IN THE **CORONERS COURT**
AT **ROCKHAMPTON**
IN THE STATE OF QUEENSLAND

No **ROK COR-00002895** of **2004**

In the matter of: **THE DEATH OF ROBERT DONALD RAWSON**

TRANSCRIPT OF PROCEEDINGS

BEFORE **HENNESSY** Coroner

AT **ROCKHAMPTON** ON **13 SEPTEMBER 2006**

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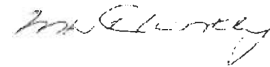
I, **MICHELE LEE HUNTLY**, a Recorder appointed under "The Recording of Evidence Act 1962 to 1968", do hereby certify that the pages of the abovementioned findings, numbered **1** to **10,** contain a true and correct transcription of the evidence and proceedings as recorded by tape recorders at the hearing of the abovementioned matter.

DATED AT **ROCKHAMPTON** this **10th** day of **JANUARY** **2007**



TRANSCRIPT OF PROCEEDINGS

CORONERS COURT

HENNESSY, Coroner

ROK-COR-002895/04

IN THE MATTER OF AN INQUEST INTO THE
CAUSE AND CIRCUMSTANCES SURROUNDING
THE DEATH OF ROBERT DONALD RAWSON

ROCKHAMPTON

..DATE 13/09/2006

FINDINGS

WARNING: The publication of information or details likely to lead to the identification of persons in some proceedings is a criminal offence. This is so particularly in relation to the identification of children who are involved in criminal proceedings or proceedings for their protection under the *Child Protection Act* 1999, and complainants in criminal sexual offences, but is not limited to those categories. You may wish to seek legal advice before giving others access to the details of any person named in these proceedings.

CORONER: ...of November 2004 at the Rockhampton Base Hospital, on the same day as undergoing a medical procedure, the insertion of an intercostal chest drain. These findings examine the circumstances surrounding Mr Rawson's death and the medical issues related to his treatment, and whether there's a need to recommend any changes aimed at reducing the likelihood of similar outcomes occurring in the future.

The jurisdiction is conferred on a Coroner to inquire into the cause and circumstances of reportable deaths. The Coroners Act 2003 provides in Section 24, that,

> "Where an inquest is held it shall be for the purpose of establishing, as far as practicable, the fact that a person has died, the identity of the deceased, when, where and how the death occurred, and whether anyone should be charged with a criminal offence of causing the death. An inquest is an inquiry into the death of a person and delivering findings which are open on the evidence heard during the inquest in relation to each of the matters referred to in Section 24 should be made. The focus of an inquest is on discovering what happened, not on attributing blame or liability to any particular person or entity. The purpose of the inquest is to inform the family and the public as to how the death occurred. The Act authorises the Coroner to make recommendations or riders with a view to reducing the likelihood of similar deaths in the future, but does not permit findings being couched in terms of determining questions of civil liability."

In relation to the evidence I have summarised only those portions of the evidence I consider necessary to explain the findings I have made. I have taken all of the evidence before me into account in considering this matter.

I was greatly assisted in my deliberations by the report from Associate Professor Darryl Wall, Director of General Surgery and Senior Liver Transplant Surgeon at the Princess Alexandra Hospital, which report was both thorough and insightful.

I strongly recommend Associate Professor Wall's report dated the 27th of July 2006 in its entirety to the Department of Health and associated organisations. The report details matters which adversely impacted the quality of Mr Rawson's treatment but did not contribute to his death and makes constructive comment regarding improvements which can be made to the health system, particularly regarding regional and rural areas.

I move to the circumstances of the treatment. Mr Rawson had been a smoker and heavy drinker and suffered from a number of serious medical conditions, including cirrhosis of liver. In the month before his death his liver disease became very advanced. During that time he was admitted to Rockhampton Hospital on four occasions for aspiration of plural effusion.

Mr Rawson was re-admitted to hospital on the 22nd of November 2004 with symptoms of dyspnea, weakness and anorexia, and with signs of a right plural effusion. A decision was taken to place an intercostal catheter to drain the fluid. That procedure was undertaken on the 24th of November 2004.

On that day, at about 3 p.m., Dr Lwin was requested by Dr Brittan to administer the intercostal catheter procedure to Mr

Rawson. General observations were taken around 4 p.m. Fresh frozen plasma was administered at 4.10 p.m. The procedure itself commenced around 4.30. Further fresh frozen plasma was administered at 5 p.m. The procedure lasted for about an hour and sometime afterwards Mr Rawson was sitting up in bed, talking and having an evening meal. Further observations were taken at 7 p.m. and an X-ray was taken at 7.29 p.m., confirming that the catheter had been correctly placed.

Ms Farrow, who had been visiting, left the hospital at 7.50 p.m. Dr Ross was asked by nursing staff to see Mr Rawson around 8 p.m. and an emergency team was called to Mr Rawson at 8.25 p.m., and he died that evening.

Dr Krause conducted the autopsy and concluded that it was very, very difficult to say whether, and to what extent the intercostal catheter procedure had a causal link to Mr Rawson's death. However, his summary indicates that he ranks the procedure with other factors as equally causative of death.

As a result of the statement that the intercostal catheter procedure contributed to Mr Rawson's death, expert opinion was sought from Associate Professor Wall. The Professor gave evidence during the inquest and he elucidated on the following matters:

Mr Rawson was in the end stages of liver cancer and a live expectancy of around two to 10 weeks at the relevant time and could have died at any time.

Mr Rawson was suffering from a build-up of fluid in his lung as a result of the chronic liver disorder.

The treatment options for Mr Rawson were a liver transplant, which may have extended his life but which Mr Rawson had decided against, or the treatment he had been given on the day in question, and on five previous occasions, which consisted of draining fluid from his chest and abdomen. This was effectively a palliative procedure to provide temporary relief.

Medical staff in Rockhampton took advice from Prince Charles Hospital clinicians regarding future therapy options for Mr Rawson given the drainage procedure is very invasive. The drainage process was the best treatment option other than a transplant. The Prince Charles Hospital clinicians were supportive of the placement of the catheter on this occasion.

The treatment administered to Mr Rawson, and in particular the insertion of the intercostal catheter, was appropriate. Whilst concern had been raised that the placement of the intercostal catheter caused arterial bleeding, the bleeding into the chest was more likely due to Mr Rawson's blood disorder and a minor arterial branch bleed rather than a massive rupture of the artery.

The bleeding from the chest wall did not contribute to Mr Rawson's sudden demise. There is evidence of bleeding at three sites. Other than that, at the site of the catheter, before the placement of the catheter. The procedure involving the insertion of the intercostal catheter would have been undertaken even if treatment to address the other bleeding was also considered. The apparent failure to detect the reduction in haemoglobin levels did not contribute to death, but would have if detected led to an endoscopic examination but not on an urgent basis. The administration of the plasma and the timing of it in relation to the catheter procedure was entirely appropriate.

Associate Professor Wall also concluded that the placement of the intercostal catheter may or may not have been relevant to Mr Rawson's death. (Page 16, lines 55-57 of transcript).

Associate Professor Wall's conclusion regarding the cause of Mr Rawson's death was, (Page 10, line 20-31 of transcript):

> "The primary problem was very, very rapid decline in liver function which made the patient susceptible to fluid collections in the plural space and in the abdomen. This was also associated with poor coagulopathy and it also made his body at risk for serious sepsis, that is, if he got the smallest bacterial overload, the liver couldn't cope. So I think the combination of fluid collection, serious sepsis at a full and circulating volume, which was due to steady blood loss over a period of many hours, led to this sudden cardiac event which was secondary to cardiac disease, which in turn was due to diabetes. So it's a layer, upon layer, upon layer, the first being the liver disease, the second being the bleeding, and the third being a heart attack and arrhythmia."

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He further stated (Page 16, lines 4-13):

> "The combination of the unknown gastrointestinal haemorrhage, and the plural drainage, might have been just enough to diminish heart performance, diminish the blood profusion going through his coronary vessels, and that would have led to an infarct and a cardiac arrest. So to place an intercostal catheter may not have changed the natural history of Mr Rawson."

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There are various systemic issues which were highlighted during the inquest which caused concern to some of the family and friends of Mr Rawson, most particularly, the physical setting, personnel and circumstances of the medical procedure on the day of his death. Those concerns included:

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The conduct of the medical procedure in the ward, as opposed to a sterile procedure room or theatre;

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The conduct of the procedure by a medical practitioner inexperienced in the procedure;

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The ill-fitting tubing which needed to be manipulated and adapted to fit the catheter used in the procedure, and may have been ineffective; and

A perceived lack of appropriate monitoring of Mr Rawson during and after the procedure.

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Associate Professor Wall looked at these issues and made the following remarks:

> "There's difficulty in maintaining supplies of standard sets of equipment to regional centres, which needs to be addressed, in this case the catheter equipment. There is a lack of a uniform high standard of care in regional areas compared to major public hospitals due to financial limitations and staff and hospital structures. The clinicians were aware of the ill-fitting catheter tubing and were aware that the join was critical, and checked it on a couple of occasions during Mr Rawson's decline, and noted the chart that the junction was still functional and working as designed, despite the fact that the tubing connections did not match." (Page 17, lines 45-51.)

There were shortcomings in the documentation, particularly regarding discussions with the family and Mr Rawson regarding the procedures. The report noted that there was adequate advice given to Mr Rawson regarding the procedure, albeit in the absence of a signed consent form.

The procedure of insertion of the intercostal catheter is more akin to an operation and such a procedure should take place in an appropriately equipped room.

There is a comprehensive range of clinical training available for surgical skills and this needs to be taken up by more medical and nursing personnel.

I move to findings required by Section 43(2) of the Act. I am required to find, so far as has been proven on the evidence, who the deceased was and when, where and how he came by his death. After consideration of all of the evidence and exhibited material, I make the following findings:

The deceased person was Robert Donald Rawson.

Mr Rawson died at the Rockhampton Hospital on the 24th of November 2006.

The cause of Mr Rawson's death was internal haemorrhage due to, or as a result of coagulopathy and upper gastrointestinal varices, cirrhosis of the liver, alcohol consumption, and recent myocardial infarction.

In relation to issues of concern and recommendations, taking into account the intent of the Act, the clear evidence of Associate Professor Wall that the procedure Mr Rawson underwent on the day of his death was unlikely to have contributed to his death in a significant way, and the existence of a set of serious medical conditions which did contribute to Mr Rawson's death, I do not consider that it is necessary or appropriate to make any recommendations.

Having said that, in the interests of patients and their families, in my view the matters raised in Associate Professor Wall's report must be seriously considered by Queensland Health, particularly with regard to standardising practices and preparation of equipment for procedures, improving communication with patients and families regarding medical procedures, such as the insertion of intercostal catheters, and improving documentation relating to such procedures, and to ensure appropriate and timely documentation of medical chart records.

I direct that a copy of these findings and Associate Professor Wall's report be forwarded to the Director General of Queensland Health.

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I close the inquest.

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