareness of the changes to mandatory safe standards for bunk beds and that a working party be set up to consider the feasibility of establishing and promoting government funded programmes focussing on removing unsafe bunk beds from private residences. In response to this recommendation, the Coroner was advised that a working party has been formed and met on 21 September 2007. It was planned that:

(i) OFT's "Summer Safety Campaign" for 2007 would highlight the issue of bunk beds in accommodation facilities which may be non compliant;

(ii) by Christmas 2007, operators of holiday retail accommodation would be directly emailed advising of the availability of complying bunk beds;

(iii) a dot point bunk bed safety flyer would be prepared;

(iv) research would be continued into the feasibility of removing bunk beds from consumer homes, focussing on those consumers who are most at risk and

(v) the working party would meet again before the end of 2007.

190. The OFT stated that injury data suggests that 96% of injuries occur in the domestic environment. The control of goods and services after they have been supplied, fall outside the jurisdiction of Office of Fair Trading and into the area of domestic responsibility. The OFT reported that, the feasibility of promoting a government funded programme focussed on removing "unsafe" bunk beds from private residences presents many obstacles for the OFT. The cost to consumers who may have non compliant bunk beds in their homes, to remove and replace them, as well as the operational difficulties concerning the collection and destruction of such large, bulky items, was considered to be problematic.

191. That may very well be the case but the OFT needs to make a decision as to whether it is going to move in that direction and tell the public on what basis that decision has been made. The information about the issues identified by the working party were set out in Mr Strahan's statement dated the 26 October 2007 but there seems to have been little that has followed on from there. I recommend that the working party complete its deliberations as soon as possible and the outcome be made public.

192. At the very least it would seem that if a program to remove unsafe bunk beds from the domestic market is considered not feasible, the types of awareness campaigns that have been conducted in the commercial and holiday sectors should be extended to suitable campaigns directed the domestic market.

193. I recommend that the OFT within 6 months conduct awareness campaigns of directed towards the domestic market concerning the standard for bunk beds and the risks and dangers associated with non-compliant beds particularly for children.

194. Bunk beds supplied prior to 01 November 2002 are not caught by the mandatory standard and therefore a large number of non compliant bunk beds remain in service in commercial environments, including holiday units, resorts and school camps.

195. The Ombudsman recommended that all Queensland Government agencies that own, manage or fund establishments that use bunk beds ensure they comply with the standard. The OFT stated that it would assist Government agencies in implementing the standard. That hardly could be considered controversial and it would be expected that this has largely occurred. To be certain I recommend that all bunk beds used in Queensland Government agency owned, managed or funded establishments comply with the standard.

196. It should be noted that the mandatory standard applies to all bunk beds supplied in trade and commerce but legal advice was that bunk beds used in holiday rental units fell outside the scope of the standard. It has no retrospective compliance to beds in use either domestically or commercially.

197. The Ombudsman's Office recommended that the Office of Fair Trading prepare a regulatory impact statement (RIS) to extend the bunk bed mandatory safety standard to the commercial environment to be completed for implementation within 3 years. The Minister

approved preparation of an RIS in June 2006. The OFT's overview plan stated that it would be completed in early 2008.[34]

198. Mr Strahan told the inquest that the RIS had not yet been completed and in fact is in the very early draft stage. He stated that the data to date would suggest the costs outweigh the benefits when you consider the mandatory standard appears to cover the domestic setting where the most injuries occur. There had been some consultation with interstate product safety regulators and the collection of data but that aside there seems to have been little progress on the completion of the RSI. I recommend that this now be given some priority and be completed as soon as possible. I have not heard or read any evidence which explains this delay.

199. The standard has been around since 1994 and was made mandatory in 2002 so that beds sold in commerce at that time had to comply. It is plainly obvious that a bunk bed which still does not comply after effectively 15 years since the introduction of the earlier standard should be removed. I have seen photographs of the bed that Elise was sleeping in and the risks are clear. I would have thought those industry groups in the commercial rental market would have made recommendations to their members to remove them. At the very least, they should be warned that continued use of such non-compliant beds is a very real liability risk and opens them up to litigation in the event of an accident.

200. It may be that the RIS has to be completed but I cannot think of any reason why they should be allowed to continue to be used in any sector, commercial, domestic or otherwise.

201. At the very least further safety campaigns as took place at the end of 2007 should continue on a yearly basis. Mr Strahan thought that this would not be an onerous commitment for the OFT taking into account its responsibilities for the real estate letting sector. I recommend accordingly.

Findings required by s43

202. I am required to find, as far as is possible, who the deceased was, when and where she died, what caused the death and how she came by her death. I have already dealt with the last of these issues, being the circumstances of Elise'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.

[34] Attachment 7 to exhibit C15

(i) The identity of the deceased was Elise Susannah Neville
(ii) The place of death was Royal Children's Hospital, Brisbane, Queensland.
(iii) The date of death was 9 January 2002.
(iv) The formal cause of death was:
1(a) Head Injuries, due to, or as a consequence of
1(b) Fall from a bunk bed

203. Elise Neville fell out of a bunk bed which did not comply with an 8 year old Australian standard. The simple precaution of having a guard rail was absent. She then died because a doctor failed in his duty of care to her as his patient. There was a failure to properly assess her. She was not given the opportunity of being admitted for observation because of what was tantamount to a policy of non-admission of children for observation. Elise was not referred to other hospitals. She was sent home. There was a failure to diagnose the cause of her deteriorating neurological condition. This was the principal cause of her death.

204. When she presented the second time that morning at the Emergency Department of Caloundra Hospital there were then delays that occurred in providing necessary treatment for head injuries. This was compounded even further by delays in the retrieval process. It is clear that Elise was given very little chance of survival because of all of these factors and there were failures at many levels in the immediate medical care.

205. It did not end there. There was a deficient and flawed reporting of the adverse incident from the beginning, starting with the Executive Director's report. The nightmare for Elise's parents was compounded. There were delays in the investigation by a number of bodies. Their initial responses were found lacking in many respects. Eventually those investigations were completed and disciplinary proceedings took place against Dr Doneman and RN Duncan.

206. Dr Doneman had been working a 24 hour shift and was into the 19th hour of that shift when Elise first presented. The issue of whether this may have contributed to the flawed clinical decision was fairly raised and generally the issue of excessive hours worked by doctors was investigated as it was considered an important public health and safety issue.

207. I have referred to the efforts of the Ombudsman at some length in my decision. The report is a significant and important document. It has provided me with enormous assistance. It has not been publicly released until the completion of the coronial proceedings and it should now be released. The Ombudsman should be commended for the efforts that were made in the production of that report. The Ombudsman formed a number of opinions and made 25

recommendations to the various authorities who were the subject of scrutiny.

208. As a result some significant progress and improvements have been made addressing many of the failures which occurred.. Naturally there is always more that can be done.

209. Queensland now has a much more efficient and coordinated emergency retrieval system in place. There is a much better system of open disclosure, reporting and investigation of adverse hospital events.

210. Queensland Health has taken some significant steps towards addressing and managing the problems associated with doctor's working hours. More needs to be done. The Medical Board of Queensland accepted responsibility to develop a standard or other policy alternative on doctors' working hours. This would also regulate the private health and hospital system where similar problems are reported. It has not completed its work and should do so with priority.

211. The Office of Fair Trading has been involved in the issues regarding the regulation of the Australian Standard. Bunk beds without guard rails are inherently dangerous. They should be removed from use in domestic and commercial settings.

212. Although all beds manufactured and sold since November 2002 must comply with the standard, it is expected that there will be a considerable number of years before those non-compliant beds find their way to the scrap heap. The Office of Fair Trading needs to make a decision as to how it is going to manage this problem. Is it going to regulate and enforce the standard in the domestic and/or commercial sector, or is it going to manage the risks through public awareness and education campaigns?

213. I would have preferred the former, as I am sure would the Nevilles, but it is complex and needs to be worked through. The OFT responded to the Ombudsman's recommendations by setting up a working party, and commencing a Regulatory Impact Statement process. The problem is that after two years of deliberations there has not been any resolution, nor does it seem that one is imminent.

Riders/Recommendations

Recommendation 1

214. I recommend to the Ombudsman that "The Neville Report, *An investigation into the adequacy of the health complaint mechanisms in Queensland, and other systemic issues identified as a result of the death of Elise Neville, aged 10 years"* be released and made public.

Queensland Health/Retrieval Issues

Recommendation 2

215. I recommend that Queensland Health conduct a review of the capacity of rural or remote hospital facilities or regions to perform emergency neurosurgical and vascular surgical procedures, and to identify what staff, training and technology would be required to allow such medical procedures to take place.

Recommendation 3

216. I recommend that the proposal presently with Queensland Health for funding for medical crewing of retrieval teams for aircraft be approved and implemented as soon as possible.

Recommendation 4

217. I recommend, if it has not already occurred, that the proposed delivery of the single pilot Instrument Flight Rules helicopter to the Sunshine Coast retrieval service proceed at the earliest opportunity.

Recommendation 5

218. I recommend that the telemedicine project be brought on line across the state, and be adequately resourced in money and staff terms. I would expect that as part of any implementation program there would be a review of which Hospitals have perceived gaps in their treatment options so that they can be included.

Recommendation 6

219 I recommend that the request for a half to one FTE senior medical officer for the Emergency Department at Caloundra Hospital be approved.

Recommendation 7

220. Although approval for the installation of a CT scanner has been given and is expected to be in place by August 2009 t o be abundantly clear I recommend that a CT scanner be installed at Caloundra Hospital by August 2009.

Queensland Medical Board Issues

Recommendation 8

221. I recommend that the Medical Board of Queensland progress with some priority to the development of a Standard or other suitable policy alternative regarding the regulation of excessive working hours for doctors in the public and private hospitals sectors.

Office of Fair Trading Issues

Recommendation 9

222. I recommend that the warning label on bunk beds as provided by the Australian Standard be reviewed by the Office of fair trading and other relevant authorities as soon as possible with a consideration that if there is to be a label for bunk beds it should not be age specific or at the very least increasing the age categories for the warning to up to age 14.

Recommendation 10

223. I recommend that the working party set up to consider the feasibility of establishing and promoting government funded programmes focussing on removing unsafe bunk beds from private residences proceed to completing its deliberations as soon as possible and the outcome be made public.

Recommendation 11

224. I recommend that the OFT conduct awareness campaigns directed towards the domestic market concerning the standard for bunk beds and the risks and dangers associated with non-compliant beds particularly for children.

Recommendation 12

225. To the extent that it is necessary I recommend that all bunk beds used in Queensland Government agency owned, managed or funded establishments comply with the Australian Standard.

Recommendation 13

226. I recommend that the Regulatory Impact Statement process commenced in June 2006 be finalised with priority.

My condolences are expressed to Dr and Mrs Neville and their family. I close this inquest.

John Lock
Brisbane Coroner

12 September 2008