INQUEST INTO THE CAUSE AND CIRCUMSTANCES SURROUNDING THE DEATH OF KENNETH MAGGABLE ON THE 9TH AUGUST, 2005

FINDINGS

Kenneth (Kenny) Maggable, who was born on 26th May, 1935, died at his residence at 13 Madang Street, Trinity Beach early on the morning of the 9th August, 2005. He was aged 70 years as at the date of his demise.

I will throughout these findings, at the request of Ms Maggable, the deceased's widow refer to Mr Maggable as "Kenny".

Twice in the preceding 24 hours Kenny had presented at the Cairns Base Hospital on the recommendation of his General Practitioner Dr Nora Duffield who, with full knowledge of his physical health, had become concerned about his complaints of the severity of respiratory ailments. Following his second presentation, the Hospital discharged Mr Maggable about 4.50am on the 9th August, 2005, to go home with his wife.

It is sad to say that shortly after his arrival at his home Kenny collapsed and despite the concerted efforts of both Mrs Maggable and Dr Duffield he passed away at about 6.25am.

A subsequent autopsy established the cause of death to be:

1(a) Acute Coronary Occlusion due to or as a consequence of extensive coronary atherosclerosis.

The autopsy also revealed that Mr Maggable suffered from other conditions that contributed to his death:

1 Chronic Obstructive Pulmonary disease;
2. Prostate cancer.

It seems that Kenny had, previously, been a heavy smoker.

The fact that Kenny passed on so shortly after his discharge from the hospital raised concerns with Dr Duffield, Mrs Maggable and myself as Coroner as to the quality of care afforded him at the Cairns Base Hospital. In particular:

a. Was the assessment and treatment of the patient on each occasion he presented to the Hospital on the 8th August, 2005 in accordance with appropriate clinical practices for a patient with his medical history?;
b. If not, to what extent, if any, did organisational factors within the Hospital contribute to Kenny's demise;
c. Additionally, if there were contributing organisational factors, to what extent, if any, did any supporting structures and processes within the Queensland Health Department contribute to that outcome.

Kenny suffered a significant past history of asthma and chronic lung disease that substantially impaired lung function. His prescribed medication, prednisone, indicated that that condition was quite severe. He was not a well man, all in all, also suffering prostate cancer which had been treated with hormone therapy and irradiation.

His illness had required his admission to the Hospital on the 9th July, 2005, approximately one month prior to his death. An exacerbation of the chronic lung disease, coupled with pneumonia, was diagnosed. In Dr Duffield's view, he had not recovered from pneumonia by the time of his admission on the 8th August.

When admitted on the 8th August Kenny was given oxygen therapy. Oxygen saturation rates are measured and monitored by a device that attaches to the patient's finger and checks alterations in oxygen saturation at room air and during oxygen therapy.

On his first admission on the 8th August, at about 8.45pm, the Ambulance bearer reported to the triage nurse that the patient had an oxygen saturation rate, at room air, of 93%. This was noted on the emergency department's triage sheet. This sheet records that at 10.20pm the room air saturation rate had decreased to 91%. At the inquest, when asked for an opinion, Dr Cullen accepted this as a possibility but, in that there could have been a number of reasons for the lower reading, he did not consider it strong evidence of a deterioration in the patient's state. For example, a coughing fit or going to sleep might have been the cause of the lower reading.

It is suggested however that it is appropriate, if there were those "other reasons" that the relevant notation be made on the triage sheet, the admission record.

At 11.00pm, according to the triage sheet, oxygen saturation while nebulised and utilising a piece of equipment called a Hudson mask was recorded at 98%. This observation was repeated at 2.15am or, perhaps, 4.15am. There is some confusion resulting from the handwriting.

At 3.40am, the triage notes record that a "spirometry done". It is presumed that this means the measurement of Kenny's breathing capacity by means of a spirometer. However, there is no other reference on the notes as to the results of that check of lung function. The notes reveal that about the same time, Dr Tan prescribed medication.

The doctor's medical notes, as distinct from the triage notes, indicate that Dr Tan first saw the patient at 3.00am. Dr Tan notes oxygen rates of 91% at room air and 98% using the Hudson mask. It seems highly likely that Dr Tan transposed the reading of 91% from the notes on the triage sheet after admission, but it is possible that he may have taken a reading contemporaneously with making the note. If that is so, it would have indicated that the patient's condition had not improved since 10.20pm the previous evening. However, that seems unlikely given other observations that indicated that the patient reported "feeling better; able to tolerate walking a lot better" and, importantly "happy for D/C " i.e. discharge.

The difficulty is that, on the face of the medical record, it cannot be demonstrated that the patient's room air oxygen saturation rate had improved between the reading of 91% on admission and the time it was decided to discharge him.

Whether the decision to discharge Kenny was based on adequate clinical examination and findings, the opinion of Dr Paul Cullen, Staff Specialist in the Emergency Medical Department (which I accept) is that irrespective of the continuation of oxygen therapy would not have forestalled the patient's death. This opinion is based on the post-mortem examination findings which disclosed a complete occlusion of the left anterior descending artery proximally with distal disease. Therefore the degree of oxygen saturation was irrelevant as a contributing factor in the cause of death. Dr Cullen thought that Kenny's emphysema would have had an impact on the coronary occlusion but not in the 48 hours leading up to the death.

There is another significant area of concern. According to Dr Cullen's evidence, interns, such as Dr Tan, are not authorised to make final decisions about treatments plans (including discharge) without reference to a senior medical officer, such as a registrar or consultant.

There is no record able to be produced to the Inquest that verifies that Dr Tan consulted with the Registrar on call, a Dr Bala. Attempts to locate Dr Bala for the purposes of the inquest were unsuccessful.

Unfortunately, Dr Tan has no independent recollection of his examination of Kenny and was, during the course of his evidence, entirely reliant on the medical notes. According to Dr Tan it would have been his normal procedure to consider his patient's oxygen saturation rate at room air and would, normally have consulted a senior practitioner about any treatment plan and/or decision to discharge. Dr Tan agreed that his normal practice would also have been to make relevant notes on the record and his only explanation for any failure to do was that it was a busy night and the making of notes may have been overlooked.

Dr Tan, a first year intern, was rostered in the position normally performed by a second year graduate apparently due to staff shortages being experience by the hospital at the time. The evidence is that the staffing of the Emergency Department has been increased since the time of this incident.

Initially, there was a concern about the discharge of an obviously unwell man in the early hours of the morning and it was conceded that generally speaking this was not appropriate. However, the evidence is that Kenny was desirous or at least amenable to being discharged. No doubt the choice between going home and remaining in busy, noisy unpleasant environment where rest was difficult may have been easily made.

One matter raised by Dr Duffield was a gap in patient information, in the form of discharge letters or summaries, being provided by the hospital treating team to the patient's General Practitioner. It seems that this matter has been addressed and facsimiles of the relevant material are now being forwarded to the patient's doctor so that they are received in a timely fashion.

I am not persuaded that there is sufficient evidence to justify a finding that Dr Tan's care of Mr Maggable was less than of an adequate standard. I think it as least as likely as not that an assessment of oxygen saturation rate at room air was undertaken prior to discharge and that Dr Tan's only oversight was a failure to make proper recordings of the specifics.

This, from any perspective but certainly from a patient treatment point of view, is a serious omission in record keeping.

Dr Paul Cullen, Staff Specialist in the Emergency Medical Department, a senior and experienced medical practitioner gave evidence that he had never had experience with any independent audit of an intern's record keeping competency. Although the Emergency Department now produces a booklet for the use of interns that encompasses this procedure and others, in his view, induction processes leave something to be desired. Mentoring of junior staff and an audit of written charts would be a useful tool.

It seems that the hospital's system of record keeping is antiquated with no electronic or computerised system available. It is certain that any such system would markedly improve appropriate record keeping.

In the inquest into the cause and circumstances surrounding the deaths of Barlow, Baggott and Lusk a Cairns Coroner made the following recommendation:

"That the Director of Mental Health accelerate the implementation of a state wide electronic network of patient information that allows treating health professionals, including both inpatient and community staff, to rapidly access patient data throughout the State; and that Queensland Health provide the necessary finding as a matter of priority.

The State Coroner in the Inquest into the death of Sparka Isarva Huntington made this recommendation:

*"**Adequate access to mental health records.***

I recommend that as a matter of urgency Queensland Health develops an electronic data base to enable clinicians to instantly access medical records of mental health patients who have been treated at any public health service throughout the State.

These recommendations related to electronic records for mental health patients. However, my thoughts turn to the Inquest of **Yeatman,** conducted by me in Cairns in 2003. This concerned a young child who was originally treated at the Yarrabah (a community distant from Cairns) clinic before attending at the Cairns Base Hospital where, because the records of the Yarrabah clinic were not available, she was misdiagnosed and subsequently passed away. At the conclusion of the inquest I made these comments by way of a rider:

"There must nevertheless be systems put in place that optimize the resources available so that there is adequate supervision of inexperienced doctors."

AND

".....the lack of an ability by doctors to access the records of a patient from other medical facilities makes proper diagnosis difficult. One wonders whether if Dr Barton had been able to call upon the notes of the Yarrabah medico would her assessment of Jessica's deteriorating condition been more acute. There are matters of patient confidentiality but a free exchange of medical information between practitioners should be in the best interests of the patient."

As a consequence, and pursuant to my obligation as set out in Section 46(1)(a) of the Coroner's Act 2003, I recommend that as a matter of urgency, the Regional Health Authority in conjunction with Queensland Health review or (if appropriate) develop and implement procedures for the auditing of interns in their clinical record keeping practices and procedures.

The fact that a consultation was had with a Registrar or other consultant and the time of such consultation ought to be a matter of some substance to be included in the clinical record.

Secondly, it is recommended that Queensland Health undertake a feasibility study into the implementation of an integrated electronic/computerised patient information system, incorporating clinical notes, treatment plans and discharge summaries, allowing for access to patient data across the Cairns Health Service District, at least.

I reiterate that the evidence shows that the staff of the Cairns Base Hospital did their best to comfort and treat Mr Maggable within the scope of the available resources and prevailing circumstances. There is no evidence that any person has done any act or made any omission that amounts to misconduct or the commission of any offence. I make no recommendation to any governing or disciplinary body pursuant to Section 48 of the Coroner's Act.

I do offer, again, my sincere condolences to Mrs Maggable and the rest of Kenny's family. Time has passed but I'm sure Kenny's loss is still felt deeply. I trust that these findings give some closure to the family.

This inquest is closed.

DATED at Cairns

This 17th **day of** June **2008**

T. J. Burke