OFFICE OF THE STATE CORONER

FINDINGS OF INQUEST

CITATION: **Inquest into the death of Margaret Florance Anne BODELL**

TITLE OF COURT: Coroner's Court

JURISDICTION: Brisbane

FILE NO(s): COR 1996/06(1)

DELIVERED ON: 23 November 2007

DELIVERED AT: Brisbane

HEARING DATE(s): 9 August 2006, 12, 13 and 14 November 2007

FINDINGS OF: Ms Christine Clements, Deputy State Coroner

CATCHWORDS: CORONERS: Inquest – chronic obstructive airways disorder; fitness for endoscopy; duodenal ulcer; end of life decision making; autopsy after exhumation; reportable deaths, duties under Coroners Act 2003, carbon dioxide retainers,

REPRESENTATION:

Mr S Hamlyn-Harris– appearing to assist the Coroner

Mr K Parrot – representing the Northside District Health Service; instructed by Crown Law

CORONERS FINDINGS AND DECISION

1. The *Coroners Act 2003* provides in s45 that when an inquest is held into a death, the coroner's written findings must be given to the family of the person who died and to each of the persons or organisations granted leave to appear at the inquest. These are my finding in relation to the death of Margaret Florance Anne Bodell. They will be distributed in accordance with the requirements of the Act and placed on the website of the Office of the State Coroner.

The Coroner's jurisdiction

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

The scope of the Coroner's inquiry and findings

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

- 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.

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

5. An inquest is not a trial between opposing parties but an inquiry into the death. In a leading English case it was described in this way:-

> *"It is an inquisitorial process, a process of investigation quite unlike a criminal trial where the prosecutor accuses and the accused defends… The function of an inquest is to seek out and record as many of the facts concerning the death as the public interest requires."* [1]

6. The focus is on discovering what happened, not on ascribing guilt, attributing blame or apportioning liability. The purpose is to inform the family and the public of how the death occurred with a view to reducing the likelihood of similar deaths. 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 the findings or any comments or recommendations, statements that a person is or maybe guilty of an offence or is or maybe civilly liable for something.[3]

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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)

The admissibility of evidence and the standard of proof

7. Proceedings in a coroner's court are not bound by the rules of evidence because section 37 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.

8. 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]

9. A coroner should apply the civil standard of proof, namely the balance of probabilities but the approach referred to as the *Briginshaw* sliding scale is applicable.[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 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]

10. 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.

Summary of Events

11. Margaret Florance Anne Bodell ("Mrs Bodell") was born on 23 November 1940. She was married to Dennis Bodell for approximately 30 years. They had 1 daughter together. Mrs Bodell also had 3 daughters from a previous marriage. She and Mr Bodell shared the care and custody of her teenage grandson.

12. Mrs Bodell was admitted to the Redcliffe Hospital on 13 June 2006. She died on 25 June 2006. On admission her condition was assessed by a medical registrar, Dr Majid Rahgozar. He noted her previous medical history and the established diagnosis of chronic obstructive pulmonary disease and emphysema. He examined her and confirmed she was short of breath even at rest and that she had a productive cough. She could not speak in sentences due to breathlessness. Mrs Bodell had smoked all her adult life and had not been able to stop smoking.

13. Dr Rahgozar's impression was that Mrs Bodell was suffering type II respiratory failure secondary to an infection that had worsened her chronic obstructive airways disease ("COAD").

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[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
[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

14. Mrs Bodell was admitted to the ward under the care of consultant physician Dr Peter Stride. Blood tests and sputum cultures were ordered and intravenous antibiotics commenced as well as the steroid Prednisone to assist in her treatment. Nebulised ventolin was ordered and chest physiotherapy was commenced together with a dietary review. A blood gas test revealed she retained carbon dioxide due to her inefficient breathing caused by the disease. Her heart rate was elevated which was also interpreted as a sign of reduced oxygen levels. A chest x-ray confirmed she did not have pneumonia but there was evidence of hyperinflation and signs of emphysema.

15. Dr Rahgozar initially ordered 2 to 3 litres of oxygen aimed at achieving a saturation level above 90 %. This was a balance between her need for oxygen and her problem with retaining carbon dioxide. The level of carbon dioxide is the usual drive for the body to breathe, but when this level becomes abnormally high the trigger to breathe is switched to decreased oxygen levels. Too much oxygen then can stop the driving mechanism for such people to breathe and can trigger a respiratory arrest. A balance is therefore required when a person retains carbon dioxide and requires supplemented oxygen.

16. Mrs Bodell's condition was reviewed the next day by Dr Stride together with Dr Rahgozar and the resident medical officer ("RMO"), Dr Anthony Havyatt. This became her treating team of doctors.

17. Mrs Bodell still had reduced air entry to the lungs, she wheezed on breathing out and she was working hard to draw every breath in and out of her lungs. Her temperature and her blood pressure were normal. She was considered to be stable but she was not making improvement. Dr Stride therefore added intravenous Aminophylline. A respiratory function test was performed which showed that her ability to exhale was reduced to about twenty per cent of the normal volume for a woman of her age. This test demonstrated that Mrs Bodell had very severe lung disease. Doctors considered whether heart problems were contributing to her shortness of breath. Tests were performed and this was ruled out.

18. Over the course of her admission the treating doctors' opinion was that they could only see slight improvement in her respiratory condition. There were some other difficulties that Mrs Bodell experienced while she was in hospital. She suffered panic attacks during the night and became distressed. She could not remember all of what had happened and that upset her more. The doctors considered the various options that might explain what was happening. Theoretically there was the possibility that nicotine or alcohol withdrawal could cause such incidents. Low oxygen levels (hypoxia) due to the respiratory difficulties caused by her disease could also trigger such episodes. She also had some background history of anxiety which would no doubt be worsened by being unwell and anxious about her deteriorating state of health. Another patient in the shared ward was also experiencing similar symptoms which added to the overall distress. A mental health review was arranged. It was considered probable that more than one of these factors affected Mrs Bodell's pre-existing anxiety and triggered episodes of distress.

19. By Monday 19 June 2006 the treating team of doctors thought they had probably achieved as much as they could regarding her lung function. Her lung function test remained very poor but slightly better than when she was admitted. The underlying lung disease is not a curable condition but one that can be treated and managed. Over time there will be a gradual decline in the patient's condition. There was evidence at the inquest from a study that show patients live a median of 6 years (5 years for men and 8 years for women) after their first admission from COAD. The time is likely to be shorter for those patients who have developed emphysema as part of the COAD.[9] Mrs Bodell had been diagnosed with emphysema and this was confirmed on autopsy.

20. Mrs Bodell's condition did vary from day to day. On 20 June 2006, Dr Rahgozar came to see her and recorded that she was feeling very depressed and frustrated. She was feeling short of breath and her heart and breathing rates had gone up again. She was again prescribed intravenous antibiotics. Her retention level of carbon dioxide had increased. Dr Rahgozar decided to stop her oxygen supplement for a period of time to see if this would prompt her body to respond to the lower level of oxygen and to breathe more deeply. The aim was to try to stimulate her ability to breathe. Oxygen was then reintroduced via nasal prongs at a lower rate of 1 litre per minute.

21. Dr Rahgozar told the inquest that he discussed Mrs Bodell's management with his consultant Dr Stride and made his decisions with his guidance. Dr Stride's room was close to Mrs Bodell's bed. The treating team's overall impression was that Mrs Bodell was in serious trouble with her lung disease. There were some preliminary discussions about how she would manage going home. An indication of how poorly Mrs Bodell was feeling is that the notes record that she became even more anxious when this was raised by the hospital staff. She wanted to go home and to be back with her family and particularly continue with the care of her grandson, but she was clearly feeling very unwell and was worried about her own condition.

22. The treating team reached the considered view that Mrs Bodell's overall condition was such that she would not benefit from being admitted to intensive care. She was unlikely to be able to regain her own ability to breathe if she was placed on a ventilator or if she was intubated with a tube or tracheostomy. This decision was made after discussion between Dr Stride and Dr Rahgozar. It was documented in her chart on 20 June 2006. This was not a decision to stop treating Mrs Bodell. At that attendance Dr Rahgozar re-started the Aminophylline medication because her breathing was worsening. He also ordered another antibiotic, Ceftriaxone and Azithromycin. Atrovent and ventolin nebulisers were ordered to continue to help open the airways. The steroid Prednisone was increased to 50 mg per day to reduce inflammation in the airways. More tests were ordered to monitor the levels of medication and for signs of infection. She was continuing to receive active medical treatment.

[9] Exhibit E2, "Readmission and survival following hospitalisation for chronic obstructive pulmonary disease"long term trends", Internal Medicine Journal, 37 (2007), 87 – 94 at p. 89.

23. At Redcliffe Hospital there is a practice of calling for the medical emergency team ("MET team") if a patient's condition caused concern and if a patient went into cardiac or respiratory arrest. This applied to Mrs Bodell, but any response by the MET team was within the established parameters that certain procedures could not help her condition.

24. Mrs Bodell's hospitalisation was very difficult for her family members. They were used to Mrs Bodell being capable and in some ways "tough" enough to shrug aside her illness and continue to be actively involved in raising her teenage grandson. It was a shock to see her so unwell and clearly not able to bounce back. The problems in comprehending the seriousness of the situation were made more difficult by the fluctuating nature of her condition and, to some extent, the mixed messages they were receiving from both Mrs Bodell and her treating team.

25. There were some early discussions regarding plans for Mrs Bodell's discharge but Mr Bodell took exception to Dr Stride raising the prospect that nursing home care would be needed. Of course the communication difficulties experienced by the family with hospital staff both during her admission and after her death can be reviewed with the benefit of hindsight. The family assumed Mrs Bodell was coming home as she had in the past after a period of treatment. The treating team recognised that the progression of her lung disease, and its very limited response to the treatment, meant that her condition was serious. It is always a hard task for any doctor or nurse to raise the topic with a patient and/or a family member that the patient might not survive the illness. Dr Rahgozar spoke with Mr Bodell on several occasions. He thought that Mr Bodell understood his advice that his wife was very sick and that perhaps the family should be informed of the seriousness.

26. On 21 June 2006, the very next morning after the treating team had reached the assessment that Mrs Bodell's condition was so serious that she would not benefit from intensive care or ventilation, she appeared to have rallied. The corresponding notes in her medical chart made by the RMO Dr Havyatt (after attending with Dr Rahgozar) state:

> "*Feels better today. Looks a lot better, 98% saturation on 1 litre of oxygen. Bibasal inspiratory crackles, improved air entry, equal entry."*

27. Her medications were ordered to be continued and an echocardiogram was ordered.

28. However, by the afternoon the nursing entry shows her condition had again declined.

29. On 22 June 2006, Dr Stride reviewed her condition with Dr Rahgozar and Dr Havyatt. Her saturation level had dropped back to 92% but it was considered that she was doing well on the Aminophylline. The swelling and fluid retention in her leg had improved with Lasix. The plan was still to work towards a discharge, although she was not well enough yet. There was discussion about a referral for bone density testing after discharge.

30. The decisions the doctors had made about the types of treatment that would not be given if her condition became life threatening were not discussed directly with Mrs Bodell that morning. She had been anxious and the discussion was put off, but it was noted in the chart that this needed to be discussed later. Dr Havyatt recorded in the notes *"To discuss Not For Resuscitation orders later."*

31. By about 2.00pm that afternoon Dr Rahgozar was called back to the ward when Mrs Bodell deteriorated. She was even more short of breath and her ankle swelling had increased. This was the episode where an inexperienced agency nurse had noticed the patient's condition had declined and called for review by a more senior nurse. Registered Nurse Woollard was not assigned to care for Mrs Bodell. She knew nothing of her background. When she entered the room she observed Mrs Bodell to be in respiratory distress. Not surprisingly she immediately increased the oxygen flow rate to 2 litres per minute. Although this is considered to be the standard response to alleviate respiratory distress, it is contraindicated for a patient such as Mrs Bodell who retains carbon dioxide. She needed her oxygen supplementation to be carefully monitored and kept at a level so that it did not prompt her respiratory system to go into arrest. This was because her breathing was so poor that she did not exhale sufficient carbon dioxide but instead retained it. This caused a switch for the trigger to breathe to be activated by levels of oxygen in the blood rather than levels of carbon dioxide in the blood. Her oxygen supplement had to be kept at just a sufficient level to maintain saturations but not to cause respiratory arrest.

32. There was some degree of conflict in the evidence. Mr Bodell recognised that his wife's condition was still failing after the oxygen was increased. He said her hand went limp and he thought she was fading from consciousness. He rushed out to get help, just as Dr Rahgozar was approaching the room.

33. The nurse was defensive in her evidence after having realised that she had made an error. She denied that Mrs Bodell's level of consciousness was affected, but Dr Rahgozar certainly commented that she appeared drowsy and was not breathing deeply enough because of decreased respiratory drive.[10] He immediately recognised the problem as being the increase of oxygen which had had the opposite effect to what the nurse had hoped to achieve. The nurse was experienced and she was aware of the potential problem of carbon dioxide retention in some patients who suffer from COAD. She acted in good faith, in a quick response to the situation but without informing herself from the nursing care plan about the instructions for this patient.

34. On 22 June 2006 the nursing care plan recorded under the heading "Treatment/Wound Care" that Mrs Bodell was to receive oxygen of 1 litre (per minute) by nasal prong.

35. Dr Rahgozar addressed the problem by reducing the oxygen level temporarily to half a litre per minute to be reviewed after 15 to 30 minutes. He specifically stated in the records that it was not to go above 1.5 litres per minute because Mrs Bodell was a carbon dioxide retainer. The aim for saturation levels was adjusted

[10] Exhibit D3 (appendix item 28,paragraph 69, page 11)

downwards to 87–90%. He encouraged her to sit up and reassured her while she exhaled as forcefully as she could to restore her breathing.

36. There was no long term adverse effect from this incident. I find that there is absolutely no basis to consider that this increase in oxygen level precipitated, or contributed to Mrs Bodell's later problem of bleeding from an, as yet, undiagnosed duodenal ulcer. Independent medical review by Dr Ross Elliott (a gastroenterologist from St Vincent's Hospital Melbourne) emphatically dismissed this proposition.[11] Similarly, all other medical opinions obtained in the review of this case rejected this suggestion. This includes the report of the pathologist who performed the autopsy.

37. Dr Rahgozar explained to Mr and Mrs Bodell how the oxygen level interacted with the problem of carbon dioxide retention. He noted that she was tachycardic with a heart rate of 150 beats per minute which was higher then previously recorded. He ordered an echocardiogram. There was no complaint of any symptoms of pain or other indication that she might be developing other medical problems.

38. At 6.30pm on 22 June, another ward call was made by nurses who requested a review of Mrs Bodell. Mrs Bodell was becoming increasingly anxious and tachycardic. A first year intern Dr Churchman attended upon Mrs Bodell. He saw that Mrs Bodell was very anxious and straining to breathe using her auxiliary muscles. On examination he could hear crepitations from her chest. He ordered medication to reduce the build up of fluid in her chest and he ordered another echocardiogram to check her heart. The result was the same as that taken earlier that day. There was no report of any other symptoms. Mr Bodell was there with his wife and Dr Churchman stayed to provide reassurance until Mrs Bodell's heart rate had settled. He saw on the charts that the issue of "not for resuscitation" did not appear to have been discussed with them. He took the initiative to have this discussion. Both Mr and Mrs Bodell were upset.

39. Dr Churchman thought the Bodell's understood that he was explaining to them the seriousness of Mrs Bodell's condition and the limitations of certain measures being taken. His statement indicated he took quite some time to talk with Mr and Mrs Bodell. From his conversation he understood that these issues had been brought to their attention to some extent, but they had not thought them through or reached an acceptance of the reality of her condition. He thought that Mrs Bodell had a clearer understanding of how ill she was. When he raised the issue of resuscitation it seemed they did not want to continue the conversation and so he left it at that point. He noted that he should be contacted if there were any further concerns. He reviewed Mrs Bodell later that evening and saw Mr Bodell again. He thought there were no difficulties with their conversation and he thought that Mrs Bodell looked a bit better and was not so anxious. At this time, there was no report from Mrs Bodell that she was experiencing abdominal pain and there was nothing to indicate that she might be suffering internal bleeding.

[11] Exhibit D3 (appendix item 35)

40. At 1.25am on 23 June, Mrs Bodell passed a melena stool, (meaning she had blood in her bowel motion) indicating gastrointestinal bleeding. The on call doctor from the emergency department, Dr Hughes attended upon Mrs Bodell. Dr Hughes was aware of the patient because Dr Churchman had given her an overview before he left. He indicated that Mrs Bodell had been distressed and anxious and that she was suffering type II respiratory failure. He advised Dr Hughes that Mrs Bodell may be developing fluid in the lungs and that he had given her Lasix to alleviate the problem. Dr Hughes examined Mrs Bodell after reviewing her medical chart. She noted that Mrs Bodell was taking steroids which can predispose a person to having an ulcer. Mr Bodell was present. Mrs Bodell's only complaint at the time was that she felt nauseous, so Maxolon was prescribed. Mrs Bodell denied that she had ever had a similar episode in the past. Dr Hughes considered the most likely diagnosis was a bleeding ulcer from her stomach or the top of the small intestine. She ordered that Mrs Bodell should not receive any fluid or food by mouth. This was a precaution in case she needed any treatment, as an empty stomach would be safer. Dr Hughes was not in a position to make decisions about whether any type of formal investigation (endoscopy) or surgery would be undertaken. However, Dr Hughes doubted a general anaesthetic could be given because of Mrs Bodell's respiratory condition.

41. Dr Hughes commenced treatment assuming the problem was a bleeding ulcer and ordered intravenous Nexium and arrangements for blood transfusions. She consulted the registrar in the emergency department to check the dosage rate. Mrs Bodell was to be observed on an hourly basis and nurses were to call the doctor if there were any concerns. The diagnosis was explained to Mr and Mrs Bodell. Subsequent independent review by the specialist gastroenterologist (Dr Elliott) confirmed Dr Hughes' decision to order intravenous Nexium in order to reduce acid production in the stomach.

42. The next morning at about 9:45 am, Dr Rahgozar reviewed Mrs Bodell with Dr Havyatt present. Mrs Bodell was still panicky and her heart rate was 107. Dr Rahgozar reviewed her condition and decided she was not fit to undergo an endoscopy on the basis of her respiratory condition.

43. An endoscopy is a medical procedure in which a camera is passed into the stomach and small intestine. It is useful to confirm the diagnosis of an ulcer and the source of gastrointestinal bleeding. Further, it can be used as a means to stop the bleeding (through the application of adrenaline and or use of a diathermy). This is the usual treatment for bleeding ulcers. An endoscopy requires a degree of sedation and any degree of sedation was a threat to Mrs Bodell's impaired respiration. An endoscopy with limited sedation requires the patient's ability to co-operate with the procedure which can take some time. The back of the throat is numbed with local anaesthetic to enable the passage of the endoscope instrument. The instrument is passed down to try to pinpoint the source of the bleeding. Any bleeding needs to be cleared to then address the source of bleeding. This is usually done by injecting adrenalin to stop the bleeding. Mrs Bodell was feeling panicky when examined by Dr Rahgozar and had a history of such episodes throughout her admission. Apart from her respiratory condition it was highly unlikely that she would have been able to tolerate the procedure without becoming distressed and being at greater risk.

44. This assessment that she was not fit for an endoscopy was later reviewed by Dr Stride who Dr Rahgozar had kept informed throughout Mrs Bodell's treatment. Dr Stride agreed that she was too unwell to undergo the sedation required and then to tolerate the endoscopic examination and treatment.

45. Subsequent reviews by three independent doctors agreed with this decision.[12] The consultant physician (Dr Trembath) and the anaesthetist (Professor Loughnan) both considered her respiratory disease too severe to withstand the degree of sedation required to tolerate the procedure. The risk was too great to proceed. The independent gastroenterologist considered that an endoscopy could have been undertaken. This would have confirmed the diagnosis of a bleeding ulcer and possibly, provided an opportunity to actively treat it with an injection into the bleeding site. Dr Elliot qualified his opinion about a proposed endoscopy by deferring to the other two specialists on the initial question of whether or not Mrs Bodell was fit to undergo the procedure itself and to withstand the necessary sedation required. He acknowledged the special expertise of the expert physician Dr Trembath and the anaesthetist Professor Loughnan on this issue. He also accepted that the doctors who were treating Mrs Bodell at the time were in the best position to evaluate the question of whether she was fit enough to undergo an endoscopy.

46. Significantly Dr Elliott confirmed that the decision made to continue treatment of the ulcer by means of continued intravenous delivery of the drug Nexium was the appropriate treatment when an endoscopy could not be performed. There was some discussion about whether or not Nexium should have been continued intravenously the following day rather than being given orally from that time, but Dr Elliott did not think this would have had any effect on the ultimate outcome.

47. The decision not to proceed with an endoscopy was not a decision to stop treating Mrs Bodell. It was a decision based on her medical condition that it was too risky to undertake the procedure. It was still considered that she had a bleeding ulcer and conservative treatment continued. She was given a blood transfusion. I also note she could not tolerate the chest physiotherapy that afternoon.

48. An examination on 24 June recorded that she was sitting up and her breathing was a little better. There had not been any further episodes of melena indicating that the drug treatment and blood transfusion had addressed the bleeding ulcer for the time being. A further unit of packed blood cells was ordered and her haemoglobin level was being monitored daily. Her observations were to continue, particularly for any further sign of melena stools. Any concerns were to be notified to medical staff. It was considered that she was still unfit for an endoscopy.

49. That afternoon she underwent some physiotherapy for her chest but only wanted to be gently patted.

50. Registered Nurse (RN) Knowles commenced duty on an early shift on 25 June 2006. She presented as caring and competent. RN Knowles first looked after Mrs Bodell on 23 June. On entering her room Mrs Bodell told her she was breathless

[12] Exhibit D3 (appendix items 34,35,36)

and the nurse went to turn up the oxygen. Not surprisingly, Mr Bodell and a daughter of Mrs Bodell yelled at her and informed her that Mrs Bodell was a carbon dioxide retainer and should not have her oxygen turned up. The information had not been handed over to RN Knowles at the start of her shift. This is surprising given the previous recent episode when Dr Rahgozar had stipulated that oxygen was not to be higher than 1.5 litres. The information was in prominent display on her notes, but these were not immediately visible at the end of the bed as they were next to where Mr Bodell was sitting.

51. Subsequently Mr Bodell raised this issue with Dr Rahgozar and Dr Rahgozar then instigated a sign to be placed near the oxygen outlet informing staff that the patient was a carbon dioxide retainer and the level of oxygen was not to be increased.

52. It was the morning of 25 June that Mrs Bodell's condition suddenly deteriorated. During the handover RN Knowles had been given it was indicated that Mrs Bodell had been nauseous, so she went to check on her immediately. Mrs Bodell was refusing her breakfast and had already received Maxolon (an antiemetic). RN Knowles asked her whether she could wait until the doctors were due on the ward to see if another medication could be added. The clinical nurse in charge of that shift, RN Andrew, arranged for a telephone order of a different drug that Mrs Bodell could take. RN Knowles checked the drug for RN Andrew which is standard procedure. An agency nurse then came out of Mrs Bodell's room and RN Knowles asked her what she was doing. The agency nurse advised that Mrs Bodell was not feeling well and had chest pain. She was going to do her observations. RN Knowles was immediately concerned because RN Andrew had just completed observations which indicated that Mrs Bodell was alright. RN Knowles went into the room and found Mrs Bodell distressed. She could not detect her blood pressure and her oxygen saturation level was reduced.

53. A medical emergency call was made immediately. Dr Yousef, a medial registrar, attended as part of the MET team. An echocardiogram was performed to evaluate what was happening. Dr Yousef had received a handover from the doctor finishing his shift with information that Mrs Bodell was not very well and was not for resuscitation. If her condition declined and Dr Yousef was called, he would need to discuss the not for resuscitation order with Mr Bodell. This was a difficult situation for both Dr Yousef and, more particularly, for Mr Bodell who was suddenly faced with his wife's final decline and having to come to terms with the fact that resuscitation would not save her in the long term.

54. Mr Bodell was initially asked to wait outside because it was an urgent situation and distressing to witness. Dr Yousef noted Mrs Bodell's condition and had reference to her medical history. He noted the recent episode of the melena and the presumed diagnosis of and treatment for a bleeding ulcer. He noted the assessment that Mrs Bodell was not fit for endoscopy and the seriousness of her underlying lung disease. He had regard to the treating team's medical decision that ventilation, intubation and transfer to intensive care were not appropriate. But he also had the difficult task to manage the situation as best he could with family members who had not fully accepted the medical decision not to proceed with certain medical interventions if an arrest occurred. He followed the treatment

decisions that had been made and made Mrs Bodell as comfortable as he could. Mr Bodell was called back into the room and the situation explained to him. He stayed with his wife and comforted her until she died at 8.25am on 25 June 2006.

55. After her death it was RN Knowles who was in attendance to clean and prepare her body for burial. In attending to these duties she observed blood coming from Mrs Bodell's mouth. She discussed this with her superior RN Andrew and reported it to a doctor. She was not clear who this was, but it was probably Dr Yousef. The reason for her report was to ensure the doctor was fully informed before completing the cause of death certificate, or to inform the coroner if the cause of death was uncertain and required an autopsy.

56. The response that was provided, which I accept to be truthful, was that the doctor did not consider that an autopsy was necessary. The decision was made on the basis that he did not think it was necessary or appropriate to put the family through the requirement of having an autopsy performed. I see no reason to think that this decision was sinister or intended to avoid an autopsy. It appeared from the evidence of the treating team that the consensus was that the overwhelming cause of Mrs Bodell' demise was the longstanding and worsening COAD.

57. RN Knowles thought she had recorded this information on the charts. This entry could not be located. Her evidence at the inquest was that it had been a very busy shift and she may have overlooked writing the entry. The weight of evidence suggests that there was no written note recorded of the observation of blood from Mrs Bodell's mouth after her death.

58. After Mrs Bodell died a cause of death certificate was completed by Dr Anthony Havyatt.[13] He completed the certificate when he came back on duty the next morning. He had not been present when Mrs Bodell died. He had been involved as part of the treating team. The certificate stated the cause of death to be "infective exacerbation of chronic obstructive airways disease".

59. Dr Havyatt told the inquest he considered carefully what he should write. He was aware that Mrs Bodell had the melena stool and that since then she had been treated conservatively on the assumption that she had a bleeding ulcer as well as the COAD and emphysema. He had access to the medical records but there was no reference in those notes to the blood that had come from her mouth after death. Without that information Dr Havyatt considered that the predominant illness that had caused her death was the COAD which had been worsened by infection. In hindsight he acknowledged that it was likely that the bleeding ulcer would also have contributed to her death. I find that Dr Havyatt conscientiously completed the certificate. Given the advantage of information from the autopsy it is now clear that it was the gastrointestinal bleed from the ulcer that was the most significant role in her death. However, it is also without doubt that the underlying chronic obstructive airways disease was severe and worsening and would have caused death irrespective of the presence of the ulcer. Together, the two medical conditions were too much for Mrs Bodell to overcome.

[13] Exhibit A15

60. I note that the responsibility for completion of the cause of death certificate fell to the most junior doctor of the treating team. This is a common practice throughout hospitals. I also note that Redcliffe Hospital has since instigated a review and established a system so that senior treating doctors review all cause of death certificates. I commend this initiative.

61. Mrs Bodell's death was not reported to the coroner and she was buried. Mr Bodell was devastated by the death of his wife. Her death was a shock to him despite her serious illness. He did not accept the accuracy of the cause of death certificate and instigated a coronial exhumation of his wife's body to enable an autopsy to be performed. He provided sufficient information to raise doubts about the accuracy of the cause of death certificate. An initial independent review of the medical records also raised questions about the accuracy of the cause of death certificate. A coronial order for exhumation was made together with an order for internal autopsy.[14]

62. On 14 July 2006, Dr Rebecca Williams ("the pathologist") performed an autopsy on the body of Mrs Bodell. The autopsy confirmed the changes in the lungs caused by emphysema. The extent of the lung disease could not be demonstrated due to the time that had passed before the autopsy was conducted.

63. The pathologist noted that the arteries of the heart showed severe narrowing (coronary atherosclerosis). The pathologist noted that the stomach contained 500mls of blood and blood clot. There was a further 750mls of blood, blood clot and melena in the bowel. An ulcer, measuring 24 mm by 22 mm in size, was observed in the first part of the duodenum. Examination of the duodenum tissue under the microscope showed the presence of a medium sized artery, which would have played a role in the bleeding within the gastrointestinal tract. The presentation of the ulcer itself suggested it was chronic rather than acute. In the pathologist's opinion its appearance suggested the ulcer was "at least some months old."[15]

64. After performing the autopsy and reviewing the medical record, it was the pathologist's opinion that cause of death was the gastrointestinal haemorrhage from the duodenal ulcer. Chronic obstructive airways disease (emphysema) and coronary atherosclerosis were significant but lesser contributing factors in her death. I accept Dr Williams' conclusions as to the cause of death and the respective contributing factors.

65. Arrangements were made requesting the Health Quality and Complaints Commission ("HQCC") to assist with the investigation of Mrs Bodell's medical treatment at Redcliffe Hospital. Mr Geoff Murphy (Director of Investigations) undertook the investigation on behalf of the HQCC into the quality of care that Mrs Bodell received. He is well qualified for the position with a background of twenty years in the Queensland Police Service complimented by formal qualifications and experience in nursing and midwifery. He reviewed the medical records and

[14] Exhibits A4 and A6
[15] Exhibit A14, page 6, paragraph 7.

arranged interviews with all medical personnel involved in her care from the time of her admission to hospital to the events of the 25 June 2006. [16]

66. The resultant HQCC reports tendered at the inquest also made recommendations directed at improvements focusing on quality of health care issues.[17] Many of these matters have been acted upon by the Redcliffe Hospital.

Findings pursuant to section 45 Coroner's Act 2003

67. Margaret Florance Anne Bodell died on 25 June 2006 at the Redcliffe Hospital. The cause of death was gastrointestinal haemorrhage due to duodenal ulcer. The underlying chronic obstructive airway disease (emphysema) and coronary atherosclerosis significantly contributed to her death. This was confirmed both by the autopsy report and the independent review by the expert gastroenterologist Dr Elliott.

68. Mrs Bodell had been admitted to hospital on 13 June 2006 due to her breathlessness caused by her severe lung disease. Her lung condition was stabilised but did not really improve to any extent. The condition of duodenal ulcer was first suspected in the early hours of 23 June 2006 when Mrs Bodell passed a melena stool. She was treated appropriately, having regard to her condition via the medication Nexium which was given intravenously to reduce acidity in the duodenum. Additionally she was ordered to receive a blood transfusion and a second order for packed cells. Endoscopic confirmation of the condition and possible treatment was considered but it was too risky to proceed due to her very poor respiratory condition. That decision was reviewed by independent experts and confirmed to be appropriate in all the circumstances.

Coroner's Comments pursuant to section 46 Coroners Act 2003

69. There are several matters that I will comment upon as in my view they relate to public health and safety.

70. Chronic obstructive airways disease is unfortunately a frequent cause of death of elderly people, particularly where there has been a history of cigarette smoking. One of the journal articles tendered at the inquest stated that it is the fourth leading cause of mortality in Australia.[18] In a certain proportion of these patients there is a known condition of carbon dioxide retention due to inefficient exhalation. The trigger for respiration can change from the level of carbon dioxide in the blood to the level of oxygen in the blood. When this has been identified it is important to monitor the level of oxygen supplementation to avoid too high a level of oxygen. Otherwise, respiratory arrest could be inadvertently triggered.

71. The risk is that apparent respiratory distress can influence nursing staff to automatically respond by increasing the level of oxygen flow. It is important that where carbon dioxide retention has been identified, this information is clearly handed over at the end of each change of shift of medical and nursing staff. It is also important that prominent documentation is displayed at the oxygen outlet itself

[16] Exhibit D3
[17] Exhibits D1 and D2
[18] Exhibit E2, p. 87

informing all staff of the need to maintain the current level of oxygen flow for the patient as ordered by the doctor.

72. I note that the Redcliffe Hospital has initiated training on this issue and the display of the information at the oxygen outlet point. This action is commended. It is a safety precaution that should be considered across both Queensland Health and private health service facilities. I repeat my finding that in Mrs Bodell's case the increase of oxygen level did not cause her any permanent ill effect and did not precipitate or contribute to her death.

73. Medical and nursing staff all work toward improving a patient's state of health by providing a successful course of treatment resulting in the patient being discharged home. The reality of course is that all of us will die and some of these deaths will occur in hospital in the course of an admission. It is a difficult task for all staff to raise this topic with a patient and their family, but it is necessary for this to be done to properly inform a patient and family of treatment decisions.

74. The difficulty can be worsened where a patient's condition is variable and the discussion is postponed. For the Bodell family, Mrs Bodell's death was harder to accept because of her fluctuating presentation and the discussions about plans for discharge. The fact was that her condition had not improved much overall during her admission. Based on a sound review of her medical condition, a decision was made by the treating team that it was medically inappropriate (in the event of a cardiac or respiratory arrest) to transfer her to the intensive care unit or to ventilate or intubate her. This plan was noted in the medical records. The evidence indicated there was some variation amongst nursing staff as to their understanding of what "not for resuscitation" actually meant. There was also a delay in discussing the issue with the patient and her family. The doctor who ventured to perform this difficult task does not appear to have been a primary member of the treating team. Mrs Bodell and Mr Bodell had difficulty in accepting the reality of the information and the doctor left the issue to be discussed again when appropriate. Events overtook a suitable opportunity and Mrs Bodell died before the treatment decisions could be discussed again. The family was to some extent unprepared for her death. Misunderstandings about whether or not Mrs Bodell had received proper and sufficient treatment arose in this context.

75. Since Mrs Bodell's death Redcliffe Hospital has initiated discussion around protocols of how to discuss these matters with family and how to document them.[19] In this regard I note the report of Professor Malcolm Fisher (a consultant physician) provided to the HQCC on the issue of the notation "not for resuscitation" as it applied to Mrs Bodell.[20] It is Professor Fisher's recommendation that an appropriate "do not resuscitate" order must include the following:

    i. The time and date of the discussion;
    ii. The persons who participated in the discussion;
    iii. The reasons that active treatment is not considered being the best option for the patient;

[19] Exhibit E3
[20] Exhibit D3 (appendix item 37)

iv. What was agreed;
v. What is to be withheld, what is to be discontinued or not commenced; and
vi. When the decision is to be reviewed;

76. I have seen variation in documentation and in practice from reading many medical files about this issue and I have seen the problems it can lead to with communication with families. This was evident in this case where the Bodell family were not sufficiently informed about Mrs Bodell's risk of demise and the treatment decisions that had been made. I strongly recommend a full review of this issue. Agreement on uniform standards of practice and documentation across public and private hospitals can only improve the quality of care for patients facing their likely demise. This would also help families understand treatment decisions.

77. The current practice in many hospitals leaves the responsibility for completion of the cause of death certificate to a junior member of the treating team. This can lead to inadvertent oversights and errors. The advent of the HQCC and the establishment of a standard in reporting deaths should see an improvement in this area. I note again that since Mrs Bodell's death the Redcliffe Hospital has implemented changes to ensure a review of cause of death certificate by senior clinicians. I would encourage all hospitals to take on review of this documentation by senior clinicians.

78. It was apparent from this inquest that various hospital staff had very little knowledge of their obligations to inform the coroner of a reportable death under the *Coroners Act 2003*.[21] Education about the *Coroners Act* continues to be promoted by the Office of the State Coroner. However, given the enormous mobility and turnover of medical staff, Queensland Health and medical and nursing courses should also consider other methods of ensuring compliance with legislative requirements. Standardisation of any forms to be completed when a patient dies in hospital would be a helpful starting point.[22] An online system which prompted referral to the coroner in certain circumstances might assist.

79. Mrs Bodell died on a weekend. Redcliffe Hospital did not have sufficient staff for an overnight or weekend medical registrar. Patients were covered by the registrar from the emergency department. Again, this situation adds to the possibility of discontinuity in care and possible problems with establishing sufficient rapport to enable meaningful communication. I recommend a review to provide sufficient resources to adequately staff the hospital overnight and on weekends.

80. Finally, to Mr Bodell and his family I remark that although they still grieve the loss of their wife, mother and grandmother, they should take comfort in her legacy. Mr Bodell's efforts prompted an autopsy to be performed and the cause of death was changed to include all major medical conditions that caused and contributed to her death. There have been significant changes made at the Redcliffe Hospital including more training of staff regarding management of patients suffering from the prevalent and often fatal condition of chronic obstructive airways disease.

[21] See ss 7 and 8 *Coroners Act 2003*
[22] Exhibit B1 - The "Notification of deceased patient" document on Mrs Bodell's medical records did not provide much guidance about what was a reportable death.

81. Initiatives at the hospital have been discussed and trialled to improve the reliability of information handed over between medical and nursing staff. The particular medical ward has been reorganised to limit the number of patients on telemetry monitoring. An acute bay area with up to four patients has been created.

82. It has been recommended that state wide protocols be developed to:

    i. properly document and advise staff that oxygen is being administered at a required level to people who retain carbon dioxide due to pulmonary disease; and

    ii. clarify the decision making, documentation and communication of decisions involving the reduction, withdrawal or withholding of life sustaining treatment, in particular “do not resuscitate orders”;

I trust that now the Bodell family have had the opportunity of listening to the evidence from those that treated Mrs Bodell, they have a greater understanding of the decisions that were made. Sincere condolences are extended to Mrs Bodell’s family.

I thank counsel assisting the inquest and counsel for the hospital.

I have prepared these findings without access to transcript and I reserve the right to correct or amend this document should this be required.

The inquest is now closed.

Chris Clements
Deputy State Coroner
23 November 2007