QUEENSLAND COURTS

OFFICE OF THE STATE CORONER

FINDING OF INQUEST

CITATION:	**Inquest into the death of Deborah Denise BURGEN**
TITLE OF COURT:	**Coroner's Court**
JURISDICTION:	Brisbane
FILE NO(s):	COR-454/05(2)
DELIVERED ON:	07 December 2007
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FINDINGS OF:	Mr Michael Barnes, State Coroner
CATCHWORDS:	**CORONERS: Inquest, Mt Isa Hospital, post operative internal bleeding, compliance with hospital policies, triaging of ED patients, tele medicine, referral to medical board.**

REPRESENTATION:

Counsel Assisting:	Ms Jennifer Rosengren
Queensland Health:	Mr Michael Fellows (Barrister-at-Law)
Dr Frederick Rowland:	Ms Stephanie Gallagher (instructed by TressCox Lawyers)
Dr Naseem Ashraf:	Mr Craig Chowdhury (instructed by Cooper Grace Ward Lawyers)
Dr Matthew Nettle:	Mr John Allen (instructed by Minter Ellison Lawyers)
Queensland Nurses Union:	Mr Gavin Rebetzke (Roberts & Kane Solicitors)
Medical Board of Queensland:	Ms Kathryn McMillan SC (instructed by Gilshenan & Luton Lawyers)

The Coroners Act 2003 (the Act) provides in sections 45 and 46 that when an inquest is held, the coroner's written findings and comments must be given to the family of the person who died, each of the persons or organisations granted leave to appear at the inquest and to various officials with responsibility for the subject of any recommendations or comments. These are my finding in relation to the death of Deborah Denise Burgen. They will be distributed in accordance with the requirements of the Act and posted on the website of the Office of the State Coroner.

Introduction

On the morning of 25 February 2005, Deborah Burgen was brought to the Mount Isa Base Hospital by an ambulance complaining of severe abdominal pain. It was her sixth attendance in connection with this ailment in eleven days. She was admitted to the surgical ward after being diagnosed with a bowel obstruction. She was operated on two days later. Post operatively, Deborah was transferred to the intensive care unit (ICU) where it was quickly realised by the nurses that she was not recovering as would be expected. The doctors who were called to the ICU at intervals throughout the night made various attempts to address her decline but none succeeded and she died the following morning, soon after 10.00 am.

These findings seek to establish the cause of death, explain how it happened and assess whether the death could have been prevented. They determine whether the conduct of any of the doctors involved should be referred to the Director of Pubic Prosecutions or the Medical Board for consideration of prosecution or disciplinary action. I also consider whether the Medical Board and Queensland Health adequately discharged their responsibilities when registering and employing the overseas trained doctors involved and whether any changes are needed to the policies and procedures of either body.

The Coroner's jurisdiction

Before turning to the evidence, I will say something about the nature of the coronial jurisdiction.

The basis of the jurisdiction

Because Deborah was not expected to die as a result of the operation she underwent, s8(3)(d) of the Act required those who became aware of her death to report it to a coroner. Section 28 authorises the holding on an inquest into such deaths.

The scope of a Coroner's inquiry and findings

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

- whether a death in fact happened;
- the identity of the deceased;
- when, where and how the death occurred; and

- what caused the person to die.

I will now say something about the general nature of inquests.

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]

The focus is on discovering what happened, not on ascribing guilt, attributing blame or apportioning liability. The purpose is to inform the family and the public of how the death occurred with a view to reducing the likelihood of similar deaths. As a result, the Act authorises a coroner to make preventive recommendations concerning public health or safety, the administration of justice or ways to prevent deaths from happening in similar circumstances in future.[2] However, a coroner must not include in his or her findings a statement that a person is or maybe guilty of an offence or civilly liable for something.[3]

The admissibility of evidence and the standard of proof

Proceedings in a coroner's court are not bound by the rules of evidence because s37 of the Act provides that the court "*may inform itself in any way it considers appropriate."* That doesn't 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 provenance when determining what weight should be given to the information.

This flexibility has been explained as a consequence of an inquest being a fact-finding exercise rather than a means of apportioning guilt: an inquiry rather than a trial.[4]

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.[5] This means that the more significant the issue to be determined, the more serious an allegation or the more inherently unlikely an occurrence, the

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[1] *R v South London Coroner; ex parte Thompson* (1982) 126 S.J. 625
[2] s46
[3] s45(5) and 46(3)
[4] *R v South London Coroner; ex parte Thompson* per Lord Lane CJ, (1982) 126 S.J. 625
[5] *Anderson v Blashki* [1993] 2 VR 89 at 96 per Gobbo J

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.[6]

It is also clear that a coroner is obliged to comply with the rules of natural justice and to act judicially.[7] 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*[8] 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.

The investigation

Deborah's death was reported to local police about 15 minutes after it occurred. Constable Firth went tho the hospital and received preliminary details about the death. Deborah's partner identified her body to that officer. A scenes of crime officer attended and took photographs of Deborah's body *in situ* and a detective came to the hospital and took possession of the medical records. Over the next nine months local police attempted to obtain statements from the doctors involved in caring for Deborah. In most cases these were very cursory. No independent experts were consulted. These comments are not meant to be critical of the efforts of those officers; I have observed in findings in other inquests into medical deaths that these are not matters that general duties police or even most detectives have the training or experience to undertake effectively.

A report on the police investigation was forwarded to the Mt Isa Coroner in early January 2006. He understandably came to the conclusion that this was likely to be a protracted matter that could more easily be managed in the Office of the State Coroner. Accordingly, I agreed to assume responsibility for it.

Staff of my office then redoubled efforts to have the various practitioners who had been involved in Deborah's care give a detailed account of their knowledge of her treatment. This was exceedingly difficult in some cases. A number of quite senior practitioners refused to co-operate with the investigation; in some cases even failing to comply with statutory notices to provide statements or documents. Their conduct could lead to a conclusion that they were seeking to hide the truth from this inquiry or that they believed that they should not be subject to any external scrutiny. In either case, it was conduct unbecoming of people in their positions and has the potential to undermine public confidence in the individuals concerned, Queensland Health and/or the medical profession.

Staff assisting me briefed independent experts to review the records and witness statements. I was greatly assisted by the reports and oral evidence of Dr Anthony

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[6] Briginshaw v Briginshaw (1938) 60 CLR 336 at 361 per Sir Owen Dixon J
[7] *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
[8] (1990) 65 ALJR 167 at 168

Brown, senior staff specialist, Department of Emergency Medicine, Royal Brisbane and Women's Hospital, Dr Peter Kruger, senior intensive care specialist, Princess Alexandra Hospital Brisbane and Dr Andrew Stevenson, senior colorectal surgeon from Holy Spirit, Northside. Each of these doctors has extensive experience practicing in fields relevant to the consideration of Ms Burgen's case. In addition, each of them has researched and published in highly regarded professional journals and/or published books, chapters and monographs.

I am satisfied that as a result of the sterling efforts of staff of the Office of the State Coroner and counsel assisting by the time the inquest concluded, the matter had been effectively investigated.

The inquest

The inquest was opened with a pre-inquest conference on 14 August 2006. Ms Rosengren was appointed counsel assisting and leave to appear was granted to Queensland Health, the Queensland Nurses Union and three of the clinicians involved in the matter who elected to be separately represented. Because some of the potential witnesses had still not provided adequate statements, the matter was not immediately listed for hearing but rather further attempts were made to source the necessary material. Unfortunately, Crown Law, acting on behalf of the department, was unable to contact some of the practitioners and unable to persuade others to provide adequate statements. A further two pre-inquest conferences were convened before the matter was ready to proceed to hearing.

The inquest finally convened in Mt Isa on 5 March 2007 and evidence was heard over 10 days before the hearing was adjourned to Brisbane for a further two days of evidence in April. At that hearing the Medial Board of Queensland was granted leave to appear and its Chair gave evidence.

In all, 34 witnesses gave evidence and 106 exhibits were tendered.

After the conclusion of the hearing, the lawyers for all of those granted leave to appear provided comprehensive written submissions which I found very helpful.

The evidence

Social history

Deborah Burgen was born in Mt Isa on 7 June 1955 to parents, Reginald and Ellen Burgen. She was the seventh of ten children. Her father, Reginald was a stockman. Her mother, Ellen was a homemaker.

Ms Burgen completed high school to year 10 in Mt Isa and Townsville. She had three children, Clarissa, Meagan and Shannon whom she predominately raised on her own.

For fifteen years prior to her death, Ms Burgen lived in a de-facto relationship with Warren Bailie. They had one child, Kade who is now 11. Ms Burgen was also the principal carer of her grandson Duncan, who suffers from autism. Duncan is now 18 years of age.

Ms Burgen was a well respected member of the Mt Isa community. She was actively involved in fundraising for the Mt Isa Special School, loved sports and prided herself on her award winning garden.

It is apparent to me that Deborah Burgen was a central member in a close and loving, extended family. Her family's active participation in this inquest evidences their deep commitment to her. They have suffered a great loss that has brought them severe grief. I offer them my sincere condolences and hope that the knowledge that lessons have been learnt from this sad death, to some small extent, ameliorates their pain.

Medical history

Ms Burgen's family says that generally she was of good health. In 1997, she underwent a gall bladder operation but it seems she recovered from this completely.

Mr Bailie, Ms Burgen's partner, recalls that towards the end of 2003 Ms Burgen began feeling unwell. She experienced symptoms of tiredness and sleepiness. Blood tests were ordered and it was discovered that Deborah was suffering from mild hypothyroidism. She was prescribed a minimal dose of Thyroxine. Although some of the evidence suggests that soon after she started taking this medication she experienced abnormal bowel symptoms and some abdominal pain, there is no evidence that she returned to the medical practitioner who prescribed it. Indeed there is no evidence of Ms Burgen seeking any medical assistance after November 2003 until she presented at the Mt Isa Base Hospital ("MIBH") two weeks before her death in February 2005.

I will now deal with the evidence concerning Ms Burgen's treatment at the MIBH in three parts: outpatient treatment, inpatient and peri-operative care and post operative care. At the end of each of those sections, I will critique the quality of the care provided by reference to the expert evidence of the independent specialists called at the inquest.

Outpatient treatment

Presentation to Emergency Department – 14 February

Ms Burgen went to the emergency department at the MIBH at about 9.00am on 14 February 2005 complaining of pain to the left side of her abdomen. She reported having experienced abdominal pain and diarrhoea for the previous twelve months. This time period coincided with when she commenced taking Thyroxine.

Dr Chris Wellard, a junior house officer, examined Ms Burgen and found her to be tender in the left side of her abdomen with guarding – the involuntary tensing of the abdominal wall muscles to guard inflamed organs within the abdomen from the pain of pressure. It is detected by palpating the abdomen.

His differential diagnoses included an infective cause, an adverse reaction to Thyroxine, a surgical cause such as diverticular disease or a medical cause such as inflammatory bowel disease. He ordered blood and stool tests and discharged Ms Burgen after prescribing Panadeine Forte for her pain. Dr Wellard considered that it was not practical to have Ms Burgen remain in the emergency department awaiting the blood results, as it was only a 10 bed facility, treating on average approximately 80 - 90 patients per day.

Presentation to results clinic – 16 February

On 16 February 2005, Ms Burgen attended the "results clinic" to find out the results of the tests ordered by Dr Wellard. Dr Rose Govender, a junior doctor was working in the clinic on this day and she reviewed the blood test results, which she thought indicated that Ms Burgen was anaemic. She also had the stool and thyroid function tests, both of which were normal.

The tests result showing Thyroxine in therapeutic levels in Ms Brugen's blood should have enabled Dr Govender to exclude the drug as a cause for any of Ms Burgen's symptoms. However, Dr Govender gave evidence that although she was aware of the normal results, she did not have the expertise to interpret them and she relied on the fact that Ms Burgen had told her that her general practitioner had considered there was some causal relationship between the taking of the Thyroxine and the diarrhoea. The records from Ms Burgen's general practitioner, Dr Lola Power suggest that this was not correct.

Dr Govender thought that there may have been a gastrointestinal explanation for the anaemia reported in the blood test results and considered that further investigation was required through the surgical outpatients' department. She gave evidence that Ms Burgen told her that she would prefer to organise any such referral through her general practitioner, as she thought she might be able to get an earlier appointment. Unfortunately, I found Dr Govender to be a most unconvincing witness who seemed unable or unwilling to relay what transpired during her examination of Ms Burgen. I do not accept that Ms Burgen declined an offer of further investigation of her intestinal symptoms. I don't believe any such offer was made.

Dr Govender prescribed Ms Burgen iron tablets, ordered iron tests to be performed and advised her to return to the emergency department on the following Monday, 21 February 2005, at which time her outstanding blood results would be available.

Presentation to Emergency Department on 21 February

Ms Burgen did indeed attend at the hospital on that day but not as planned. Instead, at approximately 7.30am on 21 February, she went to the emergency department complaining of abdominal pain, which she described as being 7/8 out of 10 in terms of severity, vomiting and diarrhoea. She was seen by a medical student and then by Dr Bishop.

When examined, Ms Burgen gave a history similar to that which she reported to Dr Wellard on the 14 February 2005. She further indicated that she had vomited the previous day after eating a sandwich and had not eaten since. She had been experiencing pain and distension after every meal regardless of the type of food she had eaten. She also advised that she had lost eight kilograms over the previous two months and was not getting any pain relief from over the counter analgesics.

Dr Bishop gave relatively vague evidence regarding the interpretation of his notes and felt that any attempt to attribute significance to any aspect of them would be mere speculation. It is however, apparent from the medical records that Dr Bishop sought the advice of the senior doctor in the emergency department, Dr Robina McCann. Neither Dr Bishop nor Dr McCann had any recollection of the discussion and Dr McCann could not recall whether she even saw Ms Burgen. When giving evidence, Dr McCann accepted that the medical records indicate that Ms Burgen's symptoms were of sufficient severity to require inpatient treatment. However, regrettably, the seriousness of Ms Burgen's condition was obviously not appreciated and she was sent home from the hospital for the third time in a week. I consider Dr McCann was principally responsible for this happening and do not accept her assertion that it was all a decision for Dr Bishop.

Ms Burgen was advised to return the following day for a CT scan and an abdominal x-ray and told that she would be referred to the surgical outpatient clinic for consideration of a colonoscopy.

Presentation to the Radiology Department on 22 February

Ms Burgen returned for the radiological investigations as planned on 22 February and was subsequently seen in the results clinic by a sixth year medical student and then by Dr Matthew Nettle, a principal house officer. He was at a significant disadvantage in providing advice and treatment for Ms Burgen's continuing abdominal symptoms because he did not have her full medical chart detailing her previous attendances at the emergency department. This appears to have been a systems failure to a large extent, although Dr Nettle conceded that there was no good reason why he could not have taken steps to obtain her chart prior to making the decision to discharge her that day.

Dr Nettle was aware that Ms Burgen had had a CT scan but was unaware she had also had an abdominal x-ray earlier that day. He only reviewed the results of

the CT images on the computer screen and thought they demonstrated some abnormalities. As the written report was not yet available, he discussed the images with Dr Morgan, the radiologist whose role it was to provide such reports.

Dr Morgan said he had no recollection of any discussion with Dr Nettle. However, I accept such a discussion did take place and that Dr Morgan told Dr Nettle that he considered the images showed a mass that was potentially a renal cell carcinoma which required a biopsy and also that there appeared to be gaseous distension in the bowel. He did not tell Dr Nettle that the CT scan showed a large bowel obstruction even though independent expert evidence given at the inquest was to the effect that this was clearly discernible from the images and indeed in the radiology report, produced some days later, Dr Morgan said "*There are loops of distended large bowel with air fluid levels visible on the erect film. The appearances are very suggestive of a distal large gut obstruction."*

Dr Nettle arranged for Dr Morgan to perform a fine needle biopsy the following day. Dr Nettle also completed a referral form for Deborah to have the suspected bowel abnormality investigated via a colonoscopy. The procedure could not be performed that day as she was required to undertake bowel preparation prior to undergoing it. However the form seems to have been swallowed up by the system as there is no evidence that any firm arrangements were in fact made for Deborah to have this procedure.

Finally, Dr Nettle ordered that Ms Burgen be given some re-hydrating fluids, some more Panadeine Forte and some Buscopan, an antispasmodic which reduces bowel contractions, to help with her ongoing diarrhoea and fluid loss.

Unfortunately, because he did not have her full chart, Dr Nettle did not know that earlier in the day, when she had the x-ray scans taken, another doctor had given Ms Burgen Maxalon, an anti-nausea medication which causes bowel contractions to increase. For obvious reasons the two medicines should not be used together.

Dr Nettle explained his focus on the suspected renal cell carcinoma was the result of his concern about Ms Burgen's weight loss over the preceding months. He said that he did not consider her presenting symptoms indicated a bowel obstruction and therefore paid little regard to the loops of distended large bowel also seen on the CT scan.

Ms Burgen was again discharged home and told to return tomorrow for the biopsy.

Presentation to Emergency Department on 23 February

On 23 February, Ms Burgen attended the hospital for the renal biopsy as arranged. Following this procedure, she was admitted to the day surgery ward for observation for a few hours to ensure she did not suffer any complications of the procedure.

By this time, Dr Nettle had had an opportunity to review Deborah's medical chart and became aware of the abdominal x-ray taken the day before. Dr Morgan's radiology reports were available. They referred to the presence of air fluid levels in the large intestine that enabled Dr Nettle to conclude that Ms Burgen had a large bowel obstruction.

Dr Nettle contacted Dr Gallery, the Director of Surgery, and discussed Ms Burgen's ongoing abdominal symptoms, her history and the radiology reports and images, including the abdominal x-ray. He did this because Dr Gallery would need to approve admitting Ms Burgen for surgery or a colonoscopy. Dr Nettle says Dr Gallery informed him that he had reviewed the CT images and the x-ray films and indeed he was looking at the radiology reports and the images on his computer screen during the telephone conversation.

Dr Gallery agreed, according to Dr Nettle, that there was evidence of a gaseous distension in the bowel and that a colonoscopy was warranted "*at some point but not immediately.*" According to Dr Nettle, Dr Gallery advised that Ms Burgen's symptoms were more consistent with a transient problem as opposed to a complete obstruction.

Dr Nettle says he suggested to Dr Gallery that at least a sigmoidoscopy could be performed before Ms Burgen was discharged home. This is a relatively straightforward procedure which usually takes five to ten minutes and involves examination of the distal part of the colon. It can exclude an obstruction or mechanical fault in this part of the bowel. It does not require any anaesthetic or other preparation.

Dr Nettle also says that he suggested to Dr Gallery that Ms Burgen be admitted overnight for observation to monitor her symptoms. Dr Nettle says that Dr Gallery declined to perform the sigmoidoscopy and did not agree that Ms Burgen required admission. Instead he instructed Dr Nettle to arrange a further abdominal x-ray.

Dr Nettle did this and said that he understood that Dr Gallery would review that film and only send the patient home if he still felt this was appropriate. However this did not occur and nor was Dr Nettle contacted in accordance with the notation he had made in the chart. Instead, the x-ray was taken shortly after 2.00pm and Ms Burgen was discharged at 2:10pm without being reviewed by anyone.

Dr Gallery's evidence in relation to these aspects of Ms Burgen's care is unhelpful. His first statement to the court was so brief that I can quote in full. Other than the formal parts his statement read:

> *I do not think I examined Ms Burgen during her final illness, but I recall discussing her condition in the emergency department probably on 23 February 2005. I consider that the biopsy of her renal tumour was the main priority and the bowel symptoms could be assessed more leisurely in the outpatient department.*

In a subsequent statement dated 13 February 2007, Dr Gallery says that when he was contacted about Ms Burgen he considered there were two salient features of her condition, "*firstly, a newly discovered renal tumour….. and secondly, a long standing problem of abdominal pain and bowel dysfunction*". Dr Gallery goes on to state, "*I accept Dr Nettle's recollection of our conversation. I do not recall the details of the exchange, but I do not think there was any disagreement about the choice of investigations and management priorities.*"

As the summary of Dr Nettle's evidence outlined above shows, he clearly has a different recollection of what was discussed and the decisions Dr Gallery made. When questioned, Dr Gallery said in evidence that he was aware as a result of seeing or being told about the x-ray of Ms Burgen's abdomen that she was suffering a gaseous distension in her bowel. He also agrees that he was given details of Ms Burgen's history and symptoms and that he and Dr Nettle agreed an investigation of her colon was needed. He seemed unwilling to acknowledge that Dr Nettle was urging that such an investigation take place immediately and that Ms Burgen be admitted pending the results whereas Dr Gallery, consistent with both of his statements, was happy for the investigation of the bowel symptoms to occur "*more leisurely*" in "*the following week."*

It transpired under cross-examination that Dr Gallery did not have a memory of any details of the conversation between he and Dr Nettle and he is not, therefore, in a position to contradict Dr Nettle's version. Dr Gallery however, maintained that "*there was no significant change in her (*Ms Burgen's*) status over the proceeding days to indicate a change in plans other than she should have been admitted for the designated number of hours following the radiological procedure.*" In those circumstances Dr Gallery did not consider that he needed to review Ms Burgen's condition prior to her being released and nor did he consider that it was his responsibility to review the x-ray he told Dr Nettle to arrange to have done.

I accept Dr Nettle's evidence that during the course of the telephone call:

- Dr Gallery informed him that he had reviewed the radiology findings on the computer;
- Dr Gallery agreed with him that the images showed gaseous distension in the bowel;
- Dr Nettle suggested that Ms Burgen required inpatient treatment or at least a sigmoidoscopy before she was discharged home and that Dr Gallery rejected both of these suggestions; and

- Dr Gallery instructed Dr Nettle to order a further abdominal x-ray to help determine whether Ms Burgen's bowel condition was of a transient nature.

Quite reasonably, it was Dr Nettle's understanding that having spoken with Dr Gallery, that he was handing her future care, management and treatment over to Dr Gallery and his surgical team. Dr Nettle, it will be recalled, was working in the emergency department. Dr Gallery did not dispute this but also gave evidence that Dr Nettle seemed in no way concerned about Ms Burgen's condition and that he did not know why he had been contacted. This seems highly unlikely and I do not accept it.

In cross-examination Dr Gallery said that in respect of the management of the bowel obstruction, he was "*stalling*" until he had the results of the renal biopsy even though that would not resolve the issue of the bowel obstruction and there was no reason the separate complaints needed to be dealt with sequentially rather than simultaneously. He accepted that he did not attach sufficient urgency to it and that he now wished he had reviewed Ms Burgen on this day.

Dr Gallery left Mt Isa on leave two days later and did not return until after Ms Burgen had died. As a result of Dr Gallery's decision that Ms Burgen not be admitted, she was again sent home and told to return on 25 February.

The renal biopsy results did not become available until after Ms Burgen's death. They revealed that no renal tissue had been sampled, i.e. it seems that despite using real-time CT monitoring to guide the probe, Dr Morgan entirely missed the kidney and the suspicious mass. Incongruously, Dr Morgan recorded after taking the biopsy that, "*a good tissue sample was obtained and sent to the laboratory.*" He should perhaps review his practice.

Ms Burgen did return to the MIBH on 25 February but not as planned. As will be detailed later, she came in an ambulance as an emergency admission. Before describing the events that followed, it is appropriate to make some comments on her "treatment" thus far.

Critique and comments concerning pre-admission care

Between 14 and 25 February Ms Burgen went to MIBH seeking help on six occasions before she was admitted. On each occasion, the symptoms she reported were much the same, and on each visit some test or investigation was commenced, but on none of them were the results obtained, considered and acted upon. This approach to managing patients presenting to the emergency department was explained as an unavoidable consequence of high demand and limited resources. It was suggested the emergency department of the MIBH was used as a general practice clinic by many local residents and that protocols utilised in metropolitan emergency departments were not apposite. For example, it was said that on occasions up to 140 patients could seek assistance from the

ten bed emergency department on a single day and that they averaged 80 to 90 patients per day.

I accept the difficulties that this may have created for the hospital but according to Dr Brown, Ms Burgen's case was a "*true emergency*" when she first presented on 14 February. He pointed out that Dr Wellard, the junior doctor who examined her, recorded her abdominal pain as being eight out of ten in terms of severity and noted tenderness and guarding. In Dr Brown's view, guarding was the most salient feature pointing to a potential surgical problem in the abdomen. He says, "*guarding is never chronic. Guarding is an acute manifestation*" that suggests intra-abdominal pathology.

Dr Brown considered the differential diagnoses that Dr Wellard made on the first occasion Ms Burgen presented were appropriate but that when he felt it necessary to administer such a strong analgesic as Panadeine Forte, he was confirming that Ms Burgen's case was not a regular general practice presentation. According to Dr Brown, such acute pain is an emergency and should have been dealt with accordingly, namely, by admitting the patient until its cause could be identified and addressed.

When Ms Burgen returned to the hospital on 16 February to get the results of the tests taken two days earlier she was seen by another junior doctor, Rose Govender. In spite of the blood tests showing a normal thyroid function, Dr Govender concluded, "*Thyroxine most probably cause of chronic diarrhoea*."

In response to the anaemia disclosed by the blood tests, iron tablets were prescribed without any attempt to establish the underlying cause. Dr Govender gave evidence that she believed that the anaemia may have been attributable to gastrointestinal bleeding that should have been investigated by a colonoscopy. As mentioned earlier, I don't accept her reason for not arranging for this to be done.

There was inconsistency in Dr Govender's evidence as to the nature of her role in the results clinic. She at first seemed to accept that her role was that of any other doctor being consulted at a hospital but then seemed to move away from that position and claim it was only her role to relay the results of the earlier tests. It is certainly the case that she did very little to resolve Ms Burgen's ongoing problems. I agree with the evidence given by Dr Brown when he said, *"I don't think that Dr Govender adequately completed Deborah Burgen's process of care started two days earlier."*

When Ms Burgen again come to the emergency department on 21 February she was again suffering acute pain. Dr Stevenson was of the view that the history and symptoms recorded on this day "*certainly require(d) further investigation, admission and consideration for urgent operation."*

Instead, more tests were ordered and the patient was again sent away without her problem being resolved or even diagnosed. One of the blood tests was a lipase test used to monitor pancreatitis. Dr McCann conceded that such a test is only ordered if pancreatitis is suspected which led Dr Brown to comment "*if you sent the blood on the expectation that she could have it* (pancreatitis*) you can't send the patient home keeping your fingers crossed that it is going to be a negative test.*"

But that was indeed what happened. Ms Burgen was again sent home without any firm diagnosis or anything being done to address her symptoms. I agree with Dr Brown that "*This was not an acceptable nor humane standard of care."* She should have been admitted.

When Ms Burgen returned to the hospital the following morning for an abdominal x-ray and CT scan she was seen by yet another medical officer, Dr Nettle, who did not seek access to her full medical chart but simply reviewed the test results and the CT scan. Indeed it seems he was not aware that Ms Burgen had also had an x-ray that morning.

Dr Nettle discussed the CT scans with the visiting radiologist who pointed out what appeared to be a renal cell carcinoma on Ms Burgen's right kidney. They both agreed that a fine needle biopsy should be done the following day.

According to Dr Brown this was a serious error of judgement as the renal cell carcinoma, was most unlikely to account for Ms Burgen's abnormal, acute, abdominal symptoms.

On 23 February Ms Burgen again attended the hospital in order to have the fine needle biopsy undertaken. By this stage Dr Nettle had become aware that she was almost certainly suffering a large bowel obstruction and he sought to have her admitted to the surgical ward so that this could be investigated and resolved. His attempts were frustrated by Dr Gallery, the Director of Surgery, who failed to attach sufficient seriousness to the clear evidence on the CT scans and x-rays indicating that an obstruction existed. All of the experts who gave evidence said this should have been attended to urgently; that once a large bowel obstruction is apparent the patient must be admitted and treated until it is resolved. Instead, Ms Burgen was simply subjected to another x-ray and sent home without the doctor who ordered the x-ray, Dr Gallery, even checking to see what it revealed.

I again find myself agreeing with Dr Brown when he says;

> *It was simply unacceptable to keep sending Ms Burgen home without a formal diagnosis. Dr Nettle and Dr Gallery both misinterpreted the significance of the abnormal abdominal x-ray and failed to correlate this with the abnormal abdomen scan that confirmed distended large bowel*

> *consistent with mechanical obstruction and with Ms Burgen's progressively abnormal clinical status*.

Dr Brown goes on to say:

> *This was a serious error of judgement as arranging a FNA* (fine needle aspiration*) in the meantime for a renal mass that was completely asymptomatic and unrelated to Deborah Burgen's medical presentation with abnormalities on abdominal examination was totally unwarranted.*

All of the experts agreed that Ms Burgen should have been admitted at the latest on 21 or 22 February. All agree that routine investigation would have disclosed the bowel obstruction by this stage.

The questions I must try and resolve is why no decisive action was taken and how can it be prevented from happening again.

I do not consider the junior doctors who failed to adequately diagnose or treat Ms Burgen's symptoms should be held responsible for this. They were given inadequate support and assistance. In particular, Dr McCann, who Dr Bishop consulted, failed in my view to adequately engage with the challenges Deborah's case presented; nor did she provide the advice and counsel her junior colleague was entitled to expect from her.

Dr Gallery's failings were, in my view, even graver. He had before him hard proof of a serious problem that he ignored or at least did not treat with sufficient urgency, even when a junior doctor, Dr Nettle, drew it to his attention and made sensible suggestions concerning an active response. It was reasonable in my view, for Dr Nettle to consider that he was handing over the management of this patient to Dr Gallery. Arrangements should have been made for her immediate admission with a view to an active investigation of her symptoms as Dr Nettle suggested. They were not because Dr Gallery failed to sufficiently acquaint himself with the patient's history and her current condition. If he was determined to refuse her admission, he should have at least perused her chart and examined her himself.

In patient treatment and surgery

Admission to the surgical ward – 25 February

At approximately 1.30am on 25 February, Ms Burgen awoke at home with severe pain in her abdomen. An ambulance was called and she was transported to the emergency department of the hospital soon after 5.00am. She was reviewed and examined by Dr Wellard, who was the doctor who had seen Ms Burgen in the emergency department 11 days earlier when she had initially presented. Dr Wellard noted in the chart that the abdominal x-ray showed "*4 - 5 fluid levels*" and he made a provisional diagnosis of a bowel obstruction or abdominal pain

secondary to the renal tumour which had been demonstrated on the CT scan a few days earlier.

Ms Burgen was transferred to the surgical ward at 10.40am. A few hours later, Dr Whitmore, a surgical principle house officer, examined her and reviewed the radiology images and formed the view that Ms Burgen had a large mechanical bowel obstruction and that a laparotomy was required. She did not consider that conservative management was appropriate because she believed that mechanical obstructions do not usually resolve and the radiology images indicated it had been present for some days. She noted that the medical records were not complete and located the missing notes for Ms Burgen's attendances at the emergency department on 14 and 21 February 2005, with a pile of other notes and records which had also not been filed.

Dr Whitmore's firm view was that surgical intervention was indicated. However, she read the note of Dr Nettle's conversation with Dr Gallery on 23 February and understood from it that Dr Gallery had reviewed the radiology images and had considered that inpatient treatment had not been required. She recalled questioning her judgement, given that it appeared to her that the Director of Surgery appeared not to share her view regarding the need for urgent surgical intervention.

As mentioned earlier, Dr Gallery had left Mt Isa, probably on Thursday,[9] the evening before Ms Burgen's emergency admittance. The other consultant surgeon, Dr Frederick Rowland, was therefore the only surgeon available and responsible for all surgical patients who might be admitted. He was advised of the admission.

Dr Rowland, during the course of his evidence, repeatedly sought to categoris,e his involvement in Ms Burgen's care as having been simply to "*oversee"* her surgical management until Dr Gallery returned on the following Monday. I find this concerning given that Dr Rowland was the only surgeon available to look after Ms Burgen and the decision whether and if so when to operate, was a decision that rested with him. He did not seek to speak with Dr Gallery at any time and simply acted on the assumptions that Dr Gallery had seen Ms Burgen earlier that day and that Dr Gallery had made arrangements for a colonoscopy to be performed on the following Monday, 28 February 2005. Unfortunately neither of these assumptions was correct. In fact, Dr Gallery had never seen Ms Burgen and had only one conversation concerning her. This was hardly a basis for Dr Rowland to limit his responsibility for the patient's management.

Evidence was initially given by Dr Whitmore that she had a discussion with Dr Rowland regarding Ms Burgen's future management over the telephone.

[9] Dr Gallery took his wife to Townville for the weekend and was there on Saturday 26 February. He thought he probably left Mt Isa on Thursday and over-nighted en route.

However, it became apparent in cross-examination that Dr Rowland actually attended the hospital late in the afternoon on the 25 February, at which time he spoke with Dr Whitmore in person and examined Ms Burgen. Dr Whitmore was critical of Dr Rowland's involvement with Ms Burgen's care on this afternoon. She considered that his examination of Ms Burgen was inadequate in that he simply felt her stomach and walked away. She says she attempted to convey to him her concerns with respect to Ms Burgen's condition, but she found him to be dismissive to the extent that he cut her off mid sentence and appeared to take no notice.

It was Dr Rowland's opinion that Ms Burgen had a large bowel obstruction that was mechanical in nature and most probably due to a cancer, although he could not exclude diverticulitis. He considered that she did not appear to be in any discomfort and that surgery was not indicated on that day. The notes indicate the Dr Rowland considered that Ms Burgen should receive conservative treatment and that *"if the obstruction doesn't resolve, for laparotomy early next week."*

While Ms Burgen may have been comfortable at the time, Dr Rowland examined her, this was not consistent with her clinical presentation earlier in the day. The reason why she had initially been taken to the emergency department in the early hours of the morning was because she had been in pain which she rated as 9/10. Further, the nursing entry for 1.10pm noted that Ms Burgen had again been complaining of abdominal pain. During the course of the afternoon, she had required 5mg of morphine at 1.25 pm and a further 5mg at 3.35pm. In these circumstances, it was hardly surprising that Ms Burgen appeared to be relatively comfortable when Dr Rowland examined her shortly thereafter. The administering of these drugs was of course recorded in her chart which was at the end of Ms Burgen's bed.

Not only was Dr Rowland satisfied that Ms Burgen did not require surgery on this day, he also gave evidence that he was reluctant to operate over the weekend because the operating theatres and pathology and radiology departments were not fully staffed and an anaesthetic consultant was often not available. Whilst operating during normal business hours would always be a preferable option, Dr Rowland conceded that emergency staff were rostered on in the emergency department 24 hours a day and that had he considered it clinically indicated, there was no good reason why the surgery could not have been performed on the night of the 25 or at any other time prior to the 27 February. This point is demonstrated by the fact that the surgery eventually proceeded on a Sunday and that all necessary staff members were available to assist.

Dr Rowland also mentioned on a number of occasions when giving evidence that it would have been a professional discourtesy to interfere in the management of another doctor's patient, although he conceded that if this couldn't be avoided without risk to the patient then such interference would be acceptable.

Interestingly, while Dr Rowland could not recall whether he had seen the notes for 21 February when he was caring for her, he gave evidence that having had the opportunity to review them at the inquest, it was his opinion that Ms Burgen's presentation on that date indicated that she required inpatient treatment with a plan to operate on her prior to the 25 February 2005. This seems incongruous given that Dr Rowland apparently did not consider Ms Burgen required urgent surgery when he reviewed her on 25 February. He sought to clarify this contradiction on the basis that by the time that he became involved with Ms Burgen's care on 25 February, she was Dr Gallery's patient and therefore his role was somewhat more limited than had she been admitted under his care.

Continued observation on 26 February

Dr Rowland conducted his ward round between 7.30am and 9.30am on 26 February. He saw Ms Burgen at approximately 8.00am. He found her to be sitting up in bed and conversing comfortably and thought that her condition was essentially unchanged. Whilst he considered that the bowel obstruction, which had now been present for at least four days, had not resolved he still did not consider that her condition was sufficiently acute to require surgery. He said in evidence that this decision was influenced to a large extent by the fact that on examination, Ms Burgen was only minimally tender in her abdominal area and she told him that she was feeling comfortable.

However, Dr Rowland conceded that in coming to this conclusion he had given minimal regard to the nursing notes that indicated the pain Ms Burgen had been experiencing and the treatment she had been given since Dr Rowland had last seen her some 15 hours earlier. The nursing entry made at 10.30pm on the night before indicated that Ms Burgen had been in discomfort for most of the shift requiring regular pain relief and a hot pack. The nursing entry that was made less than an hour before Dr Rowland saw Ms Burgen during his morning ward round, noted that at about 6.40am Ms Burgen had been in significant pain which she had rated as 6/10. Further, had Dr Rowland taken the time to review the medication chart, it would have been apparent to him that since he had seen her the evening before, she had required a further 12.5 mg of morphine for pain relief.

The results of the blood tests that had been ordered the previous day were now available. They showed a markedly raised white cell count of 10.5 $x10^9$/L with neutrophils of 9.24 $x10^9$.

Dr Rowland ordered that Ms Burgen continue to be given sips of water and requested a further blood test with a plan to review her on his ward round on the following day.

Dr Maimuna Shah was the junior surgical doctor rostered on at the hospital for the weekend. Whilst she had worked as a doctor in Pakistan and Zimbabwe, she had only been working at the MIBH for approximately one month. She had been

given no orientation or training since she arrived. It was her recollection that it was at approximately 12.30pm that she became aware of the blood results which had been ordered by Dr Rowland earlier that day. Having seen the results she became concerned about Ms Burgen's condition because she considered a number of the results were grossly abnormal.

Dr Whitmore was working in the emergency department but because she had been worried about Ms Burgen's clinical presentation of the day before, she decided to check the blood results herself. On learning of them, she was concerned that Dr Shah was a very junior doctor and may not have appreciated their significance, in particular the elevated white blood cell count. For this reason, she telephoned Dr Shah and suggested that Dr Rowland needed to be advised of the results.

When she gave evidence, Dr Shah was adamant that within about half an hour of having seen the results, she telephoned Dr Rowland and told him that Ms Burgen's white cell count was now 19.9 x 10^9/L, check (unit) nearly double the previous reading, and that her neutrophils, urea and creatinine levels were raised. She also suggested that Ms Burgen required antibiotics, but this was rejected by Dr Rowland on the basis that Ms Burgen was afebrile. Despite the fact that Deborah had received four litres of intravenous fluids since she had been admitted, Dr Rowland suggested that the elevated results could be attributed to her being dehydrated. He directed Dr Shah to order a further blood test and indicated that he would review her later.

Dr Rowland did not dispute the content of this conversation but considered that the discussion did not take place until some hours later at approximately 5.30pm.

Dr Rowland considered that antibiotics were contra-indicated on the afternoon of 26 February because it would have made it difficult to interpret the significance of the white cell count in the tests which he had reordered.

Dr Rowland accepted that if left untreated a large bowel obstruction can result in a raised white cell count suggestive of an infective process. However, in this case he considered that the significantly raised white cell count may have been the result of some technical problem with the machine that had produced anomalous white blood cell counts in the preceding few weeks. He claimed a repeat blood test was required to check whether the white cell count was in fact accurate. This reasoning did not explain the raised urea and creatinine levels, which were also consistent with a worsening bowel obstruction. Further, Dr Rowland explained that even if he had been satisfied of the accuracy of the white cell count, he would have repeated the blood test in any event because major surgery would have been required. He did not want to embark on this unless he had a second set of results confirming the abnormalities which had been detected earlier that day. Dr Rowland adopted this approach even though he was aware of the risk

that a large bowel obstruction left untreated can cause a perforation which markedly reduces the prospects of a successful recovery.

The medical records contain an entry purportedly made by Dr Shah at 5.00pm to the effect that she conducted a ward round with Dr Rowland at around this time. In evidence, she said she had an independent recollection of having been present for the ward round and that she showed Dr Rowland the blood test results on a computer. There is evidence that the blood tests results were accessed on the computer system at about 4.00pm and 5.00pm by a person using Dr Whitmore's and Dr Hussain Shah's user identification number. Dr Rowland denied that he conducted a ward round at this time or any other time that afternoon and said the only time he saw Ms Burgen on that day was during his morning ward round. He said that after he went home from the hospital following his morning round he only spoke on the telephone to Dr Shah. His diary records a number of phone calls on the afternoon in question although he conceded he made notes of three of them, including two with Dr Shah concerning Deborah, some time after they occurred. Neither doctor had a reason to fabricate and both had notes which tended to support their versions. I am unable to resolve this conflict in the evidence.

In any event, Dr Shah caused the further blood samples to be taken for testing and then went off duty and left the hospital shortly after 5.00pm.

Dr Rowland accepted that he took no steps to ascertain the outcome of the further blood tests he ordered. He sought to absolve himself of any responsibility for this failure on the basis that Dr Shah had telephoned him with the previous results earlier in the day and therefore there was a system in place for her or another junior doctor to convey these later results to him. The following points should be made in relation to Dr Rowland's understanding in this regard:

- Dr Rowland did not request Dr Shah to telephone him with the results;
- Dr Rowland did not make arrangements for any other doctor to telephone him with the results;
- Dr Shah had telephoned him earlier that day after being prompted to do so by Dr Whitmore; and
- He offered no explanation for why he didn't telephone the hospital himself to find out the results, particularly when the reason he had requested the further test was because he was concerned that Ms Burgen would require surgery.

The medical records indicated that Ms Burgen remained significantly unwell throughout 26 February. The nursing entry at 2.45pm indicated that she was sweaty, cold and clammy to touch after mobilization. Further, she had required an additional 20mg of morphine for pain relief.

Critique and comments concerning in-patient pre-operative care

When Ms Burgen was finally admitted on her sixth attendance at the MIBH it was quickly realised that she had a bowel obstruction. In view of her previous attendances during which she reported identical symptoms, those examining her had sufficient information to realise that this condition had probably been extant for over a week. In those circumstances, urgent action should have been taken. Instead she was simply given morphine to still the pain while more blood tests were taken.

Dr Stevenson said the CT scan taken on 23 February that was reviewed by Dr Rowland on 25 February showed "*gross distension of the colon and that urgent intervention was (is) warranted."* There was some uncertainty as to which scans Dr Rowland actually saw but attempts by those representing Dr Rowland to excuse his inaction on this basis are rejected. There is no dispute that Dr Rowland knew that Ms Burgen was suffering from a bowel obstruction; if he wanted further information about its extent that he could not glean from the material available on the hospital's radiology data system, he could simply have called the radiologist.

In Dr Stevenson's view Ms Burgen should have had surgery on 25 February: "*If a patient requires continuing doses of analgesia, particularly narcotic analgesia, for symptoms of bowel obstruction then that implies the obstruction is not resolving and the patient needs surgery."*

As we know this did not happen, and even when the results of the blood tests reviewed by Dr Rowland on the morning of 26 February strongly suggested she was deteriorating, still no remedial action was taken.

Dr Stevenson said, "*The patient had had a further four doses of morphine which would indicate that the obstruction is not resolving. The underlying cause has not been treated and again the preference would be to take the patient to theatre."*

Submissions made of behalf of Dr Rowland to the effect that it could not be proven that he had seen all of the medical charts recording the narcotics administered are pointless. He only had to ask the nurses as any competent doctor would usually do when making his rounds.

I do not accept Dr Rowland's explanation for his inaction that he was simply "*overseeing*" the patient for Dr Gallery. Professional courtesy can not stand in the way of patient safety. His professional obligation was in my view, to take whatever action was necessary to arrest the patient's deterioration. His failure to even attempt to contact Dr Gallery demonstrates the sophistry of this excuse.

The claim that it would be unsafe to operate over the weekend was demonstrated as specious by the evidence of Dr Hack that he had done so without problem and

by Dr Rowland himself, when finally accepting he had to operate on Sunday morning. It was not any unavailability of staff that led to the fatal outcome.

Dr Stevenson was of the view that the rapid increase of the white cell count from 25 to 26 February confirmed that Ms Burgen urgently needed to be operated on and that Dr Rowland should have come back into the hospital to undertake this procedure when he was advised of the results of the blood tests taken after his morning rounds on 26 February. He said that Dr Rowland's decision to simply order further blood tests did not make sense. In his view, there was ample evidence of a large bowel obstruction that urgently needed surgery to resolve it. Simply giving her intravenous fluids and narcotics for pain relief was "*inappropriate or insufficient treatment."*

Dr Rowland's decision to refrain from ordering antibiotics on the basis that they might cloud the results of the further blood tests was criticised on two grounds. First, it was unnecessary because a blood specimen could be taken and the drugs then given. Second, if the drugs weren't given then an operation became imperative.

Dr Brown put it this way*, "Well, the logic to say that you don't want to give antibiotics because it might blur the picture of sepsis is just unbelievable. I mean sepsis is infection. You die of infection if you don't (*get*) antibiotics. By saying 'I'm not going to give antibiotics and I'm not going to go to theatre because I don't want to blur the edges' is just wrong. It's extraordinary."*

All of the experts also expressed the view that it was not appropriate for Dr Rowland to order further tests and then do nothing if the junior doctor to whom he gave the order did not get back to him with the results. Of that Dr Brown said*, "I have no problem with Dr Rowland reviewing the blood, but I have a huge problem with his disinterest in knowing the result."* Dr Hack and others agreed that if there was a system in place whereby junior doctors had a well recognised obligation to chase up test results and report them to senior doctors, then it was permissible for the senior doctor to rely on it. In this case, there was no evidence that any such system existed.

Dr Stevenson was of the view that the laparotomy was unduly and unnecessarily delayed and certainly, by the time the elevated white cells counts and urea levels were known after 48 hours of hydration and acute pain requiting narcotics, "*That should have been at least the final trigger to take the patient to theatre on the 26th."*

Dr Kruger expressed the view that "*during the ward care of this lady several errors of judgement occurred, leading to the severity of her illness being underestimated and the likely sequence of occurring being misunderstood. I believe that the critical review of this lady on 26 February failed to appreciate severity of her illness."*

When asked whether performing the laparotomy on 26 February would have avoided Ms Burgen's death, Dr Stevens said:

> *It's hard to know if the outcome would have been different if the patient had been taken to theatre on the 26th but I suspect that had the patient been taken to theatre on the 25th, or the 23rd, or the 21st, or even on the 15th when she first presented the outcome may well have been quite different*.

Both Dr Hack and Dr Stevenson were of the opinion that it is likely that the changes in the white blood cell counts on the morning of 26 February indicate that it was around this time that Ms Burgen's large intestine ruptured as a result of the unresolved obstruction. Dr Stevenson did not accept the reasoning that led Dr Rowland to conclude that the rupture occurred only a short time before he operated.

Dr Rowland's lawyers submitted that it was only with the benefit of hindsight that one can conclude that Ms Burgen's surgery should have been undertaken sooner. I do not accept that. Dr Hack, a surgeon from Townsville who reviewed the case at the request of the MIBH Medical Superintendent wrote in his report, *"It seems to me that her abdominal symptoms of pain were going on whilst an inpatient and it is only right at the end when perforation has occurred, that the operation is organised, and this is far too late... All in all, too much time was wasted which was in large part responsible for this lady's death."*

When he gave evidence Dr Hack was asked when the operation should have been undertaken; "*As far as I can see the diagnosis of this* (the mechanical bowel obstruction) *was fairly clear for several days before the operation occurred. So any time leading up to whenever the bowel perforated would have been associated with a better outcome."*

He was also asked*, "So, alright, so is your evidence that by the 25th, that Dr Rowland should either have done the barium enema or operated?"* He answered *"I'd prefer the operation but I could make a case for the enema, yes."* As we know, Dr Rowland did neither for another two days.

Ms Burgen is operated on

On 27 February, Dr Rowland examined Ms Burgen during his ward round between 7.30am and 8.30am. His note in the medical chart recorded her as looking well, although he gave evidence that on examination he found her abdominal tenderness to be a little more extensive than it had been previously. He reviewed the results of the blood tests and even though they confirmed the very significantly raised readings from the previous day, he still did not consider that surgery was urgently required. Instead he ordered further abdominal x-rays

and decided that if the incomplete bowel obstruction was visible on the further radiology images, he would operate on Ms Burgen the following day.

Apparently on his way home, Dr Rowland reflected further on Ms Burgen's condition and made the decision that surgery should not be further delayed. He telephoned Dr Shah and requested her to make the necessary arrangements for the surgery to be performed that day and asked her to inform Ms Burgen of this plan.

Dr Anilkumar Tirumalai was the anaesthetist on call for the weekend. Whilst he had worked as an anaesthetist in India and Dubai for a number of years, he had only commenced working at the hospital approximately one month earlier and, like Dr Shah, he had not been provided with any orientation or training since his arrival in Mt Isa. He arrived in late January 2005 and commenced working at the hospital later that day. He had no experience in the management of critically ill patients in contemporary intensive care settings.

As the anaesthetist on call, Dr Tirumalai performed a pre-operative anaesthetic evaluation. At the time of this assessment, Ms Burgen's blood pressure was 130/77 and her haemoglobin was 114. Dr Tirumalai reviewed the results of the earlier blood tests and was concerned about the raised urea and creatinine readings. For this reason, he telephoned Dr Naseem Ashraf.

Dr Ashraf commenced employment at the hospital as the Director of Anaesthetics and ICU in mid 2004. At that time, he was the only anaesthetist working at the hospital. Prior to this he had worked as an anaesthetist in Saudi Arabia, Pakistan and Brunei. Like Dr Tirumalai, he also had limited experience in assuming responsibility for the care of critically ill patients.

Dr Tirumalai gave evidence that the reason he telephoned Dr Ashraf was because it was his understanding that Dr Ashraf was the Director of Anaesthetics and he required Dr Ashraf's input into the anaesthetic management of Ms Burgen. Dr Ashraf denied this and gave evidence that Dr Tirumalai did not respect him and would not listen to his advice and did not treat him as the director but rather simply as another anaesthetist. There was clearly animosity between the two which unfortunately negatively impacted upon their ability to work collaboratively. It seems to me that each of them sought to blame the other for questionable decisions.

During the course of the telephone conversation, the two anaesthetists discussed whether Ms Burgen needed to be transferred to Townsville Hospital which, as a tertiary facility, was able to provide more intensive care for seriously ill patients. Dr Tirumalai gave evidence that he raised this issue with Dr Ashraf because he was concerned that the elevated urea and creatinine results from the previous day were an indication that Ms Burgen was likely to require dialysis treatment following the surgery. It was his recollection that Dr Ashraf expressed the view

that there was no good reason why the surgery could not proceed in Mt Isa. Dr Ashraf denied that Dr Tirumalai asked for his advice regarding the hospital's dialysis capacity and that he simply indicated to Dr Tirumalai that if he did not feel competent to provide the necessary anaesthetic care to Ms Burgen, that he should discuss this with Dr Rowland and that a decision would then need to be made whether to transfer Ms Burgen to Townsville.

There was a discussion between Drs Rowland and Tirumalai at the desk outside the operating theatre. Dr Rowland recalled Dr Tirumalai asking him whether Ms Burgen required a central line inserted prior to the surgery commencing and he expressing the view that she did. He did not recall being involved in any discussion about the need to transfer Ms Burgen to Townsville and in any event, he did not have any serious concerns about her being able to be properly cared for at the hospital.

Dr Tirumalai gave evidence that he discussed the transfer issue with Dr Rowland and that Dr Rowland advised him that it was up to him whether to transfer Ms Burgen and that he deferred to Dr Ashraf, as his superior, to make this decision. Dr Ashraf was not present for the entirety of the conversation but could recall arriving when the issue of transfer was being discussed. It was his recollection that he expressed the view that a transfer was required but that this was rejected by Drs Rowland and Tirumalai because it was thought that it would simply delay the surgery which was urgently required. Interestingly, Dr Ashraf allegedly told Dr Rowland that he thought that Ms Burgen had been neglected and should have been operated on earlier. He could not recall whether Dr Rowland responded to this.

The operation report records that the surgery which was performed by Dr Rowland with the assistance of Dr Shah, went from 11.45am until 2.00pm. Dr Ashraf believed that Dr Tirumalai was primarily responsible for Ms Burgen's anaesthetic management while she was in the operating theatre, while Dr Tirumalai considered that it was a combined effort. Dr Ashraf was not in the operating theatre at all times.

Dr Tirumalai says he considered that Ms Burgen needed to remain intubated when she was taken to ICU because she had undergone major surgery and had received large volumes of fluid. Dr Ashraf did not agree. He considered continued intubation was not required. However, he told Dr Tirumalai that it was his decision.

The surgery performed by Dr Rowland was major colorectal surgery. A midline laparotomy was performed. It found free peritoneal gas and faecal fluid, as well as some small particulate faeces emanating from the perforated caecum secondary to an obstructed sigmoid colon. Dr Rowland removed the sigmoid colon mass and the perforated caecal mass and adjacent segments of the bowel. The histology report indicated that the length of the colon removed was

approximately 55cm. Dr Rowland then performed a total colectomy and formed a dual ileostomy and colostomy. He twice lavarged the peritoneal cavity with several litres of warmed saline fluid. Dr Shah suctioned out as much of the saline fluid as she could. No active bleeding was seen.

The volume of blood lost during the surgery was not recorded. However, both Drs Ashraf and Shah recalled that it was not significant. Whilst Dr Rowland was obviously focussed on the task at hand, he did not remember being in any way concerned that the volume lost may have been significant. He explained that in his opinion the colon he removed would have contained a greater volume of blood than a healthy colon, because once the obstruction was removed the colon would have collapsed and filled with blood. It is known from the anaesthetic record that Ms Burgen was given three units of blood in the operating theatre and two litres of fluid.

It was Dr Rowland's opinion that the perforation to the caecum that he found at the time of surgery most likely occurred in the four hours prior to the surgery. The reasons for this were that:

- at the time of his examination of Ms Burgen earlier that morning, she did not have an elevated temperature and she had no signs of shock, such as an increased pulse rate or cold sweaty skin;
- her bowel at the time of surgery was dark red and while not tensely distended there was still some pressure in it;
- the gas and faeces were coming out of three small holes in the caecum which had not progressed to form a large hole; and
- the faeces leaking from the caecum were not particularly odorous.

Ms Burgen was given 80mg of Gentamycin in the operating theatre. Dr Rowland considered that while he probably ordered this antibiotic, the decision as to the appropriate dose rested with the anaesthetists. He accepted that the dose given was sub-therapeutic and that even if the plan had been to give her a further dose a few hours later, such an approach to the administration of this medication was at odds with the accepted medical practice at the time.

Critique and comments concerning peri-operative care

None of the experts who gave evidence was critical of the quality of the surgery performed by Dr Rowland. Indeed Dr Brown commented *that "Dr Rowland did an extraordinarily good job in difficult circumstances.*" However, the weight of the expert opinion firmly supports the contention that by failing to operate on Ms Burgen in a timely fashion, the surgery was made more dangerous, as the colon perforated during the delay.

The independent experts were also of the opinion that the anaesthetists Dr Ashraf and Dr Tirumalai adequately managed that aspect of the procedure; *"induction and maintenance of anaesthesia was uneventful and appropriate,"*

according to Dr Kruger. He expressed some concerns about the adequacy of the anaesthetic record; it was difficult to read and some of the times noted appear inaccurate but nothing turns on that.

The delay in the surgery also complicated the possibility of transferring Ms Burgen to a tertiary hospital such as Townville, as by the time the seriousness of her situation was acknowledged, the perforation of her colon had made her unstable.

All of the experts agreed that a central venous line should have been inserted by the anaesthetist in charge prior to or during the operation. It would also have been appropriate for Ms Burgen to have remained ventilated when she was transferred to the ICU as it should have been anticipated that she was likely to be very unwell post operatively. These errors of judgement made the post operative management more difficult because the procedures then had to be undertaken when Ms Burgen was critically ill and rapidly deteriorating.

It was the opinion of all of the experts who gave evidence on the topic that the dosage of the antibiotics given was about one quarter of the usual therapeutic dosage for such conditions as confronted in this case. Dr Tirumalai ordered that dose in ignorance and Dr Rowland failed to correct it. It is undoubtedly the surgeon's role to determine the drugs and the quantities a patient should receive after an operation. That is not a decision for the anaesthetist.

Post operative care

Deborah is taken to the ICU

Dr Tirumalai accompanied Ms Burgen from the operating theatre to the ICU at about 3.00pm. There were three registered nurses on duty, Mr David Bohan-Shaw, Ms Samantha Partridge and Ms Samantha Mackey. Mr Bohan-Shaw was the most experienced of the nurses and was assigned to look after Ms Burgen. The ICU was a five bed facility and Ms Burgen was the only patient. This meant that Ms Partridge and Ms Mackey were available to provide assistance to Mr Bohan-Shaw in caring for Ms Burgen.

An initial nursing assessment found Ms Burgen's peripheral circulation to be diminished and her blood pressure was 90/60. This was a significant drop from her pre-operative blood pressure of 130/77 and an intra-operative blood pressure of 120/60. Mr Bohan-Shaw was concerned with this low reading and requested Dr Tirumalai to insert a central venous line so that he would be able to adequately manage it. The advantages of having such a line in place were that not only would it enable Ms Burgen's intravascular volume status to be monitored but it would also secure the most effective route for administering drugs used to treat dangerously low blood pressure. The nurses also put a warming device on Ms Burgen to assist with her poor circulation.

Despite the concern of the nurses, Dr Tirumalai did not insert the central venous line at this time and the failure to do so seems to have been largely attributable to his lack of experience in managing unwell patients in an intensive care setting. He told the nurses that such a line was not needed and he left the ICU shortly thereafter, leaving no clear management plan for the nurses.

Dr Rowland reviewed Ms Burgen in the ICU at approximately 3.30pm. He claimed to have found Ms Burgen to be peripherally well perfused and thought that she was recovering well. Dr Stevenson thought it unlikely that there would have been such a dramatic change in her level of perfusion since the earlier assessment by the nurses. Dr Rowland's explanation for this was that the nurses must not have known how to properly assess Ms Burgen's level of perfusion. They were experienced intensive care nurses and I do not accept that they would have made such an error. I reject Dr Rowland's evidence on this point. The expert evidence confirmed that it was not appropriate to reject the nurses' assessment simply on the basis that when feeling Ms Burgen's foot, Dr Rowland found it to be warm. Dr Brown, a senior intensivist, rejected the suggestion that haemorrhagic shock could be discounted on this basis; "*I think that's total rubbish,*" he said. I agree with him.

A short time later Dr Shah arrived in ICU to review Ms Burgen. Mr Bohan-Shaw again expressed his concerns with respect to the low blood pressure and the lack of a central line. Dr Shah contacted Dr Tirumalai who indicated he would return to insert the cental line at the conclusion of another procedure that was in progress.

Dr Tirumalai returned to the ICU at about 4.30pm and made a number of unsuccessful attempts to insert the central venous line. He called Dr Ashraf who came back to the ICU and successfully inserted it.

At approximately 5.30pm, Dr Rowland reviewed Ms Burgen. The results of a blood test were available which indicated that her haemoglobin had dropped from a pre-operative level of 114g/L to approximately 85g/L. Further, her systolic blood pressure had remained below 90 since her return from the operating theatre. When giving evidence at the inquest, Dr Rowland discounted the suggestion that these symptoms indicated that Ms Burgen was bleeding internally for the following reasons:-

- He had not noticed significant blood loss during the operation, and the low haemoglobin could be explained by the blood that would have pooled in the collapsed colon once the obstruction was removed.
- The low haemoglobin could also be explained by the volume of non blood fluids Ms Burgen had received, in combination with the failure to give her sufficient units of transfused blood in the operating theatre.
- There was no bleeding from the ileostomy site.
- The low blood pressure was explicable by the effects of the anaesthetic.

Dr Rowland left the ICU shortly thereafter and the two anaesthetists remained with the nurses until approximately 6.45pm.

The drug order forms indicate that about 15 minutes earlier, Dr Tirumalai had ordered that Ms Burgen be given an inotrope medication called Dobutamine, in an attempt to raise her blood pressure. Dr Ashraf said he thought that this medication was inappropriate and that he told Dr Tirumalai so. It is usually used to treat patients with heart problems, which Ms Burgen did not have. Dr Tirumalai's explanation for having ordered this drug was that he had only been working in Australia for about a month, was not provided with any orientation or training at the MIBH and was not aware that other more appropriate drugs such as noradrenalin were available.

It seems that the discussion regarding the administration of this drug was one of the many heated arguments that the two anaesthetists had. It was an unfortunate consequence of neither anaesthetist having assumed responsibility for Ms Burgen's anaesthetic management and their not being able to work collaboratively to resolve the issues presented by Ms Burgen's post–operative deterioration.

Prior to leaving the ICU, Dr Ashraf told the nurses to continue sedating Ms Burgen, to monitor her vital signs and to maintain her central venous pressure above 6. The nursing staff reasonably felt that this plan was inadequate in that they were provided with no parameters within which to seek to maintain Ms Burgen's vital signs. Ms Partridge asked Dr Ashraf what steps needed to be taken in the event that Ms Burgen's blood pressure dropped further. His only response was to assert that this would not happen.

At the time the two anaesthetists left the ICU, Ms Burgen was neither improving, nor stable. She was showing signs of oedema: despite being given many litres of fluids, her urine output was minimal, having dropped from 55mls/hr to 19mls/hr. Her temperature was elevated at 37.8, her systolic blood pressure remained below 90, her mean arterial pressure (MAP) was under 70 and her respiratory rate had risen to 26 beats per minute (bpm). The concern of the nurses that they should not have been left alone with Ms Burgen in this condition was well founded.

The first MET call – 7.20pm

At about 7.20pm, Mr Bohan-Shaw and Ms Partridge reassessed Ms Burgen and found that her blood pressure had dropped further to 55/44, her pulse was high at 110bpm and her respiration had increased to 32 bpm. The nurses knew that these signs indicated that Ms Burgen was dangerously ill and they therefore called the medical emergency team. Dr Pieter Nel, Director of the Emergency Department, responded. He examined Ms Burgen and found her blood pressure to be 49/40. He made the differential diagnoses of severe blood loss or septicaemia.

Dr Nel called in Drs Rowland, Ashraf and Tirumalai. Dr Nel recalled that when Dr Rowland arrived he discussed with him the possibility of post operative blood loss. Dr Rowland assured him that this was not the cause of Ms Burgen's deteriorating condition as there was no blood draining from the wound. Dr Rowland's evidence was that it was Dr Nel who told him that he considered it unlikely that Ms Burgen's presentation could be explained by intra-abdominal blood loss. I find Dr Nel's recollection of this conversation more likely, although it probably matters little because Dr Rowland as the treating surgeon, examined Ms Burgen and satisfied himself that she was not bleeding internally, he says, for the following reasons:

- She appeared to be well perfused, (which was at odds with the nursing observations);
- No significant abdominal distension was evident;
- There was no leakage from the ileocolostomy site; and
- There had been an improvement in her haemoglobin levels from 85g/L at 3.25pm to 122g/L at 7.40pm.

Prior to leaving the ICU, Dr Nel spoke with the anaesthetists and advised them to telephone the ICU at the Townsville Hospital for guidance regarding appropriate management. This was sensible advice given the limited experience of both anaesthetists in managing critically ill patients. It was accepted and acted upon.

Dr Ashraf spoke with Dr Parag Nalavade who was working in the ICU at the Townsville Hospital. Apparently Dr Tirumalai also spoke with Dr Nalavade during the course of the conversation. Dr Nalavade specifically enquired as to whether Ms Burgen's condition could be explained by blood loss and was informed that Dr Rowland was certain this had not occurred. Clearly any advice that Dr Nalavade provided was influenced by this assurance that Ms Burgen's treating surgeon was satisfied that there had been no post-operative bleed. A fluid therapy regime was recommended and the anaesthetists were advised to cease the Dobutamine and replace it with noradrenalin.

Following this telephone call, the nurses made a number of suggestions to the two anaesthetists regarding appropriate future management, including the need for Ms Burgen to be ventilated. By this time the nurses and Dr Tirumalai observed Ms Burgen to be agitated, anxious and in respiratory distress. Dr Ashraf accepted that such presentation is suggestive of a need for intubation but denied Ms Burgen exhibited such signs. I do not accept Dr Ashraf's recollection as accurate in this regard.

Mr Bohan-Shaw was very frustrated by the refusal of his quite reasonable request for intubation, "*I was at the end of my tether. I was really very concerned.*" While the anaesthetists were still in the ICU, he discreetly telephoned the emergency department and requested help from the doctor

working there. The doctor indicated that he could not interfere given the anaesthetists were in the ICU managing her care. Once again, the nurses were let down by the anaesthetists and Ms Burgen was not intubated prior to them leaving the ICU at around 10.30pm.

The nurses were also again left without any clear management plan. They were simply told to give Ms Burgen 250mls of fluid every hour until her blood pressure started to increase. Ms Burgen was clearly seriously unwell in that her systolic blood pressure was still below 100, her MAP was still below 70, her respiratory rate was 25 and her central venous pressure (CVP) was only 2 in circumstances where Dr Ashraf had specifically instructed the nurses that it was necessary to maintain her CVP at 6. The other concerning feature was that at 9.00pm Ms Burgen had been given 1 litre of Hartman's fluid and 1 litre of normal saline which had only produced a urinary output of 40mls over the ensuing hour.

Dr Ashraf gave evidence that when he left the ICU it was his understanding that Dr Tirumalai would remain with Ms Burgen. There does not seem to have been any basis for this assumption. When he left, Dr Ashraf did not consider that Ms Burgen was being appropriately managed with fluid replacement. He did not agree with the management plan that had been implemented by Dr Nalavade over the telephone but says he did not voice his concerns because of the hostile situation that existed between him and Dr Tirumalai. He felt that Dr Tirumalai had been "*misbehaving*" since the operating theatre and that he had "*disrespected*" him. It is concerning that these two doctors seem to have been unable to put aside their differences in the interest of providing optimal care to Ms Burgen.

Not surprisingly the nurses remained concerned about Ms Burgen's condition, particularly her low blood pressure. At approximately 10.45 pm, they asked Dr Hussain from the Emergency Department to review Deborah. It was apparent to Dr Hussain that she had impaired renal function and urine output and multiple organ failure. He telephoned Dr Tirumalai and asked him to review Ms Burgen for further management. Dr Tirumalai was at home at the time and instructed Dr Hussain to increase the fluids and indicated that he would review her in two hours. Dr Tirumalai gave evidence that he was in no doubt that Ms Burgen's condition was deteriorating but he did not want to go back to the hospital to review Ms Burgen because he was tired. This was inexcusable given what he knew about Ms Burgen's condition.

Nurses change-over – 11.00pm

At 11.00pm, the nursing shift changed and nurses Christine Brown and Catherine Pullinger came on duty. Ms Brown was a junior nurse and Ms Pullinger was primarily responsible for the nursing care provided to Ms Burgen until the conclusion of her shift on the following morning. She was an experienced nurse who had post graduate qualifications in intensive care nursing, two years experience at the Royal Brisbane and Women's Hospital ICU and two years

experience at the MIBH. Nevertheless, Mr Bohan-Shaw had been so worried about Ms Burgen and the lack of medical direction and support that he had received, that he remained at the hospital for about an hour to offer his assistance. Indeed, after he went home he called twice during the night to ascertain how Ms Burgen was progressing and came back to the ICU the next morning even though he was rostered off. It seems he slept very little that night.

From the beginning of this shift, Ms Burgen complained to the nurses that she was in discomfort and having difficulty breathing. The nurses found her to have cold extremities with almost no urine output. She had a MAP of only 52 compared to a more normal reading of 70 meaning that her internal organs were not sufficiently perfused with blood. This no doubt partly explained the minimal urine output; Ms Burgen's kidneys were not adequately supplied with blood to function correctly.

Soon after the change of shift the arterial line became dislodged. I expect this was a result of her becoming restless due to increasing hypoxia from the respiratory distress the nurses witnessed. When asked about this incident Dr Ashraf's said "*it must have been the nurses' fault".* I do not accept this and concur with Dr Brown that all of the nursing staff in the ICU did an outstanding job in trying to provide optimal care for Ms Burgen in what were undoubtedly very challenging circumstances.

The nurses did what they could to comfort Ms Burgen; adjusting her pillows and face mask in an effort to ease her breathing, holding her hand and talking to her about what they were doing.

When the arterial line came out, Dr Hussain was called to the ICU from the ED. He made arrangements for Dr Tirumalai to return to the hospital at about 12.15am. Ms Pullinger told Dr Tirumalai that not only did the arterial line need to be replaced, but also that she thought Ms Burgen required intubation. According to Ms Pullinger, Dr Tirumalai initially attempted to intubate Ms Burgen while she was awake and Ms Pullinger had to stop him and remind him that sedation was required. Dr Tirumalai requested Dr Ashraf to attend and Dr Ashraf requested Dr Rowland to attend. The anaesthetists phoned Townsville Hospital again and on this occasion spoke with Dr Matthew Holland in the ICU. He confirmed that intubation and replacement of the arterial line were required.

Ms Burgen was intubated by about 1.15am and the anaesthetists spent almost an hour trying unsuccessfully to reinsert the arterial line. This procedure was made difficult by Ms Burgen's exceedingly low blood pressure and weak pulse. They decided that they would return in the morning. They expressed the hope that they would have more success when Ms Burgen was *"warmer.*" An arterial line provides data essential for the monitoring patient's blood pressure and blood gasses.

By the time the anaesthetists left the ICU at about 2.15am, Ms Burgen's temperature had progressively increased between 7pm and midnight from 36.7 to 38.7. The last time blood pressure was able to be taken was at 12.50am, at which time it was 68/52 and her urine output had been negligible over the previous few hours.

The arterial line was not reinserted until about 4.20am. In the intervening hours the nurses' ability to monitor the patient and regulate her ventilation accordingly was seriously compromised; particularly as in this case Ms Burgen's blood pressure was so low that it could not be manually palpated.

Ms Pullinger gave evidence that she could not believe it when the anaesthetists left. She gave evidence of her despair and the wish that she could have done more but, as she put it *"short of throwing myself in front of the doorway I didn't really know what else I could say to them to stop them*." She said that after the two anaesthetists had left she was extremely distressed and was at a loss to know how to proceed. The nurses were left in a terrible situation with a seriously ill patient who was deteriorating further with no ready means of monitoring her vital signs and no care plan with parameters or intervention points. Nurse Pullinger said she stood at the top of the bed and said in desperation to her less experienced colleague, "*I have absolutely no idea what I'm going to do next*."

Dr Tirumalai conceded in evidence that he should not have left the ICU at this time. His only explanation for having done so was that he must have been tired. Dr Ashraf said he was also tired and that Ms Burgen was in a *"strict control situation".* Clearly she was not. It was incumbent on both anaesthetists to satisfy themselves that at least one of them was going to remain with Ms Burgen. Dr Rowland left before the anaesthetists . He said in evidence that he considered he did not need to remain as Ms Burgen was in the care of the anaesthetists. He also said in evidence that by this stage he had come to the view that Ms Burgen was suffering from irreversible septic shock and that she was beyond being saved.

The second MET call – 2.45am

Fortunately for Ms Pullinger, shortly after, Dr Holland from the Townsville Hospital telephoned the ICU to check on Ms Burgen's progress. When Ms Pullinger detailed the situation, Dr Holland advised her to call a medical emergency and to also call Drs Ashraf and Rowland.

Dr Nel again responded. Ms Pullinger told him that she was concerned that she and Ms Brown were not receiving any support from the senior medical staff in charge of Ms Burgen. Ms Pullinger also expressed the view that more senior staff members were required in an effort to get co-operation from the treating doctors.

The two anaesthetists and the surgeon were again called to the hospital. Dr Tirumalai discussed Ms Burgen's situation with Dr Holland in Townsville and

followed his instructions regarding the continued fluid infusions and delivery of inotropes via the central line. Shortly after this, Dr Ashraf again unsuccessfully attempted to replace the arterial line. At approximately 4.30am Dr Rowland surgically reinserted it. Discussion with Townville ICU continued and when it became apparent that Ms Burgen's condition was not improving, a decision was made to transfer her to the Townville Hospital.

Arrival of the Royal Flying Doctor Service

Dr Rowland left the ICU at about 5.00am and at about 5.40am, the Townsville Hospital Emergency Department Clinical Co-ordinator, Dr Jason Nebbs contacted Dr John Chalkey, the on-call night shift doctor for the Mt Isa Royal Flying Doctors Service and requested an urgent transfer.

Dr Chalkey arrived in the ICU at approximately 6.20am. At about 7.00am, the flight nurse arrived and Ms Burgen was moved onto the Royal Flying Doctor Service stretcher and the monitoring equipment was attached while her assessment and treatment continued.

Dr Chalkey was concerned that Ms Burgen was very unstable and not fit for transfer and for this reason contacted Dr Bowley, the Senior Medical Officer at the Mt Isa base of the Royal Flying Doctor Service and requested he attend the hospital.

Dr Bowley arrived at about 7.30am and assumed responsibility for Ms Burgen's care. Dr Gordon, ICU consultant at the Townsville Hospital, was telephoned and advised Dr Bowley about in flight management of Ms Burgen. Ms Burgen was also reviewed by Dr John Kellett, physician. He performed a bed side ultra sound which confirmed that Ms Burgen had a markedly elevated CVP and was fluid overloaded.

Dr Whitmore arrived at the hospital a little after 8.00am. She had initially been involved in Ms Burgen's care three days earlier and when informed that Ms Burgen was in the ICU, she went there to check on her progress. Dr Bowley informed Dr Whitmore that he was trying to stabilise Ms Burgen and the plan was to transfer her to Townsville Hospital. The nursing staff indicated to Dr Whitmore that they were extremely frustrated because they felt the treating doctors had not listened to the concerns they had raised, that Ms Burgen had not been appropriately managed and that the seriousness of her condition had not been communicated to her family.

Dr Whitmore was surprised that Dr Rowland was not in attendance and informed Dr Bowley that she was going to telephone him. Dr Bowley had been told by one of the nurses that Ms Burgen was "*riddled with cancer.*" He requested Dr Whitmore to ascertain from Dr Rowland the accuracy of this information because if she had a terminal prognosis, he would be disinclined to transfer her away from where her family could easily visit her.

Dr Rowland informed Dr Whitmore over the telephone that from his observations at the time of surgery, it appeared that Ms Burgen had a sigmoid carcinoma although he did not know whether her condition was terminal. Dr Whitmore also recalled Dr Rowland instructing her not to be too pessimistic when speaking with the family as *"he felt there was still a chance".* Ms Whitmore considered this advice to be *"outrageous"* given Ms Burgen's condition. Dr Rowland had no recollection of the telephone call. I accept Dr Whitmore's evidence of it.

Dr Rowland attended the ICU between 8.00 and 8.30am. Ms Raitilla who had taken over the nursing care of Ms Burgen, recalled Dr Rowland going to Ms Burgen's bedside, lifting up the blanket and commenting that her feet were warm and that she would be alright. Dr Bowley gave evidence that Dr Rowland picked up the sheet, made some comments about Ms Burgen's feet still being warm, the fact that she was still passing urine and that Dr Rowland considered these to be good signs. Dr Bowley also attempted to clarify with Dr Rowland his opinion regarding the cancer diagnosis but felt that Dr Rowland was unable or unwilling to give him a clear answer. Dr Rowland did not recall having either of these conversations and considered it was unlikely that he would have made encouraging comments regarding Ms Burgen's chances of survival. I consider the recollections of Ms Raitilla and Dr Bowley with respect to these conversations to be more reliable.

Dr Rowland did not have any further involvement in Ms Burgen's care.

Deborah Burgen dies

Dr Bowley telephoned Dr Gordon again and he indicated that Ms Burgen had a very poor prognosis and was unlikely to survive the transfer. He recommended that she be provided with palliative care. Dr Tirumalai attended at the request of Dr Bowley but was unable to offer any suggestions as to her future management. Dr Bowley spoke with Ms Burgen's family and informed them that she was too sick to be transferred and suggested that they spend some time with her.

Ms Burgen passed away at about 10.10am.

Ms Burgen's death was reported to police and the investigation described earlier commenced. Due to the remoteness of Mt Isa and the volume of work at the John Tonge Centre, the autopsy was not undertaken until four days after the death. While this delay was undesirable, I am nonetheless satisfied that the evidence gathered at autopsy was reliable.

Critique and comments concerning post operative care

As detailed earlier, Dr Rowland, did not and still does not accept that Ms Burgen's deterioration post operatively was due to internal bleeding. He said that he considered and rejected the possibility. All of the experts who gave evidence refute his opinion in this regard.

Dr Stevenson also rejected Dr Rowland's suggestion that blood pooling in the part of the colon that was removed could explain significant blood loss.

Dr Brown did not accept the factors suggested by Dr Rowland adequately explained the rapid and significant fall in Ms Burgen's haemoglobin level in the hours after the operation. In his view, together with the low central venous pressure, this suggested low circulating blood volume or hypovolaemia. This was most likely caused by internal bleeding; indeed in his report to the court Dr Brown said that these symptoms ***"****should have suggested intra-abdominal bleeding as a first consideration."*

As the evening progressed and numerous units of blood and fluids were transfused into Ms Burgen, there were, in Dr Brown's view, only two possibilities to explain her parlous condition: septic shock or internal bleeding. He said it was, inexcusable to dismiss the possibility of bleeding without thorough investigation which almost certainly necessitated re-opening the wound and checking the operation site. When the consequences of not doing something are life threatening, a clinician has to be very certain that the action is not required. In this case Dr Brown said *"I don't think Dr Rowland got anywhere near the degree of certainty required to exclude haemorrhage, and Dr Rowland was in charge. This was his patient.*"

Dr Brown, Dr Kruger and Dr Stevenson all acknowledged that it can be difficult to distinguish between septic shock and haemorrhagic shock. It was put to Dr Brown that although in hindsight Dr Rowland was wrong to have concluded and acted upon the accuracy of his assessment that Ms Burgen was suffering only from septic shock it was a conclusion reasonably available to him. Dr Brown rejected that suggestion in the strongest terms.

> *No I think that is outrageous, I think that's wrong, I don't agree, I don't use hindsight I mean I could show this to a medical student 'what do you think might have happened' and they would say 'haemorrhagic shock'; I am not inclined to agree I don't it's – all the signs are there look at what the nurses said, look at the JVP (jugular venous pressure). Look at the amount of blood she was given. Look at what happened. She went down and down and down and down into irreversible shock. If you didn't consider bleeding you would have to ask yourself 'what on earth was I thinking' no I don't agree I can't agree with that*.

In explaining his rejection of the suggestion that Ms Burgen was primarily suffering from septic shock Dr Brown said, "*of course sepsis is possible although I don't think it fits at all well. I just don't know where all the blood's going. How do you explain 9 units of blood?.... That's 3½ litres - incidentally, what was found in her belly.* "

Not only did Dr Rowland refuse to re-open the operation site, he did not even take other basic precautions such as close monitoring of the fluids in and urine out that may have alerted him to what was happening. Submissions made on Dr Rowland's behalf seek to excuse his failure to have sufficient regard to the inability of extensive fluid therapy to address Ms Burgen's falling blood pressure. They suggest poor record keeping denied him this information. That is nonsense. He had only to ask the nurses to be informed of what fluids she had received.

There were numerous points at which the decision not to go back to theatre should have been revisited and proper investigation undertaken. Indeed Dr Nel and Dr Shah urged this course but Dr Rowland remained obstinate.

In Dr Brown's view there was "*overwhelming information staring Dr Rowland in the face; 9 units of blood, no response to fluids, no response to inotropes. You have to say to yourself, 'my goodness, you have to go back to theatre.'"*

Both Dr Stevenson and Dr Brown were asked to comment on each of the factors on which Dr Rowland relied to dismiss internal bleeding as the cause of Ms Burgen's deterioration. Both rejected them as a basis for so doing. In Dr Brown's opinion, "*Nothing Dr Rowland did enabled him to exclude bleeding….His reasons were totally flawed and totally inadequate."* According to Dr Brown this "*was an error in management that would have a cataclysmic and catastrophic outcome."*

Both of these specialists recognised that re-operating on a patient as seriously unwell as Ms Burgen clearly was by the time of the first MET call at 7.20pm is dangerous. However, both were also adamant that it was the only way to respond to internal bleeding which was almost certainly the cause of her rapid deterioration.

Both Dr Brown and Dr Kruger were concerned that there seemed to be no real medical leadership in the intensive care unit. Dr Kruger echoed the complaint of the nurses when he wrote in his report to the court *"While this lady was cared for in the ICU post operatively no clear plan for this (was) documented."*

Dr Brown was particularly critical of the decision of the anaesthetists to abandon attempts to reinsert the arterial line when it became dislodged at 11:45 pm. He said of their abandonment of this attempt with the stated intention to return in the morning to try again:

> *That's just mind-boggling. That's just unbelievable. That's just such a poor and inappropriate – it's like saying 'well the patient is so sick if I go away they might get better without me'. Well that's just not on. That's just not how intensive care is. That's not how you manage sick patients. The nurses were saying she was sick. Every aspect of her clinical condition was going worse. You can't say, 'because I can't monitor this person with an arterial line I think I will leave it till the morning.' That is just not on.*

The submission by Dr Ashraf's lawyers that; "*the sad circumstances of this case simply highlight the difficulties faced by citizen's who live in remote areas of Queensland"* suggests that they and/or their client have not yet grasped the magnitude of his failings.

Dr Brown noted that Dr Ashraf was apparently the Director of Anaesthesia and Intensive Care but neither he nor Dr Tirumali had post graduate training in anaesthesia that would be recognised in Australia. In his view, they should have been supervised by a specialist anaesthetist.

In the circumstances, Dr Brown considered that Dr Rowland was primarily responsible for caring for Ms Burgen. He was the senior doctor with the greatest experience. "*Dr Ashraf and Dr Tirumalai were way out of (their) depth. Their contribution was miniscule and inappropriate. The nurses were crying out for someone to take the case seriously and get on with it and it was really just a poor outcome*."

The effect of all of the expert opinion is that Ms Burgen was most probably suffering from hemorrhagic shock that could only be adequately treated by operating on her again. As the evening progressed, sepsis also probably intensified; when this was inadequately managed, falling blood pressure would have diminished her coagulation and this would have exacerbated the intra-abdominal bleeding.

As with the decision as to when the operation should have been undertaken, Dr Rowland again tried to down play his responsibility for Ms Burgen' post operative care seeming to suggest that he was called back to the ICU in only a subsidiary role to support the anaesthetists. This is of course baseless. He was the surgeon who had to decide whether a further operation was necessary. As Dr Brown said; *"There's only one person who can deal with the haemorrhage." W*retchedly, that person shirked his responsibility.

The performance of the ICU nurses

From the time Deborah came to the ICU, until she died approximately 19 hours later, she was primarily cared for by two shifts of nurses comprised of four women and one man. The training and experience of these nurses differed: it ranged from the traditional, hospital based, vocational training of Mr Bohan-Shaw who had been registered for eight years, to the post graduate, specialist, ICU qualifications of Ms Pullinger, who had been registered for only four years to the more limited training and experience of Nurse Brown. What did not differ was their professionalism, their dedication and their compassion.

It was suggested by Dr Ashraf that on occasions some of the nurses were less than fully co-operative; that they kept telling him what he already knew; that they

caused the arterial line to come out and that they failed to show him sufficient respect. He even suggested that they should have offered him a cup of tea rather than unnecessary advice.

Both Dr Brown and Dr Kruger said that the concerns articulated by the nurses who complained of being left with an inadequate care plan and inadequate means of monitoring Ms Burgen vital signs were valid. Dr Brown emphasised the importance of listening to nurses who are the primary carers in an ICU setting; "*its very foolish to ever ignore the nurses.*" He also pointed out that, as in this case, it is the nurses who have the continuous contact with the patient that places them in the best position to understand what is needed. *"I think the critical care is actually provided by the nursing staff. They never leave the patient's bedside and they have enormous clinical experience."*

Dr Brown said that the nurses were correct to suggest that Ms Burgen should have had a central venous line inserted when she came into the ICU and that she should have been ventilated much sooner than she was.

At times the nurses involved in caring for Ms Burgen were confronted with squabbling doctors giving contradictory instructions; at other times, they were simply left alone with a patient who urgently needed specialist attention.

In my view, none of the criticism of the nurses by Dr Ashraf has substance. The nurses were undoubtedly and justifiably distressed by what they observed in the ICU on the night in question. It may be that they allowed their frustration to manifest itself in their manner of speech but in my view, that is entirely understandable. They fully appreciated the dire condition that their patient was in; they demonstrated compassion and professionalism in their attempts to get help for Ms Burgen and they were distressed by the failure of the surgeon and the anaesthetists to adequately respond. They took all the clinical steps they could to assist her; they comforted her to ease her aguish. When it became apparent that Ms Burgen was likely to die, it was the nurses who ensured the family was informed.

I agree with Dr Brown's assessment when he said, *"I think they were absolutely outstanding in their care and in their concern."* I am of the view that all of the nurses who cared for Ms Burgen performed admirably, in very difficult circumstances.

I consider they exemplified to the values and standards of a caring profession and continued to struggle to try to get for Ms Burgen the care she so desperately needed. They were terribly let down by the treating doctors of whom they were entitled to expect more. I have no doubt that all of the nurses involved were severely distressed by their inability to secure for their patient the medical intervention they knew she needed. I consider they were secondary victims of this calamity and I offer them my condolences.

Expert evidence concerning the cause of death

A post mortem examination was performed by Dr Davis, pathology registrar, at the John Tonge Centre on 3 March 2005. The examination was supervised by Dr Ong, consultant pathologist although he was not present for the duration of it. The autopsy findings relevant to the cause of death were:-

- three litres of blood in the abdominal cavity;
- two patent stomas;
- extensive peritonitis; and
- a blood vessel, three millimetres in diameter, that emerged from the omentum and was free at the other end in the abdominal cavity.

It is pertinent that before the operation Ms Burgen weighed 89kgs: at autopsy she weighed 120kgs, reflecting the gross fluid overload that occurred during the failed and misguided attempts to address what was thought to be septic shock.

Dr Davis expressed the following opinions:

- While the three litres of blood may have contained some lavage fluids and other non blood fluids, the majority of it was blood and comprised a significant blood clot.
- The blood had collected in the abdominal cavity pre and not post mortem.
- It was not possible to ascertain the significance of the small, un-ligated blood vessel as the severity of the peritonitis had rendered the tissues vulnerable to tearing.
- The volume of blood found on autopsy was sufficient to have caused Ms Burgen's death.
- The source of the bleeding could not be identified.
- Septic shock due to peritonitis almost certainly also contributed to the death but was not the primary or proximate cause of it.

Dr Kruger and Dr Hack expressed the view that there was almost certainly severe post operative bleeding early in the evening. That was complicated later in the evening and early in the next morning by coagulopathy caused by organ failure brought about by continuing very low blood pressure and sepsis. In their view, the severity of these conditions were contributed to by the failure of the clinicians to adequately manage the developing crisis: a failure to respond to the intra-abdominal bleeding, a failure to adequately ventilate the patient, and a failure to use appropriate inotropes and antibiotics, all contributed to the hemorrhagic and septic shock worsening.

Findings – time, place and cause of death

I am required to find, as far as is possible, who the deceased was, when and where he died, what caused the death and how he came by his death. I have already dealt with this last issue, the manner of the 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.

Identity – The deceased person was Deborah Burgen

Place of death – She died at the Mount Isa Base Hospital in north western Queensland

Date of death – Ms Burgen died on 28 February 2005

Cause of death - She died from intra-abdominal haemorrhage, septic and hemorrhagic shock as a result of a laparotomy, peritonitis and a large bowel colostomy.

Was the death preventable?

The effect of all of the evidence was that had Ms Burgen been operated on before the obstruction caused her large intestine to perforate, her chances of surviving the procedure were quite good. It is the case that she had a cancer in her colon but this was removed by the surgery Dr Rowland undertook and it is likely that the mass on her kidney could also have been removed.

Once the perforation had occurred some degree of peritonitis was inevitable and Ms Burgen's post operative management was therefore critical. However, the weight of the expert evidence is that even with this complication, had she been properly monitored and the various forms of post operative shock properly responded to Ms Burgen had at least a 50% chance of surviving. As the internal bleeding was allowed to go unchecked, the peritonitis and other adverse complications were made more severe and more difficult to treat.

Ms Burgen should not have died. It is therefore important that I attempt to identify the factors that contributed to that terrible outcome with a view to obviating them.

Summary of errors that contributed to Ms Burgen's death

I have summarised the evidence of what occurred in this case and the views of the independent experts consulted in relation to it in more detail than is usual because I considered that this was necessary to ensure that those who read the findings could judge for themselves whether my conclusions were warranted. It may be convenient to set out in short form the conclusions I consider require some further response, either in the form of recommendations designed to address systemic failings or by referring the conduct of individuals to prosecuting or disciplinary bodies.

- Queensland Health did not adequately scrutinise the qualifications and experience of Dr Ashraf and Dr Tirumalai before recruiting them.

- The Medical Board of Queensland did not adequately scrutinise the suitability of Dr Ashraf and Dr Tirumalai before registering them to practice.

- MIBH clinical managers failed to provide Dr Ashraf and Dr Tirumalai with any orientation in relation to the policies and procedures at the Mt Isa Base Hospital and failed to have their scope of practice delineated by a credentialing and privileging committee in a timely fashion.

- None of the doctors who saw Ms Burgen on the 6 occasions that she attended the MIBH Emergency Department between 16 and 25 February adequately responded to her complaint.

- By failing to operate on Ms Burgen for two days after her emergency admission, Dr Rowland allowed her large intestine to perforate.

- Dr Rowland, Dr Tirumalai and Dr Ashraf did not adequately care for Ms Burgen's post operatively: they failed to ventilate her in a timely way, they failed to have in place appropriate vascular lines to assist in her management, they failed to adequately monitor her condition and they failed to give adequate guidance and support to the nurses.

- Most seriously, Dr Rowland failed to adequately investigate the possibility of internal bleeding.

- Dr Rowland did not adequately inform Ms Burgens' family of her deteriorating condition.

- My attempts to investigate the death were hindered by the failure of senior medical practitioners involved in Ms Burgen' care and the hospital managers to adequately respond to repeated requests for information about the incident during the investigation and preparation for the inquest.

Concerns, comments and recommendations

Section 46 provides that a coroner may comment on anything connected with a death that relates to public health or safety, the administration of justice or ways to prevent deaths from happening in similar circumstances in the future.

That requires the coroner to consider whether the death under investigation was preventable and/or whether other deaths could be avoided in future if changes are made to relevant policies or procedures.

Coroners, of course, do not have the expertise that would enable them to rely on personal knowledge when approaching this task; they rely on the evidence of medical specialists with qualifications and experience in the relevant field. As has already been mentioned, in this case I was greatly assisted by the reports and oral evidence of Dr Andrew Stevenson, Dr Anthony Brown and Dr Peter Kruger. I had no hesitation in accepting that their expertise ideally equips each of them to offer insightful opinions and critique of the management of Ms Burgen's case. I do not accept the suggestion contained in some of the submissions that these city based specialists were unfairly comparing the performance of their rural colleagues with a standard that might be reasonable to expect in a tertiary hospital but that was unattainable in a remote facility. It is apparent that the independent experts were careful not to do this and indeed, they were at pains to explain the differences.

I have no doubt that publicly criticising the performance of a fellow practitioner is not something that any of these senior specialists enjoys doing. However, their commitment to improving the quality of health care and patient safety outweighs such discomfort and I am persuaded that the evidence each gave was impartial and considered. It is apparent that each of these busy professionals devoted considerable time to preparing their reports and preparing for the giving of oral evidence. I am very grateful for their generosity in this regard.

I shall now deal with the systemic issues

Access to hospital information

As indicated earlier in these findings, my investigation of Ms Burgen's death was hindered by a lack of co-operation from various medical practitioners and hospital managers. This was not the first occasion on which I and local coroners have had to deal with passive obstruction of this nature. The *Coroners Act 2003* empowers coroners to compel the production of documents and the provision of information but I have been reluctant to enforce these coercive powers against health practitioners, believing, naively perhaps, that professionals involved in a sudden death would willingly assist an investigation of it.

I have expressed my concern and frustration to the Director General of Queensland Health and she has always responded positively. However an *ad hoc, post facto* response is obviously less than desirable. I am therefore grateful that the Executive Director Clinical and State-wide Services and the Director of the Patient Safety Centre have assumed responsibility for addressing this and related problems in a systematic fashion. In view of this initiative I shall refrain from making any specific recommendations for legislative or administrative reform, pending the outcome of that project.

Recruitment, orientation and credentialing

There is no basis to suspect that doctors trained in countries other than Australia are any less competent than those trained here; indeed the public health system of this country is reliant on the thousands of expert practitioners who have trained in other places and come to Australia to work.[10] I would like it to be clearly understood that I consider the Australian public are indebted to foreign trained doctors, who in the vast majority of cases serve us very well. Many of those doctors have obtained general registration which requires their qualifications and skills to be assessed to meet standards set by the Australian Medical Council in the same way an Australian medical graduate does when seeking to be registered.

However, the *Medical Practitioners Registration Act 2001* also creates another pathway for registration for those seeking to practice in a geographic region that the Minister for Health has decided is "*an area of need.*" This assessment is made on the basis that there are insufficient medical practitioners practising in that area to meet the needs of the people living there. Prior to Ms Burgen's death, Mt Isa had been stipulated to be such an area and Drs Rowland, Ashraf and Tirumalai were registered under the area of need regime.

Because such registration is not dependent upon the doctor meeting the Australian Medical Council standards it is essential that the employer, in this case Queensland Health, and the Medical Board ensure that the proposed registrant has appropriate qualifications and experience for the position under consideration.

For the reasons set out below, I am of the view that in relation to Dr Ashraf both organisations failed to do this.

After Ms Burgen's death, the capabilities of the Dr Ashraf were reviewed by a senior staff intensivist from Townville Hospital, Dr Gordon, who found that he had "*acceptable anaesthetic skills"* but "*no management or leadership skills."* Even more alarming was the assessment of Dr Ashraf's ability to care for patients who were seriously ill:-

> *He has never had formal training in intensive care….He has never practised in a 'closed' ICU and admits that the care expected in ICU in Australia is beyond him. I believe at best he is currently functioning at the level of a competent very junior registrar in ICU…(he) has no knowledge of contemporary intensive care practice. Dr Ashraf is NOT equipped to work in the critical care environment in Mount Isa.*

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[10] It is beyond the scope of these findings to question whether it is morally defensible for a country as wealthy as Australia to expect poorer countries to bear the burden of training medical practitioners and then poach them from those countries, many of which have a desperate shortage of doctors.

This of course raises the questions: why was Dr Ashraf employed as the Director of Anaesthetics and the ICU at MIBH; why did the Medical Board of Queensland register him to practice in this position; and why were his limitations not identified sooner?

Part of the answer lies in the very high turn over in key positions at the hospital. The positions of district manager and the Medical Superintendent, for example, seem to have been occupied by acting or short term appointments for some years leading up to this incident.

For many years, the MIBH has had difficulty attracting and retaining experienced practitioners in all specialties including anaesthetics. Indeed prior to employing the anaesthetists involved in this case, the hospital had depended upon the services of 22 successive locums, it being some years since they had retained permanent staff in these positions. One of the managers even referred to Dr Ashraf as the first permant anaesthetist at MIBH.

In December 2003, as a result of a number of complaints by ICU nurses at MIBH a review of the unit was undertaken by the Townville Hospital Director of ICU, Dr Corcoran and the Clinical Nurse Consultant ICU, Mr Finnigan.

The problems they found bear striking similarities to shortcomings that contributed to the mismanagement of Ms Burgen's case, namely, confusion as to the role of the anaesthetists in the ICU. The nurses believed the senior anaesthetist then working at the MIBH was the Director ICU but that practitioner, while happy to supply some ICU services of a technical nature, did not feel that it was among his duties to assume full control of the ICU. He believed that the patient should remain under the direct care of the admitting specialty.

One of the recommendations of the Corcoran review was the formal establishment of the position of Director of Critical Care who would not be primarily responsible for directing the clinical care of the patients but rather for co-ordinating resource allocation and policy development. The review also recommended that the responsibilities of those involved in admitting and managing patients within the ICU be clarified. It also suggested the hospital consider down grading the unit from a level 3 ICU to a High Dependency Unit. This would mean more complicated cases that were likely to require ICU post operative care would be transferred to a tertiary hospital like Townsville.

Obviously, none of these steps were taken and indeed the District Manager at the time of Ms Burgen's death, who joined the hospital a couple of months after Dr Corcoron's review, had never seen it until shown it during the course of this inquest.

Dr Ashraf was employed as the Director of Anaesthetics and the ICU but only registered as a senior medical officer. When the Medical Board queried this initially, the hospital conceded that he could not be registered as a specialist. Some months after Ms Burgen's death when the hospital was seeking to extend Dr Ashraf's registration he was again referred to as a director. When queried, the then Medical Superintendent, Dr De Cean, advised the Medical Board that this title was only for administrative purposes and had no clinical significance; a perspective not shared by the ICU nurses nor the other anaesthetist.

It appears Queensland Health's recruitment policies were followed, at least in form if not in substance, and Dr Ashraf was employed from August 2004. Some referee checks were made but no inquiry seems to have focussed on his ability to care for critically ill patients. He received no orientation or introduction other than an informal walk around the hospital and basic, personal introductions. He commenced work on the afternoon he arrived in Mount Isa without any assessment of his competence.

Soon after he arrived, he explained to the Medical Superintendent that he was not experienced in being responsible for, or in charge of critically ill patients, but that he could attend to the technical aspects of ICU operations that related most directly to anaesthetics.

Dr Ashraf's employment contract indicated the he would be subject to a three month probation period and receive professional supervision and development. None of these things happened.

Further, Queensland Health policy required that all medical practitioners have their credentials and clinical privileges reviewed by a committee of appropriately qualified practitioners. This process was designed to ensure that the scope of practice of doctors working in public hospitals is commensurate with their level of competence and expertise. Dr Ashraf did not undergo this process until February 2005 when he had been employed at MIBH for six months. When the process was undertaken it did not seek to assess his competence in critical care. As we now know, any searching inquiry in this regard would have quickly established his severe limitations in this area of practice.

The *Medical Practitioners Registration Act 2001* in s135 imposes on the Medical Board the obligation to determine whether an applicant has qualifications and experience suitable for practising in the area to which he/she is being recruited. In the case of Dr Ashraf, the Board purported to discharge this obligation by reviewing his written application and by a delegate having a brief conversation with him. The delegate acknowledged that this "interview" was essentially a formality undertaken after the Board had already determined the applicant's suitability. No inquiry was made as to his duties at MIBH and no inquiries were made as to whether he had the necessary experience to undertake these duties. The Board

has power to impose conditions on a registrant but did not exercise it in relation to Dr Ashraf.

The submissions on behalf of the Medical Board point to its high work load and the ability of applicants to challenge the Board's decisions.

I accept that these concerns are valid. However, the Board is charged by the statute which creates it to protect the public and uphold the standards of practice within the profession. It is obliged to ensure that registrants are capable of delivering safe and competent health care. These obligations are not relaxed or obviated just because the applicant is being employed under the area of need regime.

In my view, the Board patently failed to discharge its statutory obligations in relation to the registration of Dr Ashraf. It acted as little more than a rubber stamp on the process which it left to Queensland Health to administer. It seems Queensland Health had allowed its quality assurance processes to degrade to such an extent that there was little if any scrutiny of applicants. It also seems likely that this was contributed to by the extreme and ongoing difficulty the hospital experienced when seeking to fill senior positions at MIBH.

The submissions made by some of the parties seem to suggest that such are the difficulties of providing medical services in remote areas that the residents of those places must accept substandard practice. I reject that approach. Of course the level of services can not be the same in a remote area as in a tertiary hospital but that does not excuse a facility for holding itself out as able to deliver services that its practitioners are clearly not competent to perform.

Ms Burgen died before the Davies Commission of Inquiry into public hospitals shone its search light onto the difficulties surrounding the recruiting and supervision of overseas trained doctors to areas of need. Queensland Health and the Medical Board contend that the reforms initiated as a result of that inquiry and the Forster review have addressed the deficiencies that allowed those problems to proliferate. It is patently obvious that the managers of the MIBH did not heed the very sound suggestions of Dr Corcoran; it remains to be seen whether the recommendations of Messrs Davies and Forster are effectively implemented.

Locally, the appointment of experienced and dedicated people to the position of District Manager and Executive Director Medical Services, Ms Suzanne Sandral and Dr Greg Coffee, respectively, give cause for optimism that the delivery of services will be better managed at the MIBH henceforth. Certainly, major changes in policies concerning orientation, training and rotation of staff, review of mortality and morbidity, and the transfer of patients to more major centres evidence a concerted effort to address the failings that contributed to Ms Burgen's death.

However, policies existed in relation to all or most of those matters at the time of the debacle which resulted in Ms Burgen's death. What is needed in my view is a rigorous mechanism for ensuring those policies are adhered to and that individuals can not blithely claim that they are too busy or are unaware of their responsibilities in this regard.

Recommendation 1 – Audit and accountability for quality processes

I recommend that Mt Isa Hospital managers develop a system by which they can ensure that the policies that were ignored in this case are periodically audited for compliance and that they implement a process that ensures that those who do not discharge their responsibilities under such policies are held accountable.

Triaging of emergency department patients

As mentioned earlier, Ms Burgen was finally admitted on her sixth presentation to the MIBH Emergency Department in eleven days. On each occasion the symptoms she reported to the five different doctors she saw were much the same. On each visit some test or investigation was commenced but on none of them were the results obtained, considered and acted upon. In fact, until she was operated on 13 days after first presenting, Ms Burgen received no treatment at all; she was merely managed or processed by a system that seemed to have too little focus on making sick people better.[11]

This approach to managing patients presenting to the emergency department was explained as an unavoidable consequence of high demand and limited resources. It was suggested the emergency department of the MIBH was used as a general practice clinic by many local residents and that protocols utilised in metropolitan emergency departments were not apposite. For example, it was said that on occasions up to 140 patients could seek assistance from the ten bed emergency department on a single day and that they averaged 80 to 100 patients per day.

I accept the difficulties that this may have created for the hospital but according to Dr Brown, Ms Burgen's case was a "*true emergency*"; it was not a regular general practice presentation. According to Dr Brown, such acute pain as she was experiencing is an emergency and should have been dealt with accordingly, namely, by admitting the patient until its cause could be identified and addressed.

I do not consider the junior doctors who failed to adequately diagnose or treat Ms Burgen's symptoms should be held responsible for this. They were given inadequate support and assistance. Moreover, they were complying with a

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[11] This approach is alarmingly similar to the "*buffing and turfing*" described in the dark, satirical review of a fictional New York City hospital, the House of God; but even the desperate 'terns who struggled to keep that place functioning while *slurping* their way to the top, only practiced it on patients with some many co-morbidities that a cure was beyond reach. See, S. Shem, *The House of God*, London, Black Swan Books, 1985, p59

system whereby routinely specimens were taken for testing and the patient sent away and told to return to the "*results clinic."* Inadequate triaging failed to distinguish a patient who should instead have been admitted.

Dr Brown suggested that the MIBH should institute protocols that ensure:-

- All emergency blood tests and scans are done immediately and the results provided on the same day;
- Any patient who attends twice for the same condition are seen by a senior doctor; and
- Any patient who attends twice with the same symptoms and the diagnosis remains unclear are considered for immediate admission.

I am of the view that some changes along these lines are urgently required. I am also conscious that extensive work has been done within the health care sector in relation to these issues and that it would be inappropriate of me to make a prescriptive recommendation.

Recommendation 2 - Triaging of E.D. patients

I recommend that the clinical managers of the MIBH review the manner in which patients presenting to the emergency department are triaged to ensure that the failures of the pre-admission care exemplified by this case are eliminated.

Substandard performance of clinicians

I have detailed substandard performance by a number of medical practitioners: some of it prolonged and persistent, other, isolated instances. I have found that the death was a result of this inadequate medical care. When determining the response to this aspect of the case it is appropriate, in my view, to consider the underlying causes and levels of personal culpability.

I readily acknowledge that there is no evidence that any of those whose conduct has been criticised acted with malice towards Ms Burgen. Indeed it is unlikely that it could be proved that the doctors were guilty even of callous disregard for her welfare. Some argue that in these circumstances the focus should not be on individual responsibility but rather on *systems issues*. It is suggested that to err is human and that those seeking to eliminate errors should examine the contexts in which they occur; that blaming individuals will reduce the likelihood of an open and transparent analysis of the contributory factors that will need to be addressed if outcomes are to improve.

With all due respect to those of that view, I do not believe that the response to iatrogenic death needs to be so dichotomous – punish deliberate harm and seek remedial response to everything else. In my view, it is always appropriate to identify and respond to contextual factors that have contributed to an adverse outcome but at the same time negligence, incompetence and errors of judgement can warrant individuals being held personally accountable. This is consistent with

the criminal law which recognises that manslaughter does not necessarily involve any intentional harm and the *Health Practitioners (Professional Standards) Act 1999* which authorises the taking of disciplinary action against doctors who demonstrate a lack of skill, judgement or care.

I have already dealt with the lack of experience and skill of the two anaesthetists in the section dealing with recruitment and credentialing. Responding systematically to the surgeon's shortcomings is more difficult as he was appropriately qualified, experienced and his scope of practice had been assessed and confirmed. In my view, his standard of treatment is only likely to have been improved had he contemporaneous access to a more senior or skilful surgeon.

I am aware Queensland Health has attempted to set up clinical networks to make such assistance available and indeed in this case, advice was willingly proffered by clinicians in the Townsville Hospital ICU. However, the assistance those doctors could offer was constrained by the misdiagnosis that Dr Rowland stubbornly stuck with throughout the night. Were they able to view the patient and make their own assessment of her condition, it is possible that they may have been able to be more interventionist. In the past Townsville specialists have regularly travelled to Mt Isa to provide health care services. I am unaware of why this has been discontinued. It may be that increased demand in Townville prevents it. Further, it may be that advances in technology make it less necessary

Recommendation 3 – Tele-medicine

Queensland Health has for some time been investigating the establishment of video links to enable the practice of telemedicine in various remote locations. I understand the technology to enable this to happen in Mt Isa already exists. I recommend that that this be pursued as an urgent priority.

Referral to the DPP

The Coroners Act by s48 requires a coroner who, as a result of information obtained while investigating a death, "*reasonably suspects a person has committed an offence,"* to give the information to the appropriate prosecuting authority.

I take "*committed an offence*" to mean that there is admissible evidence that could prove the necessary elements to the criminal standard.

I have found that the death of Ms Burgen was caused or contributed to by the inadequate medical care she received at the MIBH. I am required therefore to consider whether the information gathered during the proceedings should be referred to the DPP.

The Criminal Code in s291 provides that it is unlawful to kill anybody unless it is authorised, justified or excused by law. Such killings are either murder or manslaughter.

There is no evidence suggesting any of those involved in caring for Ms Burgen deliberately set out to harm her. That excludes the possibility that anyone could be guilty of murder, which, in so far as is relevant to this case, requires proof that the accused intended to cause death or grievous bodily harm.[12]

Any person who unlawfully kills another in circumstances which do not constitute murder is guilty of manslaughter.[13]

Section 288 of the Code needs to be considered. Insofar as is relevant to this case, it provides:-

> *It is the duty of every person who…undertakes to administer surgical or medical treatment to any other person,… to have reasonable skill and to use reasonable care in doing such act, and the person is held to have caused any consequences which result to the life or health of any person by reason of any omission to observe or perform that duty.*

I am of the view that there is a substantial body of evidence indicating that Dr Gallery, Dr Tirumalai, Dr Ashraf and Dr Rowland either did not have reasonable skill or did not use reasonable care at all times when they were responsible for the care of Ms Burgen. I am therefore required to consider whether their departure for those standards was so gross as to amount to criminal negligence and whether the death of Ms Burgen resulted from such failure.

On their face, the words of s288 are redolent of civil negligence – "*reasonable care", "breach of duty"* - but the courts have consistently and understandably held that to be criminally liable the prosecution needs to prove a more blameworthy departure from the expected standards than is required by a plaintiff seeking civil redress. The classic judicial articulation of this difference is found in *R v Bateman* where Hewart LCJ said:-

> *In explaining to juries the test which they should apply to determine whether the negligence in the particular case amounted or did not amount to a crime, judges have used many epithets, such as "culpable", "criminal", "gross", "wicked", "clear", "complete". But, whatever epithet be used, and whether an epithet be used or not, in order to establish criminal liability the facts must be such that, in the opinion of the jury, the negligence of the accused went beyond a mere matter of compensation between subjects and showed such disregard for the life and safety of others as to amount*

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[12] s302(1)(a)
[13] s303

> *to a crime against the State and conduct deserving punishment … It is desirable that, as far as possible, the explanation of criminal negligence to a jury should not be a mere question of epithets. It is in a sense a question of degree and it is for the jury to draw the line, but there is a difference in kind between the negligence which gives a right to compensation and the negligence which is a crime.* [14]

I am of the view, that it could not be proved to the criminal standard that the departures from the appropriate standards by the doctors in this case was of this magnitude. I don't believe it could be shown that any of the doctors disregarded Ms Burgen's welfare in circumstances in which they knew that by so doing they were placing her life at risk. I am of the view that in the main they made errors of judgment, laboured under a lack of skill and knowledge and/or failed to apply themselves with sufficient diligence. While these failures in combination led to a death, I do not consider a charge of manslaughter would have reasonable prosects of resulting in a conviction.

Further, before I could "*reasonably suspect a person has committed an offence",* I would need to be satisfied that there is a sufficient causal link between a particular breach of duty committed by an individual doctor and the death of Ms Burgen. In this case it was a succession of failures that led to the death, rather than a discrete incident or action. The doctors were not acting in concert but the failures of each contributed to a chain of events that ended in Ms Burgen's death. I do not consider that any individual, alone should be held criminally responsible for the death.

Accordingly I find that there should not be a referral to the DPP.

Referral to the Medical Board

So far as is relevant to this case, the Act provides in s48(4) that a coroner may give information about a person's conduct to a disciplinary body for the person's profession if the coroner believes the information might cause the organisation to take steps in relation to the conduct.

The Medical Board of Queensland considers complaints and information about health care practitioners pursuant to Part 3 of the *Health Practitioners (Professional Standards) Act 1999.* When considering whether to take action, the Board considers whether the available information appears to provide grounds for disciplinary action against a practitioner registered under the Act as set out in s124 of the Act. Such grounds include "*unsatisfactory professional conduct*" which, insofar as may be relevant to this matter, is defined as:-

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[14] *R v Bateman* (1925) 94 LJKB 791; [1925] All ER Rep 45; (1925) 19 Cr App R 8

- *Professional conduct of a lesser standard than might reasonably be expected of the registrant by the public or registrant's professional peers; and*
- *Professional conduct that demonstrates incompetence or lack of adequate skill, judgment, or care in the practice of the registrant's profession.*

Some health care professionals cavil with disciplinary action being taken for unintended errors of judgement on the basis that everyone makes mistakes and it is unfair to punish those whose mistakes just happen to lead to a serious adverse event. It is suggested that such individuals are no more culpable than the many others who make equally poor decisions that, through good luck, don't have adverse outcomes.

I accept that approach when it is applied to spur of the moment decisions made in hectic circumstances, which on reflection are judged to be wrong. But that is not the situation that I am considering in relation to the treatment of Ms Burgen.

Dr Brown's comments in relation to Dr Rowland are apposite:

> *I don't know any doctors who (start) with the intention or erring but unfortunately mistakes are made. When they are made I think you have to face up to them and say 'Ok there is a possibility I am wrong' and what concerns me is that Dr Rowland just didn't allow that to happen. He was the only person who could have made any impact on the final outcome and he dug his heels and said 'she is not bleeding' and the post mortem shows he was wrong*.

Having regard to the findings I have made based on the evidence of independent experts, I am of the view that the Medical Board could reasonably conclude that:-

Dr Ross Gallery engaged in *unsatisfactory professional conduct* when he:-

- failed to examine Ms Burgen or undertake some more definitive diagnostic or remedial action before declining to admit her on 23 February 2005 when he had sufficient evidence to enable a reasonably competent surgeon to conclude that she was suffering from a mechanical bowel obstruction.

Dr Frederick Rowland engaged in *unsatisfactory professional conduct* when he:-

- failed to adequately monitor Ms Burgen's condition on 25 and 26 February and delayed operating on her until after her large intestine perforated;
- failed to monitor and adequately respond to Ms Burgen's increasingly dire condition on the evening of 27 February 2005; and
- left the ICU nurses to attempt to care for Ms Burgen without sufficient support or guidance.

Dr Naseem Ashraf engaged in *unsatisfactory professional conduct* when he:-

- failed to ensure that Ms Burgen was intubated and had a central venous line in place before she was moved to the ICU on the afternoon of 27 February 2005 or soon after, when it became apparent that these supports were needed;
- failed to monitor and adequately respond Ms Burgen's increasingly dire condition on the evening of 27 February; and
- left the ICU nurses to attempt to care for Ms Burgen without sufficient support or guidance.

I have considered whether the failure of Dr Robina McCann to provide any effective guidance to the junior medical officer who consulted her on 21 February should also be referred for consideration of the Medical Board. I concluded that as the information provided to her was limited and her position within the hospital was less senior than Dr Gallery's, a referral is not warranted. I trust she will provide more conscientious assistance if consulted by a junior colleague in future.

I have also considered the conduct of Dr Tirumalai from this perspective. Clearly, he did not effectively respond to the challenges presented by Ms Burgen's precipitous decline on the evening of 27 February. However, he was the more junior of the anaesthetists and he was entitled to rely on guidance and leadership from Dr Ashraf that was not forthcoming. It is obvious that he is not sufficiently skilled or experienced to take charge of seriously ill patients in an ICU setting but this calls for training rather than disciplinary action in my view.

I understand that some of these practitioners may no longer be practicing in Queensland. If that is the case, I consider it is the responsibility of the Medical Board to make the necessary inquiries to ensure that the equivalent regulatory authorities in other relevant jurisdictions are apprised of the information disclosed at this inquest.

I close this inquest.

Michael Barnes
State Coroner, Queensland
7 December 2007