QUEENSLAND COURTS

CORONERS COURT OF QUEENSLAND

FINDINGS OF INQUEST

CITATION:	**Inquest into the death of James Patrick Talbot**
TITLE OF COURT:	Coroners Court
JURISDICTION:	Brisbane
FILE NO(s):	2014/35
DELIVERED ON:	8 July 2016
DELIVERED AT:	Brisbane
HEARING DATE(s):	16 February 2016, 20-22 June 2016
FINDINGS OF:	John Lock, Deputy State Coroner
CATCHWORDS:	Coroners: inquest, health care related death, private hospital, missed diagnosis of bowel obstruction, communication between visiting medical officers and nursing staff, procedure for escalation of patient/family concerns

REPRESENTATION:

Counsel Assisting:	Ms M Jarvis, Office of State Coroner
The Talbot Family:	Mr S Lynch
The Wesley Hospital and staff:	Mr M Hickey i/b Minter Ellison
Drs Woodrow & Kaisar:	Ms J Rosengren i/b Avant Law
Registered Nurse Duggan:	Ms A Martens, Maurice Blackburn Lawyers

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Introduction

1. James Patrick Talbot was aged 87. He was brought to the Wesley Hospital on 29 December 2013 and he died there on 31 December 2013. He had been unwell for a number of days.

2. After his death, Dr Luis Prado, Director of Medical Services at Wesley Hospital, personally referred the matter to the Office of the State Coroner. The cause of death on a Cause of Death Certificate prepared by his treating physician was listed as Aspiration Pneumonia. It was initially considered the death was not a reportable death for reporting to the coroner, until a review of the medical records by the hospital noted there may be issues with respect to medical management and in particular the management of a likely bowel obstruction.

3. Dr Prado noted that following a review of the clinical record and discussions with Mr Talbot's family, it was apparent there were matters to be addressed regarding the diagnosis of Mr Talbot's condition, clinical deterioration over a 24 hour period and difficulties the family reported to him in receiving appropriate responses to concerns raised by them. A central issue was communication between nursing staff and Mr Talbot's doctor and communication with the family.

Issues for inquest

4. A pre-inquest hearing was held on 16 February 2016. The following issues were determined for the inquest:

    i. The findings required by s. 45 (2) of the *Coroners Act 2003*; namely the identity of the deceased, when, where and how he died and what caused his death.
    ii. The circumstances leading up to the death.
    iii. The appropriateness of the health care provided to the deceased at the Wesley Hospital in Brisbane from his admission on 29 December 2013 and up until his death.

5. The following witnesses were called to give evidence at the inquest.

    a. Dr Don BUCHANAN
    b. Ms Deborah CROXFORD
    c. Dr Mark WOODROW
    d. RN Keri DUGGAN
    e. CNM Jennifer HYDE
    f. RN Lissy Palliyan ANTHONY
    g. RN Sun YOON
    h. RN Deng PAN
    i. RN Elizabeth ASTWOOD
    j. Dr Mohammed Omar KAISAR
    k. Dr Luis PRADO
    l. Dr Edward RINGROSE
    m. Dr Wayne HERDY
    n. Dr Peter GOURLAS

Initial review by Clinical Forensic Medicine Unit (CFMU)

6. Dr Don Buchanan of the Queensland Health CFMU provided an initial advice to the coroner. Mr Talbot was an 87 year old man who was brought in by ambulance

to the Wesley Hospital on 29 December 2013 after having been generally unwell for the past two or so days, with vomiting. His past history included hypertension, cholesterol and diabetes. He was taking oral medications for these conditions. He was also taking rabeprazole, which is normally used to treat gastric reflux.

7. Dr Buchanan noted Mr Talbot was assessed at the Wesley Hospital Emergency Department and noted to appear somewhat confused. He did not have a temperature, his chest was clear and abdominal examination 'unremarkable.' Blood tests showed a mild increase in white cells (which increase in response to infection) and some worsening of kidney function compared to previous tests (which can be from dehydration).

8. Mr Talbot was considered to be dehydrated and this and his general decline were thought to be due to a possible urinary tract infection. He was commenced on intravenous fluids, an anti-emetic to treat the vomiting, and was admitted to the ward.

9. Dr Omar Kaisar, General Physician, examined Mr Talbot on 29 December and ordered the IV fluids to continue, his usual medications to be given and to review the urine test. A nursing note at 1730 hours states that the urine test could not be collected as Mr Talbot had been incontinent of urine; he refused dinner.

10. A nursing note at 2345 hours stated that Mr Talbot had vomited twice since 2000 hours; he had denied vomiting however there was green bile-like vomit on the sheets. This was discussed with Dr Kaisar and he was prescribed an IV anti-nauseant (ondansetron).

11. A nursing note at 0445 hours on 30 December noted that Mr Talbot was very confused and disorientated, and was trying to pull his drip out. It was also noted that he had vomited about 200ml of dark green vomit and that his abdomen was 'very distended.' He denied any nausea however the nurse noted that he was confused.

12. Dr Kaisar saw him later (30 December) noting him to be 'better today'. He ordered a CT head, a physiotherapy review and to await the urine test. A nursing entry at 1530 hours noted Mr Talbot to be nil by mouth due to the bile coloured (green) vomiting. His bowels had not opened but he was incontinent of urine. The CT head was reported as showing generalised atrophic changes that had mildly progressed since the previous test in 2008; there were no acute changes.

13. Another nursing entry at 2120 hours noted that he had vomited three times that evening though they were very small amounts (about 20ml each time). There was no temperature and his observations were within normal limits.

14. A Code Blue was called at 0023 hours on 31 December as Mr Talbot had been found unresponsive. The medical entry for this event noted that he had vomited what looked like coffee ground vomit; this can indicate some altered blood in the vomit. CPR was commenced however he did not respond to resuscitative measures and was declared deceased.

15. The death certificate states that he died from aspiration pneumonia, duration one day. This condition was stated as due to inhalation of vomitus. A cause for the aspiration was not provided.

16. Mr Talbot's abdomen on admission was noted to be unremarkable. However at 0445 hours on 30 December he was noted by a nurse to have vomited green coloured vomit and that his abdomen was 'very distended'. However, when examined by Dr Kaisar that day this was not noted. Vomiting and abdominal distension can indicate a bowel obstruction though there was no complaint of pain; he was however confused.

17. Dr Buchanan said he would consider that a cause of the vomiting, abdominal distension and aspiration needs to be further investigated, as the adequacy of Mr Talbot's medical management cannot otherwise be fully determined.

Autopsy results

18. A partial internal examination was performed. The main findings were in the abdominal cavity.

19. There was an obstruction of the small bowel due to adhesions. There were two loops of bowel trapped by bands of adhesions at the region of the right upper abdomen near the base of the liver. These loops of bowel were noted to be strangulated.

20. The rest of the internal examination noted the presence of mild diabetic nephropathy, emphysema of the lungs and early liver fibrosis.

21. Vitreous humour biochemistry showed changes consistent with dehydration (raised urea).

22. Death could be caused by a combination of dehydration, electrolyte imbalance, sepsis and/or toxins released by the necrotic portion (strangulation) of the bowel.

23. The history of vomiting and abdominal distension would be consistent with the post-mortem findings. The cause of death was due to strangulated small bowel due to adhesions (previous abdominal surgery).

Root Cause Analysis

24. The Wesley Hospital conducted an expeditious Root Cause Analysis. This was completed by 21 March 2013 and this greatly assisted setting a focus for the investigation. The RCA identified three factors contributing to the event.

25. Firstly, there was no agreed communication process in place to allow family/care concerns to be escalated. It was recommended that the hospital develop an agreed communication process for patients and families to escalate concerns in association with *Standard 9 Recognising and Responding to Clinical Deterioration in Acute Health Care* of the National Safety and Quality Health Service Standards.

26. Secondly, the failure to replace the Team Leader allowed a missed opportunity for assessment and communication escalation. Recommendation was for the hospital to develop a standardised approach for the Team Leader's role, including minimum rostering requirements and equivalent sick leave replacement.

27. Thirdly, there was inconsistent communication processes between the medical practitioner, the Team Leader, and the registered nurses caring for the patient, leading to a missed opportunity to recognise and manage the patient's changing condition. It was recommended the hospital review policies and protocols for clinical handover between clinical team members; that visiting medical practitioners be educated regarding the principles of the SHARED handover processes used by nursing staff and that there be an audit of compliance.

28. There were a number of lessons learnt. Firstly, no guidelines were available for retrieving a urine sample for an incontinent patient.

29. Secondly, there was no formal observation tool in place to assist staff in escalating responses to the deteriorating patient. In that regard the Q-ADDS tool is to be introduced as an escalation mapping tool to assist in matching trigger thresholds and escalation processes.

Investigation

30. Given the autopsy findings and RCA results a further investigation commenced. Family also expressed their concerns as to why further investigations were not made with respect to Mr Talbot's distended abdomen and his apparent deterioration, particularly when this had been brought to the attention of nursing staff by family members.

31. Statements were requested from all nursing and medical staff engaged in the treatment of Mr Talbot from the date of his admission until his death. Dr Buchanan was asked to review the further material when it was received. The Office of State Coroner commissioned an independent expert report from Dr Wayne Herdy. As well the office received further expert reports commissioned by the Wesley Hospital and Avant Law for Drs Woodrow and Kaisar.

32. By way of context and to give some understanding as to the systems issues identified in the RCA as contributing to the death, it should be noted the Wesley Hospital is a private hospital and one of a number of hospital facilities run by UnitingCare Health. The hospital employs and is responsible for nursing staff and some resident medical staff. The majority of patients are under the care of private Visiting Medical Practitioners (VMP) and in this case Mr Talbot was admitted under the care of a general renal physician, Dr Omar Kaisar.

33. The procedure for medical review of patients varied somewhat depending on the requirements of each individual VMP. It is apparent Dr Kaisar would perform a ward round usually between 7.30am to 8.30am. Nurses would make entries into two sets of records. A set of Observation records would be completed by them routinely and these were kept at the bedside. A set of progress notes would also be completed at times during the nurse's shift and these would be kept at the nurse's station. The practice of Dr Kaisar, consistent with the evidence of other specialists who gave evidence, is that they would not invariably read the nursing progress notes but would depend on nurses attending with them on the ward round to provide an oral update as to the patient and any concerns. Alternatively, any concerns would be passed on to the doctor at other times by telephone or other communication by nursing staff. The VMPs would usually then write in the progress notes as to any findings and changes for care.

34. The practice of nurses at the time of Mr Talbot's death was for there to be a short 10 minute Flagging Handover where all nurses were present and where any matters of concern would be flagged so the Team Leader and Clinical Nurse Manager were aware of those concerns. Nurses would then do a more complete individual patient handover to those coming on to the next shift and who would be looking after their patients. The Team Leader's role was one that supervised the nurses and updated VMPs if patients have any concerns or were deteriorating and then passing back any information to the treating nurse from the doctors. The intention was that the Team Leader would attend on ward rounds with the VMPs and pass on any flagged concerns. If the Team Leader was not available because there were multiple VMPs present, the Clinical Nurse Manager may become involved or the particular nurse in whose care the patient was would attend. Sometimes VMPs would attend ward rounds without a nurse present.

35. At the time of Mr Talbot's death there was no formal process for escalation of patient or family concerns where the patient was deteriorating.

36. The Wesley Hospital very properly conceded there were a number of lost or missed opportunities and failures of systems evident in the care provided to Mr Talbot.

Presentation to Emergency Department

37. Dr Mark Woodrow was working on the morning of 29 December 2013 at the Wesley Emergency Centre. He first saw Mr Talbot at 8am. He presented with a history of feeling unwell for a few days with oral intake, lethargy and vomiting. This history was confirmed by Mr Talbot's daughter whom he lived with. He also had unsteadiness and confusion as well as some urinary incontinence.

38. On examination he was confused but alert and not distressed. He had a temperature of 37.4°, pulse 78, blood pressure 117/58, respiratory rate 22, pulse oximetry 96% on room air. Examination of his chest was unremarkable with normal breath sounds and no respiratory distress. Heart sounds were unremarkable. Abdominal examination was unremarkable, indicating no tenderness, mass, distension or abnormal bowel sounds. An ECG was unremarkable.

39. Blood tests were collected. There was a white cell count of 10.9 with mild neutrophilia and monocytosis, thought to represent an infective process. Chest x-ray was unremarkable.

40. Dr Woodrow stated that the cause of his symptoms was unclear, and given his low-grade fever, abnormal full blood count, age and some urinary incontinence, an urinary tract infection was thought most likely although not confirmed at that stage. His abnormal biochemistry suggested dehydration as a contributing factor although it was uncertain whether this was the primary cause of his deterioration.

41. There was a mildly elevated troponin and coronary artery disease was considered but with abnormal renal failure and a normal ECG this was considered less likely. Chest infection was also considered but in the absence of respiratory symptoms and a normal chest x-ray this was also considered less likely.

42. With no complaint of abdominal pain and normal abdominal examination further intra-abdominal pathology was not considered a likely cause of his symptoms, but was not excluded. His exact diagnosis was uncertain and was one of the reasons for his admission to the ward.

43. The plan was for hospital admission for intravenous rehydration and observation and review by a general physician for further investigation as necessary to establish a diagnosis.

44. While in the emergency department over the next four hours, his vital signs remained stable and there were no complaints of pain and no vomiting.

45. Dr Woodrow discussed the presentation with Dr Kaisar who accepted him for admission and further management. Dr Kaisar reviewed the patient in the emergency department at about 11:30am. His statement and evidence at the inquest suggests he conducted an abdominal examination and it was soft, non-tender and with no abnormality. Mr Talbot was confused. Mr Talbot was not in any reported or observable pain.

46. The uncontroverted evidence of those doctors who gave evidence, including those treating Mr Talbot as well as independent experts, was that if Mr Talbot had an ischaemic bowel at this time it would be very unusual for him not to complain of or exhibit abdominal pain sufficient to require narcotic pain relief.

47. The provisional diagnosis of Dr Woodrow and Dr Kaisar was that Mr Talbot was suffering from a Urinary Tract Infection (UTI). A Microurine Test (MSU) was ordered by Dr Woodrow. This is a standard test which would confirm or negate a UTI. A urine sample was not collected by the time Mr Talbot went to the ward. As became evident, a urine sample was never collected and an MSU analysis was not completed.

Admission to ward

48. Registered Nurse (RN) Keri Duggan was rostered on the evening shift of 29 and 30 December 2013. The shift commenced at 7pm on the handover noted that Mr Talbot had come in with nausea and vomiting. She conducted hourly rounding and did not complain of any pain.

49. RN Duggan noted during one of these checks that Mr Talbot had vomited and appeared quite vague. Mr Talbot denied vomiting despite the obvious presence of vomitus. She believes he vomited a second time and then contacted Dr Kaisar at 11:30pm to obtain a phone order for an anti-emetic. This was granted and administered. A short time later she saw him vomit 100 mls–200 mls of green bile stained fluid. Mr Talbot denied feeling any nausea. He was given a further dose of an antiemetic at 1:30am.

50. During another one of her hourly checks during the night she noted Mr Talbot's abdomen was quite distended. She stated that this had not previously been noted in the chart and she made a particular note of this in the chart at 4:45am. RN Duggan cannot recall if Mr Talbot complained of abdominal pain but said her usual practice was that she would have felt his abdomen and would have documented if there was any reaction suggestive of pain. No such notation was made. She did not contact Dr Kaisar overnight as she would generally not do so unless the patient was particularly unwell or she felt there was a significant

change. She was also aware Dr Kaisar would be reviewing Mr Talbot during his ward round in the next few hours after 7:30am.

51. The distended abdomen was also flagged as an issue during the morning flagging handover. RN Duggan recalls discussing the matter with Clinical Nurse Manager Jenny Hyde who suggested Mr Talbot be kept nil by mouth pending review by the doctor that morning. She also recalls showing the oncoming nurse RN Sun Yoon Mr Talbot's distended abdomen at their handover.

52. Clinical Nurse Manager Jennifer Hyde commenced her shift at 6:30am on 30 December 2013. She stated in her statement she was advised by RN Duggan during handover that Mr Talbot that had been confused overnight so the plan was to move him closer to the nursing station for better observation.

53. CNM Hyde also became aware that Mr Talbot had been vomiting and that his stomach was distended so she suggested he be made nil by mouth until Dr Kaisar did his medical review that morning.

54. CNM Hyde did not go on the ward round with Dr Kaisar that morning but she recalls in her statement having a conversation with the Team Leader RN Anthony concerning Dr Kaisar's notation in the chart that Mr Talbot was better today and he was ordering a CT of the head without any other investigations. Clearly this was after Dr Kaisar had been on the ward round. CNM Hyde was aware Dr Kaisar relied on the nurses to provide a patient summary rather than reading progress notes.

55. Team Leader RN Lissy Palliyan Anthony had a severe migraine that was causing her to vomit with blurred vision and she left the Ward at about 9:30am and the hospital at about 11am. She has no recollection of Mr Talbot or any discussions about him. She does recall a flag at handover about a patient who had green vomit on his bed and expects this was about Mr Talbot but does not recall anything about a distended abdomen.

56. RN Anthony did not go on the ward round with Dr Kaisar. CNM Hyde could not explain why other nurses had not replaced RN Anthony for the ward rounds. At inquest she said it was her understanding RN Anthony had been on the ward round with Dr Kaisar. Although Dr Kaisar says he cannot recall if a nurse attended on the ward round with him, it seems likely none did as no-one has been identified.

57. CNM Hyde did note that Mr Talbot was walking around with the physiotherapist a short time later and considered that he did look better than he had earlier that morning. She did not physically review Mr Talbot.

58. It is now apparent Dr Kaisar started his ward round later than usual at some time after 10:30 or 11:00am.

59. RN Sun Yoon worked the morning shift from 7am to 3:30pm on 30 December 2013. She recalls receiving a hand over from RN Duggan that Mr Talbot had been vomiting overnight and his abdomen was distended. She recalled this was handed over by RN Duggan at both the Flagging handover and the bedside handover. At the time of handover it should be noted that the handover sheet

had not at this stage, or at all during the admission, make reference to the distended abdomen.

60. RN Sun Yoon also recalls Mr Talbot was made “nil by mouth” until reviewed by the Doctor. After completing the morning medication round she recalls noting that his abdomen was still very distended and reported this to either the Team Leader RN Anthony or to CNM Hyde. She said they confirmed the Doctor needed to be made aware of the abdominal distension. Neither, CNM Hyde nor RN Anthony recall this but I accept it was most likely mentioned to CNM Hyde.

61. As the Team Leader usually does the ward round with Doctor to escalate any concerns RN Sun Yoon did not take any further steps in relation to the matter. She did not speak to Dr Kaisar during the shift. She recalls Mr Talbot's family being with him from 10am and she told them that he had not vomited during her shift but his abdomen was distended.

62. She does not recall if she continued to care for Mr Talbot during the morning and does not recall anything about a urine sample needing to be collected. She observed no significant changes to his condition that would have warranted notification to the Doctor and her impression was that he was sick but stable. It was during her shift that Mr Talbot was moved from bed 11 to bed 4 so that he was closer to the nurses’ station. It is evident that during this period there appeared to be a gap of a few hours where it is unclear who was caring for Mr Talbot. It is accepted that during this period Mr Talbot had the CT scan of the head and this would partially explain some of that period.

63. At about 1:30pm CNM Hyde was advised by RN Sun Yoon that they were awaiting the urine test results. It seems no-one had realised that a sample had still not been taken.

64. RN Sun Yoon gave a handover to RN Deng Pan and thinks the handover included the distended abdomen, but she could not now recall. She wrote her own entry in the progress notes at 3:30pm after the handover. She made no reference to the distended abdomen in her note

65. RN Deng Pan was rostered on the afternoon shift from 12 noon to 10:30pm on 30 December 2013. He recalls at a later handover that Mr Talbot had abdominal discomfort and was vomiting. He was nil by mouth, he had a CT head that morning and was confused. He was incontinent so a urine sample had not yet been obtained. RN Deng Pan does not recall a reference to abdominal distension in the handover. However, given RN Deng Pan’s later evidence with respect to his interaction with Mr Talbot’s daughter, I suspect his memory is not accurate and it is likely the reference to abdominal discomfort was in fact about the abdominal distension.

66. RN Deng Pan recalls having a conversation with Mr Talbot's daughter Deborah Croxford, who asked about the treatment being provided to her father. She passed him a vomit bag that contained about 20 mls of green vomit. He advised that Dr Kaisar had ordered a CT scan of the head and he was nil by mouth due to vomiting and was receiving IV fluids to keep him hydrated. At this stage RN Deng Pan says Mr Talbot was awake, alert and in no distress.

67. RN Deng Pan says Mr Talbot's daughter was not happy with his response. This turns out to be an understatement as Ms Croxford was and remains very unhappy about RN Deng Pan's response.

68. Ms Croxford says that she came to the hospital during the afternoon of 30 December. She noted that it was obvious her father had been vomiting. She could see he was very weak and was very strained in talking to her. She noticed how swollen his stomach was and could hear his breathing was laboured. She became increasingly concerned about his care and his obvious deterioration. She spoke to her brother and was very distressed about her father and that no concern was being shown by hospital staff. She approached the nurses' station and asked to speak to someone. She eventually spoke to RN Deng Pan. He told her he could not read the doctors writing but noted a CT scan of her father's head had been ordered and they would have to wait for the results. Ms Croxford says that she questioned why a CT of the head was required as it was obvious it was not his head which was in question but his stomach was swollen, he was vomiting and was very ill. He could not explain why a CT of the head had been ordered and did not inspect her father's obvious distended stomach. She says RN Deng Pan seemed unconcerned about her concerns. She remained very upset and after comforting her father she left the hospital to go home as she did not want him to know she was upset. She regrets to this day that she had not stayed with him in what turned out to be his final hours.

69. RN Deng Pan says he does not recall the detail of this conversation and in particular does not recall any concern being expressed about his abdomen or of gurgling sounds or a query about the CT head scan. It should be clarified here that Ms Croxford's reference to gurgling sounds was not in relation to the abdomen but upper respiratory sounds.

70. RN Deng Pan says Ms Croxford did not report any concerns to him and became only aware of this after Mr Talbot's death. He agrees she was not happy with his response but did not ask her for any more information as he had other pressures and tasks to complete.

71. RN Deng Pan says Mr Talbot did vomit again during the evening and he gave him an antiemetic intravenously. During the shift he also plan to obtain a urine sample but whilst attending to pressure areas discovered a wet pad, indicating he could not obtain a urine sample at that time. There was no indication that the urine sample was urgent and he did not escalate this task. He says while changing his pad he found Mr Talbot's abdomen was soft, not distended and he was breathing normally. He did not consider Mr Talbot's condition warranted escalation.

72. Given what had been observed by RN Duggan and Ms Croxford and the later autopsy findings, RN Deng Pan's evidence that Mr Talbot's abdomen was soft and not distended cannot be correct. It is also evident that his recollection of the detail of the conversation with Ms Croxford is also deficient. He says he has reflected upon his actions and would do things differently now. He also undertook a communication training course.

73. RN Duggan commenced her next shift at 7pm on 30 December 2013. At the hand-over she was advised that Dr Kaisar had reviewed Mr Talbot and ordered a urine test, physiotherapy and a CT of the head. She recalls being confused

about the reason for the CT of the head and remembers asking RN Deng Pan if he meant a CT of the abdomen. RN Deng Pan does not recall this conversation but I accept RN Deng Pan's recollection is again deficient.

74. RN Duggan says as she was expecting some abdominal investigation to check the progress notes to make sure that something said at the morning handover had not been misunderstood. She saw Dr Kaisar's notes about Mr Talbot being "better today" and that a urine sample and physiotherapy and CT head had been ordered. Given she was not a doctor she thought she might have been wrong. She then performed hourly rounds and noted that Mr Talbot was asleep during this period of time and that he was lying on his left hand side. The bed was elevated at the head at about 35°. She did not see any vomit.

75. RN Astwood was working on another ward but was asked to stay longer after her shift had finished to provide some assistance. She found Mr Talbot unresponsive, cool to touch and bile stained fluid/him, coming from his mouth. She asked if Mr Talbot was for resuscitation and when told he was, a CODE BLUE was called. She suctioned fluid from his mouth and was surprised at the amount that was coming out.

76. RN Duggan came back to the ward at about 12:20am after a meal break at midnight. She had been asked by RN Astwood if Mr Talbot was for resuscitation. She was initially confused as a person in the next bed/room was for end of life and thought that it was this patient that was being referred to. When she arrived she identified Mr Talbot as being the patient referred to and realised he was for resuscitation.

77. A CODE BLUE was called and CPR commenced. A strong smelling dark substance came out of Mr Talbot's mouth requiring suction and it looked and smelled like faecal matter. Resuscitation was unsuccessful and RN Duggan noted that his stomach looked very distended and noticed it to be much bigger than the night before.

Statement of Mohammed Omar Kaisar

78. Dr Kaisar is a physician specialising in nephrology and General medicine. Mr Talbot's main complaints were feeling unwell for several days, increased confusion, unsteadiness, decreased oral intake, and low volume vomiting for a few days prior to admission.

79. Dr Kaisar stated there was no mention of a distended abdomen in the history provided to him. He obtained a history from the family consistent with underlying dementia. Physical examination at the time revealed that the stomach was soft and non-tender with active bowel sounds, with no abdominal distension.

80. Neurological examination was more difficult as Mr Talbot was confused. He diagnosed that Mr Talbot likely had a urinary tract infection and was advised that a urine sample would be collected in the emergency centre. He recalls receiving a telephone call from the late evening of 29 December requesting prescription of an antiemetic but states that at no time was he informed that Mr Talbot's stomach was distended.

81. Dr Kaisar reviewed Mr Talbot the next morning during his ward round. It appears this was sometime between 10:30 and 11am. He did not note at the time any

signs of abdominal distension and Mr Talbot was not vomiting when he saw him. Dr Kaisar did not perform an abdominal examination and had not read the nursing progress notes where RN Duggan referred to a 'very distended abdomen'. Dr Kaisar does recall Mr Talbot's son Shane Talbot was present.

82. Dr Kaisar ordered a CT of the head. He stated this was to investigate if there were neurological conditions, which could explain Mr Talbot's confusion and vomiting. The urine tests were not available. He was not aware at the time that the sample had not been collected. As Mr Talbot was being treated for confusion and not sepsis, the urine test was non-urgent. The treatment plan was to review the urine test results when available and determine the most appropriate treatment, that is, antibiotics, having regard to the results.

83. Dr Kaisar states that it was not his usual practice to review the nursing notes in the medical record. Rather, the nursing staff provide him with an oral summary of the nursing notes, and if no nurse is available to accompany him on the ward round he discusses the condition of the patients he sees with the nurses and they flag with him anything of note. He does review the nursing observation sheet.

84. Dr Kaisar states that he subsequently read the medical record and noted that Mr Talbot continued to vomit, with it being of low volume and bile coloured, but with his observations stable and a decision had also been made to stop giving him food. He states that none of this information was given to him at the time of his ward round or that he had been consulted about withholding food.

85. Subsequent to his ward round Dr Kaisar says he received no further communication from the nursing staff. He was unaware Mr Talbot had been vomiting subsequently during the day and had not opened his bowels. He was not aware Mrs Talbot's daughter had expressed concerns about her father at about 4:30pm saying that his abdomen was distended and that he was gurgling.

86. Dr Kaisar considers he would have expected nursing staff to have contacted him if there had been any significant changes in his condition, specifically if there was any abdominal distension, vomiting or gurgling sounds. He would have expected to have been contacted if nursing staff had been unable to collect a urine sample.

87. He states that if he had been advised of these things he would have returned to the ward, reviewed Mr Talbot and depending on his findings would likely have arranged an urgent CT of the abdomen and a chest x-ray.

88. If this had occurred Dr Kaisar would have discussed the situation with his family with two (2) options being a surgical review, or palliation. He would have organised a surgical review if requested but considered Mr Talbot was not a surgical candidate in view of his underlying medical co-morbidities and his recommendation would have been to take a conservative approach.

Further opinion by Clinical Forensic Medicine Unit

89. Dr Buchanan noted in this case that Dr Kaisar does not read the nursing notes but relies on nurses providing him with an oral summary on his ward round. Dr Kaisar's medical entry dated 30 December 2013 was immediately under the written observations of RN Duggan that Mr Talbot was confused, vomiting 200 mls of green fluid and had a very distended abdomen.

90. Dr Buchanan noted it was unclear as to who attended the ward round with Dr Kaisar that day. Team Leader Anthony would normally have attended the ward round but she developed a migraine and went off the ward at 9:30 AM. It is now evident that no nurse attended on the ward round.

91. Dr Kaisar did document that Mr Talbot bowels had opened, which was noted in the nursing observation chart. Dr Kaisar therefore considered that this did not raise the possibility of a bowel obstruction. His notes do not indicate that he examined Mr Talbot's abdomen that morning. Dr Kaisar ordered a CT scan of the head because of the history of suggestive dementia.

92. However Dr Buchanan noted that the reference to 'bowels opening' was qualified with 'patient states'. Mr Talbot had also previously told the nurse that he had not vomited when he clearly had.

93. Subsequent to the ward round Mr Talbot's observations remained stable and at no time did he complain of pain. He continued to vomit small amounts of green fluid and his abdomen remained distended and this was not a great deal different to his condition before the ward round. As such, the nursing staff did not contact the doctor.

94. The staff available were also not clinically responsive to the real concerns expressed by his daughter that afternoon. In addition, the urine test that had been ordered was never collected over this time.

95. Dr Buchanan was of the view there were communication failures at a number of levels that led to a missed diagnosis. The case was complicated by the fact that Mr Talbot had not complained of pain and that his observations remained within normal limits throughout. However, essential clinical signs that had developed overnight and observed and actioned by nursing staff after his admission to the ward, were not likely to have been adequately communicated to the doctor on the ward round. This, combined with a lack of evidence that his abdomen was clinically examined that morning, led to a conservative approach to his care that continued from then on.

96. Dr Buchanan noted Dr Kaisar stated that if the diagnosis of bowel obstruction had been made, there would have been two options, a surgical opinion or palliation. Given the findings at autopsy, surgery would have been necessary to remove the dead portion of intestine if Mr Talbot was to survive. Dr Buchanan agreed it was unlikely he would have survived such a major procedure given his additional and significant co-morbidities. Objectively, palliation would have been the better option. Dr Buchanan noted the problem of course is that Mr Talbot and his family did not get the opportunity to make such decisions.

97. Dr Buchanan agrees with the findings of the RCA and the recommendations that were made.

Report of Dr Wayne Herdy

98. Dr Herdy is a general practitioner with over 40 years' experience, particularly in residential aged care. He said he was well placed to comment on the clinical management that would have been expected of a competent and prudent general practitioner, although that might not be the same as clinical management

by a specialist physician. He said he was also well placed to comment on the normal nursing practices in a residential aged care facility, although that might not be the same practices as observed in a major private hospital.

99. Dr Herdy notes that the initial presentation to the emergency department was reviewed by Dr Mark Woodrow. Dr Herdy noted an abdominal examination was unremarkable and accordingly at this stage of the clinical course, there would have been no reason to suspect that the patient had a surgical abdominal pathology.

100. Dr Herdy noted the entries by Dr Kaisar in the medical record were highly unsatisfactory as the handwriting was unclear and the content minimal as to convey no useful information at all.

101. Dr Herdy noted that the initial investigations ordered comprised only a basic minimum cluster of blood tests and chest x-ray. In his view, a patient presenting with vomiting and dehydration sufficient to warrant hospital admission should have had further early investigations.

102. For example, it would have been reasonable to consider a diagnosis of infective gastroenteritis (it would have been wrong in retrospect) and a number of investigations could clarify that possible diagnosis. Further a patient with known diagnosed vomiting, presumed to be caused by an active process such as UTI, should be considered to possibly have a systemic infection and a blood culture should have been considered.

103. Dr Herdy stated the action that requires most explanation from Dr Kaisar is his decision on the morning of 30 December to order a CT of the head and physiotherapy. In his view the decision seems strange. If the Doctor was truly investigating a presumptive diagnosis of dementia or delirium, then a more comprehensive battery of blood tests should have been ordered with or before a CT head. Also, the treating doctor could have been expected to place high priority on urgently investigating the presenting symptoms of vomiting and dehydration, and low or no priority on investigating the chronic condition of dementia, which is not in itself a cause of vomiting. Dr Herdy was provided with an explanation as to Dr Kaisar's reasons to obtain a CT Scan of the head (he was not looking at dementia but any acute intracranial pathology such as stroke or tumour to explain the vomiting). Dr Herdy agreed this was reasonable. Dr Herdy also agreed the reason why blood cultures were not ordered was not an unreasonable explanation.

104. Dr Herdy stated that as an early investigation of a patient with vomiting, it would have made sense to order imaging of the abdomen.

105. Dr Herdy also noted Dr Kaisar had made a request for physiotherapy but gave no indication what he wanted the physiotherapist to do. It is presumed he wanted the physiotherapist to mobilise the patient in order to reduce the risk of DVT, and while this management plan is reasonable, the manner in which it was documented does not meet basic standards of communication.

106. In relation to the collection of urine, Dr Herdy said if the patient was incontinent, it was essential the nursing staff implemented and determined the plan for collection of urine. If a urine specimen had been collected, the report would have

excluded UTI as a diagnosis and would have required the treating doctor to consider alternative diagnoses.

107. Dr Herdy also believes that a prudent practitioner who believed that the diagnosis was probably UTI would have initiated antibiotic treatment without awaiting a laboratory report. In this case the initiation of antibiotics would have made no difference to the outcome.

108. With respect to the appropriateness of the nursing care, Dr Herdy noted two substantial areas of concern. Firstly, when the Team Leader went home sick, she was not replaced. The nurse who may have been expected to replace her for the Doctor's rounds was, without explanation that is apparent, not appointed and this appears to have resulted in further failure of communication between nurses and the Doctor.

109. Secondly, it is a cause for concern that a patient who was known to be confused and experiencing vomiting was left unsupervised in a semi-recumbent or supine position. In his opinion the position of the patient when he had his final episode of vomiting contributed materially to his demise. RN Astwood describes him sitting at an angle of 35–40 degrees and semi-recumbent. Dr Herdy was updated with evidence from the nurses at inquest confirming Mr Talbot had been placed on his left hand side with his head elevated at 30/40° and had been observed in that position in during a night until the observation which resulted in the CODE BLUE. He agreed that it would not have been good nursing if he had been on his back at all times but was satisfied with that scenario as being safe enough nursing. In general Dr Herdy said he had no problem with the nursing care, as they provided a lot of attention and were seeing things they should have seen. However, communication was not as good as one might have hoped for.

110. Dr Herdy stated Dr Kaisar appears to be unaware of the patient's repeated vomiting, abdominal distension, and gurgling. Either the nurses had failed to inform him, or he had failed to heed that information. There is a material discrepancy between the nurses' records of abdominal distension and the Doctor's note on the second day where he does not record any observation of abnormal abdominal signs. He finds it difficult to understand how, if Dr Kaisar performed a physical examination on the patient on the morning of 30 December he did not identify for himself that the patient had abdominal distension. The notes by nurses clearly record abdominal distension before and after the time of the ward round, and the family report abdominal distension about the same time. Dr Kaisar's notes written on 30 December only 4 lines below is a very clear entry stating "abdomen very distended."

111. Dr Herdy was of the view that it is arguable that an abdominal x-ray or CT should have been ordered at the time of admission but certainly when there was evidence of abdominal distension and increased bowel sounds. Dr Herdy was updated with the information that the reference to gurgling sounds were not from the abdomen but the chest and agreed this took away one of the factors needed to consider but was still of the opinion abdominal distension alone would have warranted a CT or at least a plain X-ray.

112. If that had occurred it is likely that an urgent surgical referral would have followed. His opinion is that a surgical opinion would have been mandatory, even if the final path was likely to be palliative.

113. Dr Herdy states that most nursing homes have a standard protocol for collecting urine samples from incontinent patients, and it is a cause for concern that a major metropolitan hospital does not have such a protocol in place.

114. After the patient had been transferred from the emergency department there seemed to be a constant confusion whether the urine had been collected, and how important urine collection was. Although there is some inconsistency among the nurse's reports, it appears they were aware the patient's abdomen was distended, but none were aware that this had not communicated.

Report of Dr Ringrose

115. Dr Edward Ringrose is a consultant physician and essentially disagrees with Dr Herdy in many respects. Dr Ringrose considered that Dr Kaisar's treatment of Mr Talbot on admission was appropriate.

116. Dr Ringrose did not agree with the criticism that Dr Kaisar failed to prescribe an antiemetic upon admission. He notes that the full examination included the fact that the abdomen was soft and non-tender with active bowel sounds and distension. The history was of low volume vomiting. There was no need to prescribe an antiemetic at that stage. If vomiting continued and nursing staff would contact Dr Kaiser and he would order the appropriate antiemetic medication.

117. Dr Ringrose also completely disagrees with the comment of Dr Herdy that if Dr Kaisar suspected that Mr Talbot was suffering from a urinary tract infection, then Dr Kaisar should have commenced treatment immediately with antibiotics before the micro urine MSU result had been returned. Dr Ringrose stated that if the patient became febrile or developed urinary symptoms then there was an indication to commence antibiotics immediately, however in this case there were no such symptoms. Dr Ringrose stated it was correct treatment to await the results of the MSU.

118. Given a urine sample was not taken Dr Ringrose was also asked whether Dr Kaisar should have followed up the MSU results when they had not been received within twenty-four hours. He believes that if the patient had a fever or urinary symptoms then he is sure Dr Kaisar would have chased the results, however there was nothing to suggest this was necessary.

119. Dr Ringrose was also asked if it was reasonable for a nurse to accompany Dr Kaisar on his ward round and summarise the nursing notes and any changes in the patient's condition rather than Dr Kaisar reading the nursing notes himself. Dr Ringrose stated it is normal and common practice for a nurse to accompany a consultant physician when doing a ward round. After examining each patient, it is normal practice for the physician to record comments in the chart and at a later time the nurse make appropriate notes from the nursing point of view about any changes in therapy or comments that the doctor has made. Dr Ringrose states that he seldom reads nursing notes because he had his own medical notes record each day to remind him of the appropriate facts about the patient. Dr Ringrose said that on a busy ward a doctor may have to do the ward round on your own and if concerned then go and see the nurse. If he was concerned he would read the nursing notes but would not do so if not concerned.

120. Dr Ringrose also considered that there was no indication to order a CT scan of the abdomen. Dr Kaisar had twice[1] examined the abdomen and found no abnormality. Apparently it did become distended in the hours prior to death, however if it had been distended when Dr Kaisar examined the patient he would certainly have reported that. Even then it may not have been necessary to order a CT scan. If there were no gross clinical abnormalities on examination then there was no indication to do a scan.

121. Dr Ringrose considered it was appropriate for Dr Kaisar to order a CT scan of the head. It was reasonable to look for intracranial pathology either in the form of a stroke or a tumour. Conditions such as these can raise intracranial pressure, which then results in vomiting.

122. Dr Ringrose was of the opinion it was mandatory for nursing staff to have contacted Dr Kaisar about the change in the patient's status and that he was vomiting.

123. Dr Ringrose stated it was reasonable for Dr Kaisar to complete the death certificate. The cause of death was certainly reasonable given the clinical status of the patient. At that stage there were no clinical evidence of the small bowel obstruction due to adhesions.

Response of Dr Kaisar

124. Dr Kaisar also disagrees with some of the comments of Dr Herdy.

125. Dr Kaisar rejects any assertion that he was aware of the symptoms of ongoing vomiting, abdominal distension and gurgling sounds. He did not observe his stomach to be distended when he examined him on 29 December 2014. He agrees he did not physically palpate his abdomen on the ward round of 30 December but he did not observe it to be so at that time.

126. Dr Kaisar was not informed by nursing staff that Mr Talbot's stomach was distended, or that he was experiencing ongoing vomiting or gurgling sounds.

127. Dr Kaisar says he spoke to Mr Talbot's son on the ward round and explained his proposal to obtain a CT scan of the head and at no time did they raise any concerns about the treatment plan or stomach distension or any other aspect of Mr Talbot's condition. It was put to Dr Kaisar that Mr Talbot raised the issue of the distended abdomen, but this was denied. Mr Talbot did not give evidence at the inquest and his earlier communications to this office indicated he could see that the belly appeared extended/bloated, but there is no specific reference to this being drawn to Dr Kaisar's attention.

128. Dr Kaisar is also in disagreement with the assertion that he should have ordered a CT of the abdomen. He states there was nothing in his clinical presentation at the time that he reviewed him, which indicated that a bowel obstruction should have been a differential diagnosis. The differential diagnosis of a UTI was reasonable in the circumstances.

[1] In fact Dr Kaisar only examined the abdomen in the Emergency Department and did not perform an abdominal examination on 30 December

129. With respect to the failure to read the nursing notes Dr Kaisar acknowledges that it is very unfortunate and no doubt upsetting for the family that he failed to read the nursing entry noting the stomach distension. Had he read this or otherwise became aware of the abdominal distension, he would have immediately reviewed him on the ward and discussed the situation with Mr Talbot's family.

130. Dr Kaisar notes Dr Buchanan's view that it is unlikely that an earlier diagnosis would have altered the outcome due to the limited treatment options available. But he does agree with Dr Buchanan that the main issue is that Mr Talbot and his family were not afforded the opportunity to consider the treatment options.

131. Dr Kaisar states that while he largely disagrees with the criticisms of Dr Herdy he acknowledges that a central issue for consideration by the coroner is communication between nursing staff and practitioners. This case has given him cause to reflect upon his practice both as an individual practitioner and as a member of the hospital environment. He has accordingly made a number of changes to his practice.

132. He now ensures that his notes in the hospital chart are clear and contain more detail.

133. He also has changed his practice to place a greater emphasis on reviewing nursing notes and also to ensure more discussion with nursing staff about the patients and any concerns they may have. He also ensures a member of nursing staff is with him on the ward round.

134. Communication between nursing staff and medical practitioners at the hospital has improved significantly since this case through both formal hospital initiatives and informal changes between nurses and doctors.

135. Dr Kaisar fully supports the development and implementation of the tool for patients and their families to escalate any of their concerns as to care provided in a more formal manner.

Report of Dr Peter Gourlas

136. Dr Gourlas is a consultant colorectal and general surgeon. He was asked to provide an independent expert report by the Wesley Hospital.

137. Dr Gourlas was of the opinion that the management of Mr Talbot at the time of admission was reasonable and appropriate. The ED department did not perform any further investigations on his abdomen but that was appropriate, given the findings. There was no indication at this point in time to involve a surgeon.

138. With respect to the remainder of the admission, the initial history, examination and assessment by Dr Kaisar was identical to that of the emergency doctor, and therefore the subsequent management was appropriate. There was no indication for further investigation of his abdomen at that time. Dr Gourlas also confirmed it was his practice to not read nursing progress notes and relied on the updating of the nurse in-charge at ward rounds or being contacted.

139. In the hours prior to his death, Dr Gourlas noted the patient’s abdomen had become distended, he had further vomiting, and there are various reports of abdominal distension and gurgling sounds. In this situation, perhaps further

assessment, including an abdominal x-ray would be appropriate. Placement of a nasogastric tube may be appropriate in this scenario, depending on the findings of the examination. At no stage is there any report of abdominal pain, or requirement for narcotic analgesia, as would be the case in ischaemic bowel pain, or significant bowel obstruction. Dr Gourlas gave evidence that the lack of complaint about pain was unusual as classically there would be significant pain. Dr Gourlas said that even with a patient such as Mr Talbot who did not like to complain or make a fuss, it would not be normal that they could mask the pain. He said that every patient he has ever seen with ischaemic bowel had severe pain. Dr Gourlas noted the autopsy findings suggesting it was the proximal portion of the bowel that was more effected and that could mean less distension and more so after a vomit.

140. Dr Gourlas stated that given the findings at the emergency department an X-Ray or CT abdomen was not warranted then. He would not have investigated for a bowel obstruction if the only symptom was of vomiting of which there are a number of causes, in the absence of awareness of abdominal distension.

141. If a finding of a bowel obstruction had been made on further investigation, this would have resulted in a surgical consultation. Most experienced surgeons would have discussed the option of palliation with the family in this setting, as opposed to surgical intervention.

142. Dr Gourlas completely agrees with the opinion of Dr Buchanan when he states that it is unlikely Mr Talbot would have survived a major procedure given his additional and significant comorbidities. Palliation would have been the better option. Dr Gourlas suspects the fact that he did not complain of pain, or require narcotic analgesia, suggests that the acute ischaemic event associated with his strangulated bowel may well have occurred prior to his admission. Dr Gourlas opined that the classical symptom is constant pain. After the ischaemic event the pain may abate. Once peritonitis sets in pain will be present.

Response to RCA by Wesley Hospital

143. Dr Luis Prado, Director of Medical Services, has provided a number of letters detailing the comprehensive response by Wesley Hospital to the recommendations of the RCA and the death of Mr Talbot in particular. There is no doubt the hospital has taken the issues raised very seriously. Dr Prado has expressed and continues to express condolences to the Talbot family. It should be noted that the concerns relating to Mr Talbot's death were raised by Dr Prado directly with the coroner's office and since the death there has been significant cooperation with our investigation.

144. The Hospital has introduced the roll out of the Queensland Adult Deterioration Detection System.

145. The Hospital has also introduced a *Team Leader Resource Guide* in response to the recommendation to develop a standardised approach for the Team Leader role, including minimum rostering requirements and equivalent sick leave replacement.

146. The Hospital acknowledged that more needed to be done in relation to communication practices, including communication and escalation available to patients, next of kin and family members. The hospital undertook a review of

patient and family escalation tools currently in use at a number of hospitals in Australia. Following this review, in November 2015 the Wesley Hospital introduced the *"Let us Know"* tool introduced by The Alfred Hospital as the best suited tool for a private hospital environment.

147. *"Let us Know"* provides information and assistance for patients and families to raise concerns directly with their care team including Visiting Medical Officers and nurses, as well as the Clinical Nurse Manager or Team Leader after hours. Patients and families can call an 1800 number which will be answered by the Hospital Nurse Manager on a designated telephone line. The Hospital Nurse Manager will respond and visit the patient to assess the concerns and further manage and escalate, as appropriate. Since its introduction up to June 2016 the hospital has received nine telephone calls about a variety of family and patient concerns. These have all been attended to as planned and each call is tabled and discussed at clinical governance and medical advisory committees. *"Let us Know"* is being introduced across all of the UnitingCare Health facilities.

148. Wesley Hospital also engaged with an independent expert to review communication practices within the hospital. That review found that, in general, communication between nursing and medical staff at the hospital was a professional and effective. A number of suggestions to enhance communication were also suggested including:–

- The hospital is currently reviewing the Queensland Adult Deterioration Detection System (QADDS) and accepted the advice that further education on the modifications to the QADDS would be beneficial.

- The hospital formally notified team leaders and VMPs, in writing shortly after the death, about the importance of attending patient rounding together, and that the hospital's expectation is that should occur. The independent review observed that process was in place and acknowledged this process as being a very effective way to communicate patient information in the issues between VMP's and nursing staff.

- The hospital has introduced another initiative to assist in timely and convenient communication between the clinical team by the provision of smart phones to each clinical area. The independent review identified this as a valuable communication tool have also recommended the hospital develop and implement a policy and procedure to guide the use of the ward mobile phone. That protocol has been developed and trialled.

- Use of the SHARED (Situation, History, Assessment, Risk, Expectation and Documentation) framework for clinical handover was noted to be a useful guideline when communicating with VMPs and other nurses. SHARED is a bedside handover tool used in a number of acute hospital facilities that follows a step-by-step approach ensuring all relevant information is communicated between members of the care team. The process is audited.

- To assist with stream lining calls to VMPs, the independent review and suggested that, where possible, the Team Leader should make such

calls. Formal education with the nursing team has been commenced, as part of mandatory and neural training, on the use of SHARED clinical handover tool in escalating patient information and concerns to VMPs by telephone. In addition, graded assertiveness and effective communication training is incorporated into the annual training program.

149. A protocol was introduced to ensure that MSU samples do not remain uncorrected and untested.

150. The Hospital has also initiated a number of improvements to enhance the care of complex medical and cognitively impaired patients and a new full-time role of Medical Care Coordinator has been introduced to assist patients and families, Doctors and the clinical team with the care planning. The Hospital recently engaged a specialist educational and management team from Blue Care to work with staff to promote a higher standard of individualised care of elderly patients,

151. The Hospital is in the process of developing a process to increase proactive discussion and documentation of clinical treatment goals and appropriate limits to treatment escalation.

Conclusions on the appropriateness of the health care provided to the deceased at the Wesley Hospital in Brisbane from his admission on 29 December 2013 and up until his death.

152. In reaching my conclusions it should be kept in mind that a coroner must not include in the findings or any comments or recommendations, statements that a person is or may be guilty of an offence or is or may be civilly liable for something. 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 deaths occurred with a view to reducing the likelihood of similar deaths.

153. The impact of hindsight bias and affected bias must also be considered when analysing the evidence. Hindsight bias and affected bias can occur where after an event has occurred, particularly where the outcome is serious, there is an inclination to see the event as predictable, despite there being few objective facts to support its prediction.

154. It is also my experience that in most health care related adverse events there are usually multifactorial issues at play and a combination of system and human errors. Poor communication, poor documentation and a lack of safeguards can result in poor decisions being made. All of those factors are evident in this case and these resulted in a number of missed opportunities to diagnose the actual condition being suffered by Mr Talbot. The Swiss Cheese model of accident causation arguably came into play in that a number of the systems in place to ensure information was disseminated failed and a single point of weakness materialised through which a failure to diagnose the bowel obstruction occurred.

155. This case also emphasised the importance of systems being in place to promote the dissemination of accurate and relevant information at clinical handovers.

Handovers have long been seen to be high risk areas for patient safety and significant work has been conducted at high levels to improve handover systems.[2]As a result there is a specific component for Clinical Handover contained in Standard 6 of *The National Safety and Quality Health Service Standards*. As the Standard states, clinical communication problems are a major contributing factor in 70% of hospital sentinel events and poor or absent clinical handover, can have extremely serious consequences and can result in a delay in diagnosis or treatment.

156. It is in the context of all these factors that I draw my conclusions.

157. There are no issues or concerns with respect to the treatment provided to Mr Talbot in the Emergency Department on 29 December 2013.

158. It should be acknowledged that the lack of complaint or exhibition of pain on the part of Mr Talbot is confounding and is atypical to a bowel obstruction resulting in ischaemic bowel. In most cases some form of narcotic pain relief is required. The lack of complaint about pain is likely to have contributed in some way to the bowel obstruction not being identified. However, there were other symptoms including vomiting and in particular abdominal distension, which should have been recognised and resulted in further investigations. It remains unclear if the bowel obstruction and in particular ischaemic bowel occurred prior to admission or during the admission.

159. The first clear symptom was the distended abdomen noted by RN Duggan in the early morning of 30 December 2013. She appropriately made a note in the nursing record. She could have telephoned Dr Kaisar that morning, but as Mr Talbot was otherwise stable, she made a decision to raise it at handover and on the reasonable understanding Dr Kaisar would be reviewing the patient in a few hours with the knowledge her observations would be handed over to him. I am not critical of RN Duggan in not telephoning Dr Kaisar in those circumstances.

160. RN Duggan then appropriately handed over the information of abdomen distension on two occasions. Firstly, she provided this information to all of the nurses coming onto the morning shift, including the Team Leader and Clinical Nurse Manager. Secondly, she handed this information over at the bedside handover with RN Sun Yoon.

161. The critical missed opportunity occurred at the first of these processes. The expectation was that the Team Leader and/or Clinical Nurse Manager would have attended any ward round with Dr Kaisar. As is now known, Team Leader Anthony became indisposed due to a migraine and did not attend the ward round. Team Leader Anthony was not replaced, and CNM Hyde for reasons uncertain, did not carry out that role herself. CNM Hyde could not explain why other nurses had not replaced Team Leader Anthony. CNM Hyde recalls a discussion about having other nurses carrying out the Team Leader's task, but even if this is correct, it was not acted upon and arguably this was a matter in her control. Whatever is the case it is evident Dr Kaisar attended his ward round without a nurse present and without receiving this vital piece of information.

[2] As an example see the OSSIE Guide to Clinical Handover Improvement developed by the Australian Commission on Safety and Quality in Healthcare.

162. The nursing handover sheet did not refer to the distended abdomen. The practice was that additional information would be written by individual nurses on a copy of the sheet. It is unclear if Team Leader Anthony or CNM Hyde made such a note on the handover sheet. Even if they had, in this case, as neither attended on Dr Kaisar, it was not passed on.

163. The fact this information was not on the handover sheet for the morning shift is understandable as this was new information, but it should have been updated by the time of the afternoon shift. Ms Jarvis noted the new Team Leader Resource Guide has a requirement that the handover sheet be updated regularly to ensure it is up to date. Ms Jarvis suggested Wesley Hospital review current practices to ensure matters raised during flagging are documented. I think that is a valid suggestion. It is not suggested the handover system, which no doubt now endeavours to meet Standard 6 of the NSQHSS, needs to be overhauled and it may be as simple as an audit of the process from time to time, similar to other auditing practices common in ensuring processes in health care are being followed.

164. Dr Kaisar attended the ward round. This was also a missed opportunity. He did not have a nurse present and he did not read the nurses progress notes. He did write in the notes after his round and if he had looked a few lines above he would have seen RN Duggan's entry with reference to a 'very distended abdomen'. Dr Kaisar did not physically examine the abdomen. He could have, but he says he had no reason to do so because he was unaware of any change in Mr Talbot's condition from his last examination the day before. He had not been given any information of concerns. He had not been informed of the decision by CNM Hyde that Mr Talbot was to be 'nil by mouth' and he was being moved closer to the nurse's station. These decisions were not recorded in the progress notes. I accept that if Dr Kaisar had been made aware at or prior to the ward round of a distended abdomen and these other concerns, he would have likely investigated.

165. Additionally, if Dr Kaisar had read the nursing entry he may also have investigated. Dr Kaisar's practice, consistent with the practice of other consultants who gave evidence is that he did not ordinarily read the nursing notes. Dr Ringrose stated if he went of a ward round alone he may read the notes if he had some concern for the patient. Dr Gourlas would always have a nurse present on his ward round and did not read nursing notes. Dr Herdy noted this was a common practice among doctors. Dr Kaisar did not discuss with nursing staff looking after Mr Talbot directly his plan of treatment, although it is evident it was put in place and a physiotherapy review occurred shortly after and a CT scan of the head also was conducted in the next few hours.

166. The family not unreasonably submit there was evidence of existence of a hesitancy of communication between nursing staff and Doctor Kaisar. That appears to be the case. Dr Kaisar's practice now is to ensure more discussion with nursing staff about patients and concerns and places a greater emphasis on reviewing nursing notes. He also undertook further training in relation to communication.

167. After the ward round there was no further contact with Dr Kaisar by nursing staff. RN Sun Yoon was aware of Mr Talbot's distended abdomen, it having been flagged, handed over and observed by her. She did not speak to Dr Kaisar as

she could reasonably assume it had been flagged on the ward round and the treatment plan took that into account.

168. The next missed opportunity occurred in the afternoon of 30 December. Deborah Croxford knew something was wrong with her father but her concerns were not heard or acted upon by RN Deng Pan. If they had been, then Dr Kaisar may have been advised and further action may have been taken. Dr Kaisar was not provided with any information from nurses after his ward round earlier that day. Since Mr Talbot's death, and very much because of it, the hospital has implemented the "*Let us know"* process for escalation of family and patient concerns similar to "*Ryan's Rule*" as adopted in the public health system.

169. When RN Duggan came back on shift she was confused about the CT Scan of the head and then noted Dr Kaisar's notes and the treatment plan. She reasonably carried on her observations and did not question the plan directed by the doctor as there was no change in condition to her previous observations.

170. Hence a range of failures to communicate and to heed concerns due to a combination of system and human errors resulted in the holes of the Swiss Cheese aligning and a missed diagnosis resulted.

171. There were a number of other issues raised in the course of the investigation and inquest. These related to the timing of introducing anti-emetics and antibiotics, conducting a Multiplex PCR and a blood culture and imaging of the abdomen. I accept there are differing medical opinions on which reasonable minds may differ and these issues do not need to be resolved by me as they were, in hindsight, not contributory to the outcome. The failure to complete the microurine test was contributory to the extent it may have indicated that a UTI was not the cause of Mr Talbot's symptoms and therefor warranted further investigation of an alternative cause. That process has been rectified by the Wesley Hospital. The decision to image the head and not image the abdomen is according to the experts understandable based on what Dr Kaisar knew. I can understand why the family remain perplexed about this.

172. I am not critical of the fact that Dr Kaisar completed a Cause of Death certificate. It is standard practice for someone from the treating team to prepare such documents. The matter was discussed with someone from the coroner's office and based on the information made available, a reasonable decision was made by the coronial registrar that the death did not require investigation. However, all major private and public hospitals in Queensland have reasonably robust internal death review standards and processes in place and on this occasion there were identified by the hospital a number of issues of concern and the case was promptly referred back to the coroner. In that respect it can be said the system of death review/reporting to the coroner worked.

173. It is evident that the most likely outcome, even if the bowel obstruction had been identified on admission, was that Mr Talbot would be given palliative care. A surgical solution was high risk and not viable.

174. As noted by Dr Buchanan the critical issue is that Mr Talbot and his family did not get the opportunity to make such decisions. Mr Talbot could have been made more comfortable and his family could have been with him. Instead he died alone and in an undignified manner.

Findings required by s. 45

Identity of the deceased – James Patrick Talbot

How he died – Mr Talbot came into Wesley Hospital unwell. He died within two days of an ischaemic strangulated small bowel. There was early identification of a distended abdomen by a nurse and later by Mr Talbot's family. Due to a number of failures in communication contributed to by some systems failures and some human error, the distended abdomen was not investigated and Mr Talbot died unexpectedly. Given Mr Talbot's age and co-morbidities a surgical option would not have been viable and palliative care would have been the likely treatment decision. The critical issue is that Mr Talbot and his family did not get the opportunity to make such decisions.

Place of death – Wesley Hospital, Auchenflower

Date of death– 31 December 2013

Cause of death – 1(a) Strangulated small bowel
1(b) Adhesions (previous abdominal surgery)

Comments and recommendations

I agree with Ms Jarvis's suggestion that Wesley Hospital review current practices to ensure matters raised during flagging handover are documented.

Dr Prado has written to me since the inquest noting the omission of recording of "abdominal distension" on the handover sheet on the transfer of information from the night shift. He says that in light of this, a Senior Registered Nurse has been allocated to review the process on the use of handover sheets and updating information on the same. Once this review is completed, the improved process will be implemented across the hospital.

Dr Prado also recognises the lack of clarity on the handover process when Mr Talbot was transferred from room 11 to room 4. This has been discussed with the Clinical Nurse managers to reiterate with staff that the responsibility for care remains with the allocated nurse until the care is formally handed over, and will become a formal part of the handover process at the hospital.

Given the comprehensive adoption of a number of improvements as recommended by the Root Cause Analysis and subsequent reviews both internal and external as well as the above it is not considered that further recommendations are required.

I close the inquest.

John Lock
Deputy State Coroner
BRISBANE
8 July 2016