QUEENSLAND COURTS

CORONERS COURT OF QUEENSLAND

FINDINGS OF INVESTIGATION

CITATION:	**Non-inquest findings into the death of Ms H**
TITLE OF COURT:	Coroners Court
JURISDICTION:	Brisbane
DATE:	14 November 2016
FILE NO(s):	2015/1762
FINDINGS OF:	Christine Clements, Brisbane Coroner
CATCHWORDS:	CORONERS: Health care related death, discharge against medical advice, and presumption of capacity to make own health care decisions, hospital unaware of patient's guardianship status at the time of discharge, stakeholders working towards improving information sharing

Introduction

1. Ms H was a 23 year old woman who lived in Queensland.

2. Ms H suffered from Asperger's syndrome, intellectual impairment and was reported to be non-compliant with medications.

3. On 20 February 2015, the Office of the Public Guardian (the OPG) was appointed by the Queensland Civil and Administrative Tribunal (QCAT) as guardian for decisions about healthcare. On 28 April 2015, the Public Trustee had been appointed in relation to the management of her finances.

4. Ms H died at the Royal Brisbane and Women's Hospital (the RBWH) on 7 May 2015 from:

    - 1a) Necrotising retroperitoneal fasciitis (surgically treated), due to, or as a consequence of,
    - 1b) Acute perforated gangrenous appendicitis (surgically treated).

Ms H's presentation to the Redcliffe Hospital on 30 April 2015

5. Ms H initially presented to the Redcliffe Hospital Emergency Department (the Hospital) on 30 April 2015 via the Queensland Ambulance Service (the QAS) with a two day history of vomiting and diarrhoea with umbilical pain radiating to the right side.

6. Ms H was triaged as Australasian Triage Scale Category 3 (i.e. assessment and commencement of treatment within 30 minutes). Ms H's two day history of diarrhoea and vomiting with umbilical pain radiating into the right side was noted. Also noted at triage was Ms H's report that she was unsure if she was pregnant, that her GP had taken bloods and that she was awaiting follow-up. The triage nurse noted that 1 gram of paracetamol had been administered to the patient by QAS due to her temperature being 38.20C, that she was declining IM ant-emetic and that she was requesting an ultrasound. It appears that no history of Asperger's syndrome or intellectual impairment was provided to assessing staff on her presentation.

7. Ms H's vital signs at triage were recorded as: Temperature (Temp) 36.6oC, Heart Rate (HR) 122 bpm, Respiration Rate (RR) 18 respirations per minute (rpm), Blood Pressure (BP) 106/67 and Oxygen Saturation (SaO2) 98% on Room Air (RA).

8. Ms H reported that she had miscarried in March 2015 when she had an elevated Beta-human chorionic gonadotropin (b-hCG), and a normal ultrasound, however she had not attended the Early Pregnancy Assessment Unit as advised. QAS had recorded an elevated temperature (38.5 degrees)

9. She remained in hospital overnight and was examined a number of times. She had an elevated pulse rate, a low blood pressure but her temperature returned to normal in the emergency department. She initially did not want to have

intravenous cannulation or to change into her gown however later agreed. A vaginal examination was essentially normal. She was diagnosed with gastroenteritis but blood testing showed acute kidney failure. Urine analysis showed white cells and she was therefore diagnosed with a urinary tract infection.

10. At approximately 08:25 on 1 May 2015, Ms H's condition was discussed by the medical team at the departmental morning handover. It was not clear that all of the symptoms and findings at that time could be explained by gastroenteritis. There were questions regarding the white cell count and tachycardia, (elevated heart rate) and urine leucocytes of 170. A plan to conduct a pelvic ultrasound to exclude pelvic causes was made.

11. The ultrasound was considered important to exclude other conditions before she could be discharged however Ms H refused to wait.

12. At 08:30, Ms H informed the nurse that she wanted to self-discharge. The nurse notified the doctor. Ms H was reviewed by the emergency department Registrar but refused to wait for the ultrasound to be performed.

13. The Registrar explained to Ms H that the untreated infection could lead to sepsis which could be fatal.

14. Ms H stated she had a referral for an outpatient ultrasound which she would book later that day. She was advised to return if her situation became worse.

15. Following a discussion about the risks of self-discharging, Ms H signed a "Discharge Against Medical Advice" form that was witnessed by her partner who identified as her fiancé. This process is supported by the Australasian College for Emergency Medicine Statement on Responsibilities for Care in Emergency Departments.

16. Staff at the Hospital were unaware that the OPG had been appointed as her guardian for decisions about healthcare.

17. Ms H was given a prescription for Trimethoprim 300mg (antibiotic) one tablet to be taken at night for three days to be filled at an outside pharmacy.

18. A letter was written by the Registrar to Ms H's General Practitioner noting her presentation and management while at the Hospital and that she had not waited for the scheduled pelvic ultrasound. A request was made for her GP to follow-up the microbiology results of her vaginal swab and to repeat her renal function tests. It was also reported to Ms H's GP that she had been advised to return if her condition deteriorated and that there were of a number of red flag symptoms for her to be on the lookout for.

Ms H's re-presentation to the hospital on 2 May 2015

19. At 08:20 the next morning (2 May 2015) Ms H was brought by QAS to the Hospital representing with a history of abdominal pain, nausea, vomiting and

reporting that her local medical officer had advised her to get an ultrasound and a chest x-ray the previous day.

20. She was noted to be sweating profusely, however denied fevers.

21. An urgent CT showed a perforated acute appendicitis and that there was moderate free fluid present. Ms H was taken to the operating theatre for emergency laparotomy, the findings of which noted: acute perforated appendix and large faecolith and four-quadrant faecal peritonitis, with large pelvic and sub-hepatic abscesses. Ms H underwent a laparotomy, appendectomy and washout and was admitted to the Intensive Care Unit (ICU) post-operatively.

22. Later that afternoon, the decision was made to return Ms H to the operating theatre for a washout and/or bowel resection and/or stoma. Laparotomy revealed necrotising fasciitis involving retroperitoneal tissue. Ms H underwent a right hemi-colectomy and ileostomy due to necrosis, and extensive excision of necrotic tissue in the retroperitoneal space.

23. A family meeting took place and it was agreed that Ms H would be transferred to the RBWH for ongoing management. This is the first time that the family knew of Ms H's health concerns, as they reported there was a breakdown in communication due to the QCAT orders being made and Ms H not accepting the need for the orders. At that time, staff raised their concerns that there was no system for them to be alerted that a patient has an appointed guardian for decisions regarding healthcare matters.

24. Once Ms H was at the RBWH, she underwent a re-look laparotomy. The findings identified: turbid fluid throughout the abdominal cavity, particularly the right side, small bowel and large bowel were noted to be viable, pale viable liver, necrotic retroperitoneal tissue on the right extending up the right lateral abdominal wall that was noted to be offensive smelling, the root of small bowel mesentery was noted to have necrotic peritoneal tissue and the pre-duodenal space was noted to contain purulent fluid. Necrotic tissue was excised, a negative pressure laparotomy dressing was applied and two drains were inserted.

25. The OPG was contacted post operatively and the decision was made to withdraw further treatment as it would be futile. Ms H subsequently passed away on 7 May 2015.

26. A cause of death certificate was initially signed by a doctor on 7 May 2015 with the following causes listed:

    - 1(a) Necrotising retro-peritoneal fasciitis;
    - 1(b) Perforated appendix; and
    - 1(c) Acute appendicitis.

Death reported as health care related and concerns expressed by Senior Staff Specialist

27. On 8 May 2015, the matter was reported by the RBWH to the Coronial Judicial Registrar due to concerns that her treating team at the Hospital had no knowledge of Ms H's guardianship status at the time she discharged against medical advice on 30 April 2015.

28. Accompanying the Form 1A report to the Coroners Court of Queensland, was a letter from a Senior Staff Specialist reiterating this concern. The doctor indicated that at the time of her presentation, Ms H had not advised staff of her guardianship status and stated that there was no formal notification process within the Queensland Health system. He opined that had clinicians at the time known her legal standing with regard to health care matters, she may not have been allowed to self-discharge and would have received treatment more promptly. He considered that the delay before she underwent laparoscopic surgery ultimately led to her death.

Review by Clinical Forensic Medicine Unit

29. On 11 May 2015, an independent doctor from the Clinical Forensic Medicine Unit (CFMU) was asked to review the matter. The doctor agreed with the RBWH Staff Specialist that the delay caused complications which led to Ms H's death. He noted that the QCAT order does not specify the sort of health care that the public guardian is responsible for deciding. The doctor highlighted that the way that the QCAT order is written it could be assumed that it applies to all health care however that the context for why it was made was not provided.

30. The reviewing doctor also commented that it seemed unusual that a person living independently such as Ms H to not be able to make decisions about any of her health care. But that if this was the case, then such a decision should not only be made known to health care professionals in the public system but also those in GP clinics and perhaps the private system.

31. He stated that he would consider that the medical assessments made on 30 April 2015 at the Hospital ultimately had decided Ms H should remain in hospital. She signed herself out against medical advice, a decision that would not likely have been accepted without input from the OPG if her guardianship status had been known at the time.

Autopsy

32. On 14 May 2015, an external autopsy was carried out by Senior Forensic Pathologist Dr Nathan Milne. A review of medical records was also undertaken. The pathologist opined that the cause of death was:

    1(a) Necrotising retroperitoneal fasciitis (surgically treated), due to, or as a consequence of,
    1(b) Acute perforated gangrenous appendicitis (surgically treated).

Family concerns

33. On 20 May 2015, Ms H's parents wrote to the Coroner to express their concerns that Ms H was able to discharge herself against medical advice when she had been under an order of the OPG. They indicated that the OPG needed to be more proactive with the patient and local health facilities. They stated that this would ensure that appropriate treatment is provided for those who are under their care. They considered that the lack of communication by the OPG hindered Ms H receiving appropriate medical care.

Letter to the OPG

34. On 3 June 2015, the Coronial Judicial Registrar wrote to the OPG outlining the concerns that had been raised by the CFMU doctor. In order to assist the investigation, the following information was required from the OPG:

    - A copy of the complete file relating to their involvement with Ms H;
    - A statement responding to the concerns expressed by Ms H's parents, the issues raised by the CFMU Review and the outcome of any review of the OPG management of Ms H's affairs and or response to any complaint made by her parents;
    - A statement addressing the broader systemic issue of how health service providers are expected to become aware of the existence of new or amended guardianship orders relating to a person's health care.

Response from the OPG

35. On July 2015, the OPG provided a response. It was noted that the role of the OPG is not to provide direct support or case management service to adults. The OPG relies on information being provided by the adults' support and care networks when administering statutory decision making functions including health care decisions. It was acknowledged that there is currently no process for hospitals to be notified of guardianship orders made by QCAT. That if health care providers consider that an adult does not have capacity to make a decision about a health care matter, they are able to contact the OPG to enquire about the existence of any guardianship orders. It was highlighted that there is also a manned 24/7 health care consent line that is maintained by the OPG.

36. It was noted that health care practitioners in Queensland are guided by the Queensland Health Guide to Informed Decision Making. This provides that if there is any evidence to suggest that the patient might not have capacity to provide consent to the particular health care concerned, the treating medical practitioner is recommended to undertake a thorough assessment of the patient's ability to make a decision.

37. The Guide also provides that it should not be assumed that a person lacks capacity to make a decision solely because of their age, disability, appearance, behaviour medical condition beliefs etc.

38. It was noted that health care practitioners work on the presumption that every adult patient has the capacity to decide whether to agree to or decline health care. In Ms H's case, the health practitioners determined that Ms H had the capacity to provide informed consent for health care and to discharge herself against medical advice on 31 April 2015.

39. The OPG considered that even if such treatment had been approved by the OPG, her cooperation to remain at the Hospital would still have been required.

40. In responding to the request to address the broader systemic issue of how health services are expected to become aware of the existence of new or amended guardianship orders, it was also highlighted that whilst notification of new or amended orders to health service providers may have some utility in some cases, there are a number of problems with such a system including:

    - Which service providers should be notified? i.e. hospital, GP's or others;
    - Should the notification be area specific, state-wide or nation-wide?
    - The difficulties encountered with the name used in guardianship orders as opposed to the name proffered by the patient.

41. The OPG said that reliance is placed on the health practitioner to follow the appropriate guidelines to ensure that the patient has the capacity to consent. If there is doubt, then the practitioner has the ability to contact the OPG.

Root Cause Analysis

42. On 29 November 2015, the Metro North Hospital and Health Service (which operates the Hospital) delivered their Root Cause Analysis (RCA) in respect of Ms H's death.

43. This is a systemic analysis of what happened and why and is designed to make recommendations to prevent adverse health outcomes from happening again, rather than to apportion blame or determine liability. Nor is it an investigation of an individual clinician's professional competence. It is conducted by a review team who had no involvement in the patient's care.

44. It was noted that one of the contributing factors was that the absence of an automated electronic information and alert system linking the OPG and Healthcare services, contributed to the treating team at the Hospital being unaware that a patient presenting to the emergency department was subject to an appointed guardian for decisions regarding healthcare matters.

45. It was considered that this may have allowed the self-discharge by Ms H against clear and strongly worded medical advice prior to a definitive diagnosis and treatment plan being made without the notification of the OPG. It was considered that this may have contributed to the missed opportunity to diagnose and treat Ms H's appendicitis which resulted in her death from necrotising retroperitoneal fasciitis due to acute perforated gangrenous appendicitis.

46. The RCA team considered that although the possible system vulnerability was unlikely to have directly contributed to the adverse event in this case, it was nonetheless significant. It was noted that earlier consideration of acute appendicitis as a potential diagnosis for Ms H's presentation may have been appropriate. This was due to the fact that Ms H presented at various stages with:

- Abdominal pain initially in the umbilical region that later radiated to the right lower (and upper) quadrants;
- Associated diarrhoea and vomiting;
- Anorexia (off food);
- Fever;
- Tachycardia;
- Right sided abdominal tenderness; and
- High white cell count.

47. It was noted that earlier consideration of acute appendicitis may not have altered the outcome in this case, due to Ms H self-discharging against clear and strong worded medical advice. However, earlier consideration of the possibility of acute appendicitis may have led to earlier imaging such as abdominal CT and / or an earlier expert Emergency Medicine Consultant or surgical opinion.

48. It was recommended that (Recommendation 1) the Hospital Director of Medical Services:
    - Escalate to the OPG and Healthcare services the need for an automated link to electronic records to alert healthcare facilities if patients are under the care of the OPG, and
    - Enlist the assistance of the OPG to provide education to Hospital staff in relation to legislative obligations around health care decision making.

49. It was also recommended that (Lesson learnt Recommendation 1) Emergency Department staff are reminded via suitable departmental teaching forums:
    - Of the presenting symptoms and signs of the differential diagnoses of abdominal pain, including appendicitis, and
    - That when doubt about a diagnosis exists, as there was in this case, a suitable senior Emergency and Department medical opinion should be sought at the earliest opportunity, particularly if self-discharge against medical advice is a possibility.

50. The RCA recommendations were accepted by the Executive Director of the Hospital on 30 November 2015.

Root Cause Analysis Outcomes

51. In response to the RCA recommendations, the Hospital Director of Medical Services escalated to the OPG and Healthcare services the need for an automated link to electronic records to alert healthcare facilities if patients are under the care of the OPG.

52. The Hospital also escalated the concerns to the Metro North Hospital and Health Service Chief Information Officer and the Queensland Health Services Information Agency (QHSIA).

53. On 18 June 2015 the Director of the QHSIA corresponded with the OPG highlighting the need for interagency information sharing and the potential benefit in having an automatic link between the respective client and patient databases.

54. On 13 of August 2015 the Manager of Guardianship of the OPG indicated that the OPG was interested in discussing interagency information sharing and inclusion of key stakeholders, including QCAT, the Public Trustee of Queensland and the Office of the Public Advocate. The Manager of Guardianship of the OPG also noted in their correspondence with the QHSIA that processes currently exist to manage situations where health practitioners are concerned about a patient's ability to make informed decisions and include the:

    - Health practitioner contacting either to OPG or the QCAT to check on the existence of an order;
    - Health practitioners utilising the OPG healthcare consent line (operating twenty-four hours seven days a week); and
    - OPG providing extensive education to medical students and the wider healthcare community in relation to legislative obligations around health care decision making.

55. In subsequent correspondence, the Hospital also advised that since Ms H's death, a number of training sessions have been provided in respect of consent to health care, capacity and substitute decision making, including:

    - On 18 February 2015, the OPG provided a session titled 'Substituted Decision Making and Health Care' which was attended by 60 staff;
    - On 17 March 2015, the Director of Medicine and Older Persons presented at Ground Rounds on a topic titled: 'Transition from Children's to Adults Hospital – how do we care for people with disabilities'. This was attended by 33 staff;
    - On 16 April 2016, a Professor from the University of Queensland School of Medicine presented on the issue of 'Withholding/withdrawing treatment from adults without capacity'. This was attended by 55 staff;
    - Between 18 and 22 May 2015, the Director of Medical Services at the Hospital provided training to senior medical staff on the topics of consent, indemnity and the coronial jurisdiction. This was attended by 39 staff;
    - On 15 June 2015, the Director of Medical Services at the Hospital provided training to the Anaesthetic Department on the topics of consent, indemnity and the coronial jurisdiction; and
    - On 16 June 2015, the Director of Medical Services at the Hospital provided training to senior medical officers in the emergency department on the topics of consent, indemnity and the coronial jurisdiction.

56. The Hospital also advised that a number of training sessions have been provided regarding the differential diagnosis of abdominal pain including:

- On 7 August 2015, a session was held on the assessment of acute abdominal pain which was attended by 34 junior doctors;
- On 1 July 2016, a grand rounds session was held titled “Acute Abdominal Pain”. This focussed on the presentation of the acute abdomen, differential diagnosis, supporting clinical features, potential pitfalls, evaluation and management;
- The emergency department has an education program for junior doctors and registrars which is comprised of the following:
    - Registrar training: CT abdomen interpretation, testicular pathology, abdominal pathology with appendicitis being discussed as a differential;
    - Registrar Training: *Mental health Act 2000*; and
    - Resident Medical Officer training: including topics such as lower quadrant pain in women, renal colic/pyelonephritis; biliary tree & pancreatitis, imaging and abdominal pain, abdominal pain in the elderly and children and PV bleeding.

57. The Hospital also advised that a number of changes have also occurred in the emergency department since Ms H’s death including:

- Governance of the emergency department including Fellow of the Australian College of Emergency Medicine (FACEM) consultant led model of supervision. Registrar appointment is now usually at a minimum Post Graduate Year 4 level and only when deemed suitable by the local consultants;
- Resident Medical Officers are required to discuss all cases with a FACEM or Registrar. This is reiterated during the standard orientation and listed as a "rules" in the emergency department medical orientation manual. The rules also provides that Interns, Junior House Officers and Senior House Officer have no rights of discharge and must discuss all patients with the Consultant or Registrar prior to their discharge;
- FACEMs are practising registered specialists and are expected to be competent in assessment of abdominal pain as well as competent in assessment of a patient's "capacity"; and
- Registrars at the Hospital are usually at least in their fourth post graduate year of practice and are expected to have had sufficient exposure and experience in assessment of both abdominal pain and "capacity" to practice safely with minimal supervision.

58. The Hospital advised that there is not yet a standard question asked/answered on presentation/admission to hospital/emergency department as to whether the OPG is involved with the patient. That said, the Hospital has undertaken to speak to staff at the emergency department to ascertain whether this could be asked bearing in mind that there will be occasions when people will not reveal that the OPG is involved.

59. The Director of the emergency department also advised that when doubt about a diagnosis exists, a suitable senior emergency department medical opinion is always sought at the earliest opportunity, particularly if discharge against medical advice is a possibility.

60. On 27 June 2016, further correspondence was received from the OPG about the implementation of the RCA recommendations. Of particular note from that correspondence is as follows:

- There remain technical barriers to the introduction of an automated link to electronic records to alert healthcare facilities if patients are under the care of the OPG. The Director of Guardianship advised that OPG's current IT system does not have functionality for easy data transfer externally, and that this functionality would be needed as regular updates of client information would be required in order to maintain the currency of Queensland Health's data;
- OPG was in the early stages of scoping a new client information management system, and that this system would likely enhance OPG's capacity to share data with external agencies;
- State-wide hospitals are currently operating on a number of different IT platforms, and that work was underway to align these various systems and to convert all patient files from paper-based form to electronic format;
- The OPG could only provide details of adults for whom the OPG has been appointed either as guardian by the QCAT or as an attorney under an enduring document. They do not have information on adults for whom QCAT had appointed a private guardian (only one-half of all QCAT appointments go to the OPG);
- OPG does not have information on adults whose healthcare decisions are made by private (i.e. non-OPG) attorneys, or on an informal basis (i.e. by someone acting as the person's statutory health attorney;
- OPG and Queensland Health are considering publishing detailed information on the QH intranet about the operation of section 67 of the *Guardianship and Administration Act 2000* (Guardianship Act) which relates to the effect of an adult's objection to health care;
- Discussions with Queensland Health regarding electronic data sharing are continuing;
- OPG is continuing its education efforts to train medical staff on the legislative requirements of statutory health care decision making; and
- OPG has also engaged the Department of Justice and Attorney-General's ITS division to develop an interactive online tool to guide doctors through the process of healthcare decision-making for adults with impaired capacity, and to assist them to navigate the legislative requirements. This project is in the planning stages.

Conclusion

This matter demonstrates the difficulties that are sometimes experienced with the practical application of the Guardianship Act in the health care context.

The Guardianship Act provides a mechanism for decisions to be made on behalf of an adult if they lose capacity due to accident, illness or age. However as identified in section 11 of the Guardianship Act, an adult is presumed to have capacity for a matter.

The Guardianship Act enables QCAT to appoint Guardians to make decisions on behalf of the adult. Once appointed, Guardians can make decisions on personal, health and lifestyle matters as well as other legal matters not related to the adult's finances or property.

A person may have impaired capacity if they are unable to understand, make or implement a decision. Capacity for a person means the person is capable of:

- Understanding the nature and effect of the decisions about the matter;
- Deciding freely and voluntarily;
- Communicating the decision in some way (for example orally, in writing or other methods of communication, such as sign language).

Whilst Ms H may have received more timely medical treatment had she not self-discharged herself on 30 April 2015, the health care practitioner determined that she had capacity to make that decision. This meant that the application of the Guardianship Act was not called into question.

There is nothing to suggest that there was anything known about her history of Asperger's nor that any active enquiry was made of her guardianship status.

The medical records show that on 30 April 2015, Ms H signed the patient election upon presentation to the Hospital. She consented to various aspects of her health care including vaginal examinations and blood tests. She also initially declined to receive certain health care including IV cannulation which is consistent with an adult's right to refuse health care (section 12(4) of the Guardianship Act).

There has been significant communication between relevant agencies and they are working towards sharing information however it is acknowledged that this will take time.

There has been a significant amount of training and education provided at the Hospital since Ms H's death on the issues of consent to health care, capacity, substitute decision and differential diagnoses of abdominal pain.

The Hospital has co-operated with the coronial investigation and clinically reviewed the events and circumstances surrounding Ms H's care and treatment.

In all these circumstances it is not in the public interest that an inquest should be convened.

The focus of the Coroner's jurisdiction is to reach findings required in section 45 of the *Coroners Act 2003* if at all possible. There is sufficient information to do so and the findings are as follows:

a) That the deceased person is Ms H;

b) Ms H presented to the Redcliffe Hospital Emergency Department on 30 April 2015 with abdominal pain and a two day history of diarrhoea and vomiting. She was admitted overnight but discharged herself against medical advice the following day. A definitive diagnosis had not yet been established. At the time, it was unknown to staff that the Office of the Public Guardian had been appointed to make health care decisions on her behalf as Ms H had Asperger's syndrome.

   Ms H represented to the Hospital on 2 May 2015 with ongoing abdominal pain, nausea and vomiting. A CT showed a perforated acute appendicitis with severe peritonitis. Despite numerous surgical interventions (including washout and debridement to address septic shock and necrosis), antibiotic therapy and transfer to a tertiary facility for ongoing management, Ms H ultimately passed away from her illness.

c) Ms H died on 7 May 2015;

d) Ms H died at the Royal Brisbane and Women's Hospital;

e) Ms H died as a result of:

   - Necrotising retroperitoneal fasciitis (surgically treated), *due to, or as a consequence of*,
   - Acute perforated gangrenous appendicitis (surgically treated).

Christine Clements
Brisbane Coroner
14 November 2016