# TRANSCRIPT OF PROCEEDINGS

CORONERS COURT

SPRINGER, Coroner

COR-000001007/06/(8)

IN THE MATTER OF AN INQUEST INTO THE
CAUSE AND CIRCUMSTANCES SURROUNDING
THE DEATH OF PATRICIA DELL NEWMAN

ROCKHAMPTON

..DATE 20/12/2007

FINDINGS

CORONER: Pursuant to the Coroners Act 2003 an Inquest was conducted into the death of Patricia Dell Newman. The Act provides that when an Inquest is held the Coroner's written findings must be given to the family of the person who died and to each of the persons or organisations granted leave to appear at the Inquest. These brief oral reasons are extracted from the written reasons that I published to the parties who were represented at the Inquest.

At the time of her death Mrs Newman was the mother of three adult children, Amanda, Kerrod and Natalie. Mrs Newman was born on the 10th of October 1933. She was admitted to the Rockhampton Base Hospital on the 11th of March 2006 and remained there until her death.

The day before Mrs Newman's admission to the hospital she complained to both of her adult daughters separately that she was feeling unwell and had been vomiting. Both of her adult daughters gave evidence that they had been visiting her on a regular and frequent basis and that, to their knowledge, their mother had been eating and had fresh food in her home with grocery shopping undertaken by one of her daughters.

On the day of her admission to hospital one of the daughters found Mrs Newman on the floor inside her home. She had fallen and was feeling very poorly. An ambulance was called.

My written reasons will be distributed in accordance with the requirements of the Act and a copy will be sent to the office of the State Coroner.

The family has raised a number of concerns about Mrs Newman's care in the hospital. Her adult children wrote collectively to the Coroner on the 25th of May 2006. Those concerns were set out in a document signed by two of the three children of Mrs Newman. That document was tendered and became Exhibit 6 in the Inquest.

The issues and complaints raised by Mrs Newman's children relate to the care of their mother at the Rockhampton Base Hospital between the 11th and the 29th of March 2006. Many of the complaints are criticisms of the quality of the care that the family perceived their mother was receiving as well as the quantity and quality of information that they were being given about their mother's diagnosis and prognosis.

During the Inquest two of the family members gave evidence. They were the daughters of Mrs Newman, Ms Amanda Perry who appears today and Ms Natalie Barnett. They did not expand on the issues set out in Exhibit 6 in their oral evidence.

Other evidence came from Queensland Health in the form of written statements with the makers of some of those being required for cross-examination.

The forensic pathologist Dr Nigel Buxton and specialist who was an experienced physician with a specialty in thoracic medicine was engaged by me, Dr Donald Cain. They also gave written and oral evidence.

The clinical findings about the poor state of Mrs Newman when she was admitted are informative. Dr Barry Rigby was a locum specialist at the Rockhampton Hospital. He stated,

> "On admission she suffered from profound hypotension which had caused acute renal failure. She was very malnourished. She provided history of diarrhoea and vomiting for two weeks but for her to deteriorate to the condition in which she presented at the hospital would have taken weeks to months of poor nutrition."

Dr Rigby continued,

> "Mrs Newman's blood tests did not indicate a specific cause for her problem. The majority of the tests were normal, however, the results of these tests indicate that malnutrition and that her condition was of long-standing chronic nature rather than something that had developed over the previous week."

Dr Donald Cain, engaged by me to review the hospital's records. Dr Cain confirmed that Mrs Newman was peripherally shut down meaning the circulation of blood to her peripheral tissues was compromised and that her condition demonstrated acute renal failure.

Dr Graves gave evidence that Mrs Newman's poor condition had existed for some time prior to her admission to hospital and

his best estimate was that she had been very unwell for a period of weeks to months rather than days to weeks. Thus, there is evidence which I accept that although Mrs Newman presented to normal visual observation as someone who was not gravely ill, that presentation hid significant clinical findings showing the contrary.

I am satisfied at the time of her admission to hospital on the 11th of March 2006 Mrs Newman was profoundly unwell, suffering from the effects of multi-organ failure over a period of weeks to months and that this condition was not properly understood or appreciated by her family.

Dr Buxton performed an autopsy on the 31st of March 2006 at the Rockhampton mortuary and reported on that procedure on the 19th of April 2006. In summary, Dr Buxton reported the matter to be a complex case with evidence of sepsis. He believed the death to be the result of a congestive cardiac failure as a result of essential hypotension and other contributing but not causative factors of a clinical nature. This included Meige's Syndrome.

The family have alleged that a medical practitioner said words to the effect that their mother would not be resuscitated in the event that was required as their mother was not worth the $2,000 a day that it would cost to keep her in the intensive

care unit. This statement - or words to that effect - has been denied by all of the medical practitioners who were cross-examined at the Inquest with a specific denial by them.

A statement such as that described by the family referred to above about Mrs Newman not being worth $2,000 per day to keep her in the intensive care unit would be highly improper in the circumstances and would be grossly offensive to the family of any patient, however, I am not satisfied that matters of funding of public health in the Rockhampton Hospital affected in any way the proper clinical care of Mrs Newman.

Having regard to the gravely ill position in which Mrs Newman was in - or on her admission, I am satisfied that all appropriate investigations were conducted and no further investigations could or should have been conducted that would have been of assistance in the circumstances.

There is no evidence before me to suggest that Mrs Newman received anything but extensive investigations, appropriate treatment and satisfactory care and that the doctors who made the decisions as to her care took into account only proper considerations.

There is, in my view, insufficient evidence for me to be satisfied on the requisite standard that an offensive comment

was made to the family of the nature set out above about the cost of maintaining Mrs Newman in the intensive care unit. Further, the evidence does not indicate that the comment reflected the reality of the care that was being given to Mrs Newman.

There was also no evidence to suggest that the intensive care unit of the Rockhampton Base Hospital was, at the time of Mrs Newman's death making decisions as to the care of its patients based on monetary considerations rather than on proper clinical considerations.

There was no issue identified that points to any systemic or endemic failure in the public health system and no evidence which would satisfy the Court that other than proper clinical decisions were made by the relevant decision makers in the care that Mrs Newman received at the hospital.

The grave illness and probable imminent death of a beloved parent is obviously very distressing. Patients and family members are often given information about a patient's prognosis and treatment options at a time when they are tired and stressed.

The ability of health professionals to convey important information in an informative and empathetic way will vary across individuals. Consequently, the information being given by a health professional in some situations may not be properly understood. If that is the situation or the information is not conveyed clearly, it may create an added layer of stress and possible hostility between the people involved.

It is important that health professionals make every effort to ensure that the people with whom they are speaking understanding the information that is being given to them. Where patients or family members feel that they have not understood the information that has been provided to them they should not feel constrained about seeking clarification of that information. This could be done, for example, through a hospital social worker or by arrangement through further discussion with the clinician who provided the information.

While appreciating the workload that many medical professionals are working under in hospitals under the control of Queensland Health it is recommended that Queensland Health consider developing a brochure to be provided to family members at the time they are being given important information about the prognosis and treatment of a gravely ill family member. The brochure could set out how family members can

obtain additional or clearer information about their treatment of their ill or injured family member with relevant contact numbers provided.

It is hoped that the coronial process has enabled the family of Mrs Newman to have a better understanding of the treatment and clinical factors that preceded her death.

I make these findings under the Coroners Act:

- Patricia Dell Newman died on the 29th of March 2006. She died at the Rockhampton Hospital while being treated for multiple organ failure and congestive cardiac failure.
- The cause of her death was congestive cardiac failure due to or as a consequence of essential hypertension.

I provide to all parties a full version of my written reasons.

Thank you.

Ms Demack or Ms Perry, is there anything you wish to say at this time?

MS DEMACK: No, thank you.

MS PERRY: No, thank you, your honour.

CORONER: Thank you. Ms Cameron, is there anything from you?

MS CAMERON: Ah, no thank you, your honour.

CORONER: We'll organise a hard copy of the reasons to be sent to you in today's mail.

MS CAMERON: Thank you very much.

CORONER: Thank you. The court's adjourned.

---