IN THE CORONERS COURT No 5/05
AT IPSWICH
IN THE STATE OF QUEENSLAND

In the matter of:
AN INQUEST INTO THE DEATH OF LILLIAN MARGARET SHAW

Before: Mr McLaughlin Coroner

Facts which are not in contention

Mrs Lillian Shaw was a dog enthusiast and on Sunday the 9th January 2005 she attended a dog show in Toowoomba, apparently in good health. She continued to be well the following day however on Tuesday the 11th January she informed her husband she felt unwell, and spent the day resting.

Mrs Shaw had a long history of health related problems and had been a patient of the Lowood Medical Centre since at least June 2000. She had seen a number of doctors at the medical centre over the years. She was a 67 year old woman who was 164cm in height and weighed 86kgs, placing her in the severely obese range. She had been prescribed some medications to help with weight loss. She had been diagnosed as having a large hiatus hernia, which it seems was left untreated. She had for years also suffered from back and hip pain and as a result, over time, had been prescribed a range of non-steroidal anti-inflammatory drugs including piroxicam (Feldene), celecoxib (Celebrex) and meloxicam (Mobic), with the last prescription being written on 25th October 2004 for Celebrex. Additionally, she had been diagnosed as suffering gastroesophageal reflux disease.

On Wednesday the 12th January Mrs Shaw's condition had worsened and she was vomiting. Her husband, Ian Shaw, arranged for a doctor from the Lowood medical centre to make a home visit and as a result Dr Jaideep Bali attended the residence that afternoon. Mrs Shaw was given an intramuscular injection of tramadol (Maxalon) to control the vomiting. Although several other doctors from the Lowood Medical centre had previously seen Mrs Shaw, Dr Bali had only seen her once before, on the 15th April 2004, in relation to back and neck pain.

On the morning of Thursday the 13th January her condition had not improved and she was vomiting, distressed and suffering abdominal pain. Dr Bali was again requested by Mr Shaw to make a home visit. He arrived late in the morning and administered a further injection of Maxalon as well as an intramuscular injection of Pethedine to alleviate pain. Later that day there was still no improvement in her condition and Dr Bali was again requested to visit her. Before attending this third time, Dr Bali issued a prescription in the name of Mr Shaw for Ranitidine in oral form and for Maxalon in ampule form for injecting, apparently because the medical centre had no stocks of either drug left. Mr Shaw collected the drugs from a chemist.

Dr Bali arrived at about 4.30pm and administered a third injection of Maxalon from the drugs obtained by Mr Shaw. He also administered an intramuscular injection of Morphine from drugs he had brought with him from the medical centre, this drug being given for pain relief from the continuing abdominal pain. The Ranitidine was intended to reduce reflux or peptic ulcer symptoms, and was to be given orally that night.

A little after 7pm that evening Mr Shaw found Mrs Shaw kneeling on the floor at the head of her bed with her head resting on the bed. Upon checking her he found her to be cold and with her eyes open and fixed. There was no sign of life and he therefore made an emergency call for an ambulance. He commenced attempts at CPR while waiting for the ambulance. The ambulance arrived about 20 minutes later and also attempted resuscitation, without success.

Autopsy and toxicology

An autopsy was carried out on the 14th January by Dr Nathan Milne, a pathologist at the John Tonge Centre. In a written report he noted that *"Histology showed changes in keeping with a perforated stomach (gastric) ulcer."* At the inquest he explained his written report by saying :

"There was a hole in the stomach. There was blood and other fluid in the stomach and within the abdominal cavity. There was also inflammation of the peritoneum, which is the membrane that lines the abdominal cavity, so I was of the opinion there was a perforation of the stomach leaking fluid out into the peritoneal cavity and secondary inflammation of the peritoneum."

He went on to say *"…there was an inflammatory reaction in the abdominal cavity … which does not occur after death so I am satisfied that this perforation had occurred prior to death."* and that *" It is very difficult for me to give an idea of the timing of the haemorrhaging."*

Mrs Shaw's blood was analysed and Mr M Stephenson, a State Analyst with the Forensic Toxicology Laboratory, Brisbane, issued a certificate showing the following concentrations of drugs in the blood :

Alcohol - nil
Phentermine - 0.4 mg/kg
Morphine - 0.28 mg/kg
Total morphine
(morphine plus Morphine glucuronides) - 0.61 mg/kg
Metoclopramide - 0.3 mg/kg
Pethedine - 0.2 mg/kg
Tramadol - 0.08 mg/kg

Dr Milne noted that the level of Morphine *"falls within the potentially fatal range."*After considering his own findings along with the blood analysis, Dr Milne concluded in his report :

"In my opinion, the most likely cause of death is a perforated gastric ulcer. This is consistent with the history of abdominal pain.……Another potential cause of death is Morphine toxicity. It is difficult to interpret the significance of the blood Morphine concentration. Although it falls within the potentially fatal range, this does not mean it causes death in all cases. Although this cannot be completely excluded as a cause of death, the history and post mortem findings are more in keeping with death from a perforated gastric ulcer."

The husband of Mrs Shaw

Mr Ian Shaw gave evidence of his observations during the days leading up to the death of Mrs Shaw, his wife. He said that during the first visit by Dr Bali on the 12th January he informed the doctor that Mrs Shaw was in severe pain and had been vomiting a substantial quantity of dark fluid suspected of being blood or faecal matter. The vomitus had been disposed of before Dr Bali arrived. He was in the bedroom the entire time Dr Bali was present and says Dr Bali did not carry out any examination whatsoever of Mrs Shaw and made no further enquiry regarding the vomitus. He injected her with Maxalon, but did not say what the injection was, and advised her to take fluids.

On the second visit on the morning of the 13th January Mr Shaw says he was trying by telephone to arrange a home visit from 7am onwards and after a number of phonecalls to the medical centre, Dr Bali arrived at 11.40am. He again told Dr Bali Mrs Shaw was still vomiting and in severe pain, but did not describe the vomitus on this occasion. He was again present during the entire visit and is "absolutely certain" that again there was no examination of Mrs Shaw. She was injected with Maxalon and Pethedine and again Dr Bali did not say what either injection was. Mrs Shaw was again advised to take fluids and Dr Bali said to Mr Shaw "How would your wife feel about going to hospital ?" to which he replied that she probably would not like to do so. Dr Bali also advised to call him again later in the day if there was no improvement.

At 4pm Mr Shaw telephoned Dr Bali to advise there had been no improvement and it was then that Dr Bali asked Mr Shaw to come and collect a prescription, which Mr Shaw did. During the third visit that afternoon again Mr Shaw was present the entire time and again is adamant that no examination at all took place. Again, when two injections were given, this time Maxalon and Morphine, Dr Bali did not say what either injection was. Mr Shaw is also adamant that during this visit there was no discussion about Mrs Shaw going to hospital and that the only time hospital was mentioned was the previously mentioned enquiry during the second visit.

The treating doctor – background information

Dr Jaideep Bali is a medical practitioner employed at Lowood Medical centre. He holds the qualifications of MB BS and Master of Surgery from Punjab University in India. He is registered to practice in Queensland in an "area of need" pursuant to Section 135 of the Medical Practitioners Registration Act 2001. The relevant Medical

Practitioners Register kept by the Office of Health Practitioner Registration Board (Queensland Government) shows his registration category under S135 to be:

"Special Purpose Activity : To fill an area of need in rural general practice at Lowood Medical Centre and Fernvale Medical Centre."

In a published policy document the Medical Board of Queensland discusses the concept of special purpose registration to practise in an area of need and says at paragraph 4.4.1

"Registration in this category is generally only available on a temporary basis to graduates of non accredited institutions."

And at paragraph 4.4.4

"An applicant for this category must be sponsored by a hospital or public health institution, a medical practitioner with general registration, or by a locum/deputising agency."

And at paragraph 4.4.17

"The level of supervision associated with the particular position applied for will be considered by the Board. Applications for registration in this category must be accompanied by details of the supervision which will be provided to the applicant."

As I understand it, the concept of a "sponsor" and of "supervision" are the same, although the policy document is not entirely clear about this.

Section 141 of the Act provides for the Medical Board to impose on a special purpose registrant such *"conditions the board considers necessary or desirable for the applicant to competently and safely undertake the activity the subject of the application."*

The Medical Practitioners Register, under the heading "Conditions imposed on this registration" indicates *"There are no conditions imposed on this registrant."*

The treating doctor – his version of events

Dr Bali gave evidence after first refusing and then being required to do so pursuant to Section 39(2) of the Coroners Act 2003. He is therefore afforded the protection given by that section against his evidence being admissible in any other proceeding.

Dr Bali advised that while at Lowood Medical Centre he was under the supervision of Dr Crowley as required by his "area of need" registration. He also said however that he was not in fact supervised at all.

On the first day of the inquest Dr Bali stated that the following treatments had been provided to Mrs Shaw

1. 12 Januaury at 4.45pm : Maxolon, 10mgs intramuscular injection;

2. 13 Januaury at 11.30/11.40am : Maxolon, 10mgs intramuscular injection;
Pethedine, 50mgs intramuscular injection;
He observed on this occasion that Mrs Shaw was "still vomiting and she had epigastric pain and she was slightly tachycardic and her other body functions were all normal."

3. 13 January at 4.30/4.45 : Maxolon, 10mgs intramuscular injection
Morphine, 30mgs intramuscular injection
He again observed 'she still had epigastric pain. She was tachycardic." And He went on to say her other vital signs were normal. He said that he had checked temperature, blood pressure and pulse and had taken along a machine to measure blood pressure.

In a subsequent written statement Dr Bali corrected his earlier evidence and indicated that he had not taken along a machine to measure blood pressure and that "I cannot now recall why it was that I did not take the bag with me on those occasions".

When the inquest resumed on a later date, Dr Bali gave further oral evidence.

Regarding the first visit on the 12th January, Dr Bali said that he observed Mrs Shaw "did not appear to be distressed", was not "sweaty" or "clammy", was talking and well hydrated. Because of these observations he did not make any actual examination of her, and when informed she had been vomiting he did not enquire about the vomitus. Although he could not recall it, he did not dispute that Mr Shaw had described the vomitus as a "brown slurry". Later in evidence however, he said that had he been informed that the vomitus was brown and blood-like, that he would have insisted Mrs Shaw be immediately hospitalised. He had with him a stethoscope and a needle and syringe, but did not carry the "usual" bag of other equipment used on home visits. He did not use the stethoscope. He "assumed" she was suffering from gastro-enteritis.

Upon returning to the surgery Dr Bali made a computer entry that afternoon on Mrs Shaw's record which said :
" History: vomiting since the last two days, minimal intake, inj. Maxolon given IMI, adv to take plenty of fluids, lite diet, ring if need to review again."

The next morning Dr Bali was informed a further home visit was requested and he attended at about 11.40am. He was told the Maxolon had worked briefly but the vomiting had then continued. Again he saw no vomitus. Mrs Shaw complained of epigastric pain just below the sternum. Dr Bali was aware of a history of reflux.

Again the only equipment taken to the visit, apart from needles and syringes, was a stethoscope. He did not take other equipment because this was a "follow up" visit and explained that he did not use the stethoscope because he had not brought other equipment to measure blood pressure, temperature and pulse. He says he did palpate the epi-gastric area and it was tender and the "tummy quite soft". He assumed the tenderness was due to "vomiting for days."

Dr Bali had brought with him a 100ml ampule of Pethedine and he says he injected "about 50mg" of this and also gave a further injection of Maxolon. He brought the unused portion of Pethedine back to the surgery and disposed of it. When he later made a computer entry on Mrs Shaw's record there was no mention of the unused drugs being discarded, although he said it would be "usual" to make such a note.

Before leaving the house Dr Bali said that, due to the persistent vomiting and epi-gastric pain he suggested to Mr and Mrs Shaw that "it would be appropriate to go to hospital". Later in his evidence he said that he asked "How would they feel like going to the hospital" and they indicated they would prefer to stay at home. He agreed that he did not give any clear advice that Mrs Shaw should go to hospital.

Again computer notes were made upon return to the surgery as follows :
"history: nausea, vomiting continues, no diarrhoea, Hx of reflux with Hiatus hernia. Inj. Pethidine and inj. Maxolon given imi."
And, apparently, a few minutes after that entry a further entry was added :
"pain if not relieved in the next hr. convince the patient to go to hospital with ambulance, a little reluctant at the moment, or ring back at surgery".

Dr Bali says later that afternoon Mr Shaw visited him at the surgery and said that the vomiting was persisting and the pain had worsened. He said he asked Mr Shaw why his wife did not want to go to the hospital but received no answer. As the surgery had run out of supplies he provided a prescription in Mr Shaw's name for Maxolon and Ranitidine, the latter being indicated for anti-reflux and gastric ulcers. When asked why he issued the prescription in the wrong name he said "Well it happens sometimes".

Dr Bali went to the house a third time and took with him from the surgery a 30mg ampule of Morphine. On arrival he observed Mrs Shaw to be in bed and in pain. He was told she was still vomiting and the pain was worse than in the morning. He was unable to recall any further information he received. He injected Mrs Shaw with Maxolon obtained by Mr Shaw with the prescription provided, and also injected her with the 30mg Morphine he brought from the surgery.

He said that "I immediately thought she needed to go to the hospital" and thought so "because of the risk of peptic ulcer perforation". He said he again advised "more strongly than what I had said in the morning" for Mrs Shaw to go to hospital but did not remember the reply he received to this suggestion. He said this to Mrs Shaw only, and this occurred after the Morphine injection. He did not recall whether he ever told Mr or Mrs Shaw that he had administered Morphine. He did not give any advice as to what, if anything, to be on the lookout for after receiving Morphine. He learned two days later that she had died that evening.

Despite being unable to recall a reply to his suggestion, Dr Bali said "It was my belief that she would be taken to hospital". Although he agreed he could have made arrangements for her admission to hospital, he did not do so. No arrangements were made for further contact with Dr Bali that evening and no follow up appointment was made. The Lowood surgery was open until about 7pm that day but Dr Bali did not inform any person at the surgery of his afternoon visit or the injection of Morphine.

His supervisor Dr Crowley was never informed of the use of Pethedine or Morphine with Mrs Shaw.

Under cross examination Dr Bali's account of his advices regarding hospitalisation became confusing and inconsistent. At one stage he said "I should have insisted on her going to the hospital" and then a little later "I think I did" so insist. Then later still he said "All I said was that she needed to go to the hospital".

Following this late afternoon visit Dr Bali went home. He never subsequently made any entry in the surgery records of this visit or the injection of any drugs on this occasion. He explained this omission by saying "I might have missed out or not remembered" to update the records. Enquiry was made as to how a hospital would be able to know what medication Mrs Shaw had received prior to admission. Dr Bali indicated the hospital could have contacted the Lowood Medical Centre which could in turn have put the hospital in touch with Dr Bali. No comment was made as to how this might occur if hospital admission was after 7pm, that is, after the medical centre had closed.

About one week after Mrs Shaw's death Dr Bali met with two adult daughters of Mrs Shaw. He agreed in cross examination that he showed the two daughters the incomplete Medical Centre records for Mrs Shaw which made no mention of the final visit on the 13th January and no mention of Morphine. He also agreed he told both daughters that he had not administered Morphine to Mrs Shaw and when asked why he said that to them he claimed "I could not recall it at the time".

He further conceded that some months after the death he had told Mr Shaw that he did not administer Morphine and that by that stage he had become aware that Morphine had been given. Despite this he said "It wasn't at that stage I was telling a lie". As well, he agreed he had asked Mr Shaw whether Mrs Shaw had perhaps received Morphine at a hospital, even though he was aware she had died at home and had not gone to a hospital.

Resolving the conflict between the accounts of Mr Shaw and Dr Bali

I found Mr Shaw to be an impressive and intelligent witness. His evidence was clear and consistent and he presented as a man with a vivid memory of events that obviously had a major impact on him, namely the loss of his wife. He has taken a keen interest in the matter ever since the death of his wife and on a number of occasions in the months after the death he has committed his memory of events to writing. Those accounts were consistent with his oral evidence at the inquest.

Dr Bali, on the other hand, presented as a man with at best a poor memory. He says one week after the death he could not recall administering Morphine to a person who died within a couple of hours of the injection. He originally claimed to have used a device to measure blood pressure and later conceded that was not the case. He agreed that months after the death he was still telling relatives he had not administered Morphine. Even after learning of the death 2 days after the event he still "missed out" or did not remember to make any entry in the patient's record relating to the final visit.

His varying accounts of what he was told about the vomitus, what examinations of Mrs Shaw he made, and his even more varied accounts of what he did to advise Mrs Shaw to go to hospital lead me to the conclusion that Dr Bali is not a reliable witness. Combining this with the incomplete patient's record and the incorrect information provided to Mr Shaw and other relatives after the date of death leads me to strongly suspect that Dr Bali has deliberately been untruthful, and initially at least, did his best to conceal the fact that he had administered Morphine to Mrs Shaw shortly before she died.

I accept Mr Shaw's version of events where it differs from that of Dr Bali.

Specialist medical opinions

Opinions were obtained from two independent medical specialists.

Dr Graeme Macdonald, Ph D, FRACP is registered as a Medical Specialist and is the Director of the Department of Gastroenterology and Hepatology at the Princess Alexandra Hospital, Brisbane.

In reviewing the records of Lowood Medical Centre relating to Mrs Shaw, Dr Macdonald said in a written report :
"Peptic ulceration, in particular gastric ulceration, is a recognised complication of treatment with non-steroidal anti-inflammatory drugs including those prescribed."

Regarding the use of Morphine, he said :
"Morphine is a potent analgesic agent, particularly a dose of 30mg. Gastro-oesophageal reflux can be painful but usually does not require Morphine. Similarly, peptic ulcer disease, be it gastric ulceration or duodenal ulceration without perforation, is painful but usually not to the level of requiring narcotic analgesia. In contrast, gastric perforation with gastric contents moving into the abdominal cavity is generally very painful because of the inflammation (peritonitis) caused by acid and other components of the fluid. The fact that the pain was severe enough to warrant injection of narcotic analgesic agents on two occasions within one day should have raised concerns about an alternate diagnosis. In addition, morphine will mask the signs and symptoms of complications such as gastric perforation."

As to the need for hospital he said :
"The apparent severity of the pain, the fact that multiple attendances had been required within a 36-hour period and that narcotic had to be administered on two occasions, are all evidence that the patient was quite unwell and should have been referred to a hospital for further evaluation and treatment. Under these circumstances, I do not believe that it is appropriate to administer morphine at home, particularly where there is some doubt as to the diagnosis."

As to the vomitus :
"The vomitus should have been inspected (or if it had been disposed of) questions asked about the appearance of the vomitus to determine if there was any evidence of

the presence of blood. The association between non-steroidal anti-inflammatory drug use and gastro-intestinal haemorrhage is well recognised."

And as to whether hospitalisation may have resulted in a different outcome :
"I think that if Mrs Shaw had gone to hospital on the Wednesday afternoon or Thursday morning, the outcome may have been different although I suspect that if she went to hospital on the Thursday afternoon, the outcome may have been unchanged because the disease process would presumably have been quite advanced by that time."

In oral evidence Dr Macdonald said that the "sudden onset" of symptoms and the "intensity of pain" were indicators of a possible perforation. Other indicators were disappearance of bowel sounds; increased pulse rate; falling blood pressure; the abdomen becoming "rigid"; and other general signs of unwellness such as being pale and distressed. The administration of Pethedine or Morphine may slow bowel movement but would not make bowel sounds disappear, nor would it mask changes in blood pressure or pulse. He said that checking temperature, blood pressure and pulse were all an important part of the diagnosis process. Bowel sounds should have been checked using a stethoscope.

As to the chances of success in surgically repairing a perforation, he said this depended on a number of factors including the training of the doctor concerned; the amount of internal damage; the general condition of the patient and whether there was infection. Generally however, he said "the longer the delay…. the higher the likelihood" of death occurring.

As regards the drugs administered, Dr Macdonald had no criticism of the 3 injections of Maxolon, however he said treatment of a ruptured ulcer would not normally be with narcotic analgesia such as Pethedine and Morphine. Oral codeine and Panadol would be more appropriate. Also, while an injection of 50mg Pethedine was not a large dose, 30mg of Morphine was "quite a large dose" and was "too large to administer at home." While such a dose may well be effectual in significantly reducing pain, it may also reduce the level of consciousness and slow the rate of breathing, perhaps even enough to contribute to death. An advisable dose would be 5 to 10mg.

Regarding the need for hospital, Dr Macdonald advised that a doctor cannot force a patient to go to hospital, but in the circumstances of this case the patient should have been encouraged to do so. There should have been a discussion with the patient on the Thursday morning rather than simply asking her husband how she would feel about going to hospital. He explained that a patient's acceptance or rejection of the advice depended on how "strong" the doctor was in giving the advice, and that "the important thing is that the patient appears to understand and accept the consequences of their action", which may include "that she might die if she does not go to hospital". His experience is that strong recommendations for hospitalisation are "virtually always" obeyed. If the advice is still rejected then the doctor should continue to treat the patient as best they can.

Notwithstanding the concerns as to examination and diagnosis, advice to go to hospital and the administration of 30mg of Morphine at home, Dr Macdonald said he

had no reason to dispute the finding of Dr Milne that the primary cause of death was a perforated gastric ulcer.

The second specialist to give evidence was Dr Peter Pillans, Associate Professor, registered Medical Specialist and Director of Pharmacology at Princess Alexandra Hospital, Brisbane.

Again, Dr Pillans provided a written report and also gave evidence at the inquest. In his written report he commented as to administration of Morphine as follows :
"The rationale for giving morphine is not clear. It is a potent opioid analgesic which can mask the symptoms and signs of an acute abdomen (such as peritonitis) and should be avoided where such a possibility exists. Morphine is not indicated in gastric flu and is not indicated for gastro-oesophageal reflux or peptic ulcer disease."

And :
"The morphine level in the deceased is consistent with the stated injection of 30mgs."
And :
"It is noted that the morphine blood concentration of 0.28mgs/kg falls within the potentially fatal range of 0.2- 2.3mg/kg. The lower end of the range would apply to non tolerant individuals such as Mrs Shaw.……The temporal relationship with the administration of a generous dose of 30mgs of intramuscular morphine in Mrs Shaw, suggests that morphine was a likely contributor to her death."

As to the vomitus :
"Vomitus should be inspected, particularly for the presence of blood, in patients on non-steroidal anti-inflammatory drugs or patients with a history of reflux, because of the well known potential complication of ulceration with gastro-intestinal haemorrhage."

In oral evidence Dr Pillans explained that the most important effect of morphine is its effect on breathing and that "it can have a profound effect and, in fact, depress the respiration to such an extent that you stop breathing." He said this depression could be increased by the earlier injections of Maxolon and Pethedine which both have a similar, but weaker, effect on the respiratory system. Her obesity also probably made her more susceptible to respiratory depression. He went on to say that a patient who received 30mgs of morphine in a hospital would be connected to a machine called a pulse oximeter which measures oxygen in the blood and therefore indicates if there is respiratory depression. The pulse oximeter is adjusted to trigger an alarm should oxygen fall below a certain level. In addition, the patient would be observed by a nurse perhaps every 15 minutes. Should respiratory depression reach an unacceptable level, then the hospital would administer an "antagonist" drug – Naloxene – which would block the effect of the morphine.

As to the use of morphine at all in this case, Dr Pillans said :
"You really have to establish a diagnosis when it comes to abdominal pain so that you know what you're treating and if it's severe pain that warrants morphine, it really, in my opinion, warrants hospital admission and elucidation of that cause by special investigations. And in this setting where we have a history of gastro-

oesophageal reflux disease, consideration about stomach ulcers and so on, if it was pain related to an ulcer then the treatment is different, completely different, you'd be giving anti-ulcer medication. If you then had severe pain unrelated, or not responsive to anti-ulcer medication, you would be concerned about what the diagnosis was, such as a perforation. We have a history of vomiting – of dark vomitus. The husband's observation was that it was dark brown and I think he said he thought it could be blood or feculent material which obviously concerns you that it could have been blood and, if there's blood, then clearly this would suggest that there's some sort of mischief, like an ulcer, and clearly one would avoid giving morphine in that setting and definitively treating the problem after diagnosing the problem."

As to the effect of the morphine in this case he said :
"I think the probability here is fairly high that it was a significant contributor to her death." and *"I think the perforated gastric ulcer would probably have allowed her to continue living for some time, whereas I think the morphine caused a fairly rapid, you know, decline in events."* Later he was asked whether he considered it was "highly probable that Mrs Shaw's death was at least very significantly contributed to by the opiates" and he replied "*Yes, my stand was that the opiates were a significant contributor to her death; yeah*". He also agreed however, that while he considered it was unlikely to be the case, death may have in fact occurred entirely as a result of the perforated ulcer.

Findings

Given the evidence which I have summarised, it seems there is no reason to depart from the finding of Dr Milne that the primary cause of death was a perforated gastric ulcer. Dr Macdonald specifically agreed with this proposition and Dr Pillans did not put the matter any higher than saying that the administration of Morphine was probably a "significant contributor" to Mrs Shaw's death and that it caused her condition to deteriorate more rapidly.

I therefore make the following findings:-

- The person who died was Lillian Margaret Shaw.
- Mrs Shaw died at home after being ill for several days. She had been vomiting dark fluid and suffering abdominal pain. For some years she had been treated with a range of non-steroidal anti-inflammatory drugs, a known complication of which is gastric ulceration. A doctor visited the home three times over two days and administered anti-nausea medication and injections for pain relief, including on the last visit, 30mg of Morphine. Death occurred about 2 ½ hours after that injection. Autopsy revealed a perforated gastric ulcer with a significant amount of blood and other fluid in the stomach and in the abdominal cavity, with consequent inflammation of the peritoneum. Toxicology testing revealed a blood concentration of Morphine within the potentially fatal range.
- Mrs Shaw died on the 13th January 2005.
- Mrs Shaw died at 43 Muckerts Lane, Fernvale, Queensland.
- The cause of death was a perforated gastric ulcer, however Morphine toxicity also made a significant contribution to death.

Comments

Pursuant to Section 46 of the Coroner's Act 2003, I may comment on anything connected with this death that relates to public health or safety; the administration of justice, or ways to prevent deaths from happening in similar circumstances in the future.

There are a number of matters where I believe comments should be made :-

- Firstly in relation to the use of Pethedine or Morphine. While there is a register kept of such drugs showing the date of removal from storage; the quantity of drug; and the patient's name, there is no record kept of what becomes of any unused portion of those drugs. Such a register should also indicate what amount of the drug was actually administered to the patient, and if there is any amount remaining, what became of that surplus. To do otherwise leaves open the possibility of dangerous and highly sought after drugs being unaccounted for, as well as the potential for confusion as to the quantity of drug administered to a patient.
- Medical practitioners registered pursuant to Section 135 of the Medical Practitioners Registration Act 2001 need to be adequately supervised given their qualifications are from non accredited institutions. Protocols need to be put in place not only specifying in detail what level of supervision is needed, but also a system of monitoring or verifying what supervision is in fact being given. A periodic review of their performance must also be made if there is to be any assurance that the supervision is achieving what is intended.
- A protocol needs to be put in place to ensure that a subsequent medical practitioner is aware of treatment recently given by a previous practitioner, particularly where the first practitioner is aware the patient is so unwell they are likely to soon be admitted to hospital, and the first practitioner has administered drugs which the hospital should be aware of. One method is to verbally inform the patient fully of any treatment and drugs they have received, but if this is impractical for any reason then the practitioner should provide the patient with written details so that the document can then be handed to the subsequent practitioner or hospital.
- The public is entitled to be informed as to the status of a medical practitioner's right to practice. Most persons attending a medical centre would assume that any "doctor" practicing there was a fully qualified medical practitioner and would have no idea the person may have a conditional registration and be under the mandatory supervision of another medical practitioner. Persons registered to practice under S135 of the Medical Practitioners Act should be required to inform patients of this fact so that the patient may make an informed choice.

I offer my condolences to the family of Mrs Shaw and declare this inquest closed.