QUEENSLAND COURTS

CORONERS COURT OF QUEENSLAND

FINDINGS OF INQUEST

CITATION:	**Inquest into the death of Mark Anthony Plumb**
TITLE OF COURT:	Coroners Court
JURISDICTION:	BUNDABERG
FILE NO(s):	2014/3896
DELIVERED ON:	19 August 2016
DELIVERED AT:	Bundaberg
HEARING DATE(s):	6 April 2016, 27-29 July 2016
FINDINGS OF:	John Lock, Deputy State Coroner
CATCHWORDS:	Coroners: inquest, health care related death, regional private hospital, delay in recognising deteriorating patient, delay in transfer of patient

REPRESENTATION:

Counsel Assisting:	Ms Megan Jarvis
Counsel for Friendly Society Private Hospital:	Mr Matthew Hickey i/b Minter Ellison Lawyers
Counsel for Dr Pitre Anderson:	Mr A Luchich i/b Avant Law
Counsel for Dr H Gabruseva:	Ms D Callaghan i/b K & L Gates lawyers

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Introduction

1. Mark Anthony Plumb was aged 76. His family reported he was relatively healthy with his only known medical condition being Lupus.

2. Mr Plumb was admitted to the Friendly Society Private Hospital at Bundaberg on 19 September 2014 for removal of a gall stone. The procedure was performed that morning by Dr Pitre Anderson, a Specialist General Surgeon. Mr Plumb's wife, Joyce, was told soon afterwards that everything had gone well. Mr Plumb was admitted as planned for observation overnight.

3. Post-operatively and over the course of the day, Mr Plumb complained of pain and nausea, which was responded to by way of analgesia and antiemetics. In the late afternoon, Dr Anderson was contacted and advised of Mr Plumb's condition, with the main concern at that time being an inability to urinate. Dr Anderson was satisfied with the plan for managing Mr Plumb at that time and said he would come and review him later.

4. Dr Anderson reviewed Mr Plumb early that evening and inserted a catheter, which was successful in draining Mr Plumb's bladder. This indicated to Dr Anderson that Mr Plumb had urinary retention (a side effect of anaesthetic and analgesia) rather than renal failure (a sign of perforation or peritonitis). However, given Mr Plumb's other symptoms including ongoing pain and a slightly tender abdomen, Dr Anderson decided to order a CT scan and blood investigations.

5. The findings of the subsequent CT scan concluded that a perforation of the common bile duct and/or duodenum was suspected. The results were discussed by telephone by the radiologist with Dr Anderson at approximately 21:25 that night. Dr Anderson decided on a plan for conservative treatment of the suspected perforation and associated risks. He did not come in to the hospital to review Mr Plumb at this time but verbally communicated Mr Plumb's treatment needs to nursing staff, which included IV fluids, pain relief, antibiotics and a nasal gastric tube if needed overnight.

6. Dr Anderson was not contacted again until sometime after 05:30 the next morning, at which time he was advised that Mr Plumb had low urine output, increased abdominal tenderness and a rigid abdomen. Dr Anderson immediately made arrangements for Mr Plumb to be transferred to the Critical Care Unit (CCU/ICU) and he came to the hospital within a short period of time to review Mr Plumb.

7. By this time it was identified that Mr Plumb was very unwell, with acute renal failure and peritonitis. A decision was made for Mr Plumb to be referred to the Wesley Hospital in Brisbane for urgent surgical management and his transfer by way of the Royal Flying Doctor Service was effected early that afternoon.

8. On his arrival at the Wesley, Mr Plumb underwent surgery, which identified that the bile duct and pancreatic duct had been partially disconnected from the duodenal wall and were freely leaking into the abdomen. Despite surgical and intensive care measures, Mr Plumb remained critically unwell with a very poor prognosis. A decision was subsequently made for palliative care measures, and Mr Plumb passed away on 23 October 2014.

9. Mr Plumb's family voiced concerns about the medical care in the Friendly Society Private Hospital, particularly relating to the recognition of the symptoms of the post-procedure peritonitis and the subsequent management.

10. Mr Plumb's wife, Joyce, was with her husband throughout most of his admission to the Friendly Society Private Hospital, and remembers him being in agony at times such that he could not even stand to be touched. She felt there were clear warning signs to any doctor and staff that her husband needed something else done urgently, and believed that an earlier urgent operation might have saved his life.

Issues for inquest

11. After conducting an investigation including a review of the medical records and being informed by an expert review by Dr Phil Lockie of concerns, a decision was made to hold an inquest. In particular, the surgeon who conducted the procedure had not provided a statement to the coroner or a response to concerns expressed in the expert report or of family on the basis he was unwell and had since retired from medical practice. The issues determined for the inquest were as follows:

    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 appropriateness of the surgical procedure conducted by Dr Pitre Anderson on 19 September 2014;

    iii. The appropriateness of the post-operative care provided to Mr Plumb at the Friendly Society Private Hospital in Bundaberg, including whether staff recognised and responded appropriately to Mr Plumb's clinical deterioration.

    iv. The timeliness of the decision to transfer Mr Plumb to the Wesley Hospital in Brisbane for urgent surgical management.

Autopsy results

12. The family voiced objections to an autopsy taking place, as they believe the cause of death was known, and it was Mr Plumb's wishes to avoid undergoing an autopsy.

13. Accordingly, an external only examination was performed. This showed evidence of surgical and other interventions.

14. The cause of death was based on the external examination, and information contained in the medical records of Wesley Hospital. The cause of death was considered to be due to multiple organ failure due to sepsis with peritonitis and pancreatitis.

The admission to Friendly Society Private Hospital

15. Mr Plumb was admitted to the Friendly Society Private Hospital (FSPH) at Bundaberg for an elective endoscopic retrograde cholangiopancreatography (ERCP) and sphincterotomy for gall stones. ERCP is a specialised technique used to study the ducts or 'drainage tubes' of the gallbladder, pancreas and liver. Sometimes a small cut is made into the muscle surrounding the opening to the bile duct (sphincterotomy) in order to allow better drainage of the bile duct or to perform other procedures including removal of gallstones.

16. The ERCP procedure was performed on the 19 September 2014 by Dr Pitre Anderson and appears to have progressed uneventfully, although the operation report is brief. Mr Plumb remained in the recovery room from 08:49 to 11:29 and commenced to complain of pain and discomfort. He was given IV Panadol by RN Lamberton and an order was made for IV morphine by Dr Thomas, the anaesthetist, with a total of 10mg given in recovery. At 11:26 he was reviewed by Dr Anderson and RN Lamberton notes Mr Plumb was to remain nil by mouth. Dr Thomas says the prolonged stay in the recovery area was due to logistical delays in finding a ward bed.

17. Mr Plumb was stable when he returned to the ward post-procedure. However, the nursing notes indicate within 30 minutes of his return to the ward he complained about mild pain quickly increasing to severe abdominal pain rotating to his back. He was given morphine for pain relief. Morphine 10mg was administered by RN Rebecca Grimes who reported this to the ward manager who requested a review by the surgical intern, Dr Jun How Low. Mr Plumb was having problems in voiding urine. RN Grimes was of the view that Dr Low was asked to review Mr Plumb a number of times although it is clear now that Dr Low only reviewed Mr Plumb once. RN Grimes stated that Mr Plumb's vital observations[1] appeared normal but the symptoms of an unusual level of pain post an ERCP suggested something was wrong.

18. Dr Low states he reviewed Mr Plumb at 15:50 hours. He noted his pain was still 6/10 despite having been given anti-emetics and analgesia. Dr Low recalls Mr Plumb had a tender abdomen when he touched him. He did not conduct a full abdominal examination and in retrospect he would now do so and document this in the records. Dr Low agreed Mr Plumb, his wife and nursing staff were concerned about the level of pain and despite his normal vital observations considered there was something going on and he needed to be seen by the consultant. Dr Low discussed Mr Plumb's condition with Dr Anderson at 16:00 hours who said he would review him later. Dr Low states he left at the end of his shift at 16:30 and the pain and nausea were well controlled.

19. Dr Anderson reviewed Mr Plumb at about 18:40. RN Grimes recalls handing patients over and was present when Dr Anderson was speaking to Mr Plumb and his wife. They were questioning why he was in so much pain.

20. RN Renee Smidt was the Hospital Coordinator for the afternoon shift to 22:45. She says she was aware of Mr Plumb and she was told he had some trouble with pain and urinary retention post operatively, but had been reviewed by Dr Anderson and that he was settled.

21. RN Rachael See had started her shift at 18:45 and by this time devoted her time to Mr Plumb because she considered he was very obviously distressed and in pain. She escorted Mr Plumb for a CT scan at 19:50. She received a call from the CT radiologist section when they had results and gave them Dr Anderson's telephone number.

22. It is apparent the conclusion of the radiologist was that perforation of the common duct and/or duodenum was suspected. The written report says the results were discussed with the referring doctor, noted to be Dr Anderson, at 21:25 hours.

[1] These observations are taken by nursing staff and recorded on a chart and in this case consist of blood pressure, pulse or heart rate, breathing or respiratory rate, temperature, oxygen saturations as well as a pain score.

23. RN See recalls Dr Anderson rang around 21:00 to 21:15 and spoke to Mrs Plumb. He then ordered more morphine. 10 mg were administered at 21:20 and 15 mg at 23:00.Presumably he passed on to RN See that the CT scan queried a perforation, as this was the information passed on by her. There was no formal writing up of the CT scan results in the records. Critically, Dr Anderson did not decide to come to the ward to review Mr Plumb.

24. RN Smidt handed over to RN Corrinne Poddubecki at about 22:30 and said that Mr Plumb would be one to keep an eye on. RN Poddubecki confirmed the substance of this handover including that a CT scan had been completed and it queried if there was a perforation of the bowel. RN Poddubecki went and saw Mr Plumb and noted his normal observations but agreed with RN See that he was not looking well and needed a medical review.

25. RN Poddubecki requested the Critical Care Unit (CCU) medical officer Dr Helena Gabruseva review Mr Plumb sometime after her shift commenced. It is somewhat unclear when this request occurred but it would seem to be around midnight. It is evident the request was for a medical review and was not a request for an urgent or rapid response review. The main concerns expressed to Dr Gabruseva were of urinary output, nausea and ongoing pain. Dr Gabruseva was at the time looking after a number of other patients in the CCU.

26. In a second statement delivered a few days before the inquest, Dr Gabruseva noted that the CCU is a low-grade intensive care unit and is combined with a coronary care unit consisting of nine beds in total. Most of the patients are patients of interventional cardiologists. There is no intensive care specialist at the hospital. There is only one employed medical officer rostered on at the hospital, including the CCU, at any one time. Dr Gabruseva states that it is not part of her duties to conduct ward rounds outside of CCU and she would not necessarily see any patients on other wards unless called by a nurse or a new patient required admission. It is necessary for the Hospital Coordinator or nursing staff to contact her with respect to any patients who need to be seen. If a ward nurse is concerned about a patient they usually call the Hospital Coordinator but in a rapid response situation can contact her directly.

27. The requested medical review took place at 02:15. Dr Gabruseva recorded in the medical progress notes that ‘clinically perforation was highly likely’ The CT scan report was not available, although she did search for it. Dr Gabruseva stated that in retrospect she should have made further efforts to find the report. She was given details of the CT Scan from RN See. Dr Gabruseva was also aware that Dr Anderson had been made aware of the results as he provided the details to RN See. Mr Plumb’s vital signs were in normal range but were trending up. As a result, Dr Gabruseva decided that Mr Plumb’s antibiotic therapy should be increased.

28. There was some contention as to when and by whom this information concerning Dr Gabruseva’s review and plan should have been provided to Dr Anderson. Dr Gabruseva says she requested and left the responsibility of informing Dr Anderson to RN Poddubecki. In the medical records Dr Gabruseva recorded *“D/W HC to inform Dr Anderson at earliest opportunity”.*

29. RN Poddubecki agreed that Dr Anderson was to be called at the earliest opportunity but not immediately. She says that Dr Gabruseva said that although Mr Plumb would have to go to theatre in the morning a more considerate time would be to call Dr Anderson at 05:00. Dr Gabruseva says this recollection is incorrect. Given Dr Gabruseva’s contemporaneous note in the progress notes

indicates she expected Dr Anderson to be called quickly, I consider her version is the most reliable. In her later evidence Dr Gabruseva had a recollection she said to RN Poddubecki that with the care plan she put in place she expected a response by 5am, which she thought may explain where the time comes from.

30. However, Mr Plumb further deteriorated and Dr Gabruseva again reviewed Mr Plumb. There are some differences in recollections of who did what. There was certainly a further discussion with Dr Anderson by Dr Gabruseva at some time around 05:30 and before 06:15 hours and it was agreed Mr Plumb should be transferred to the Critical Care Unit (CCU). RN Poddubecki recalls a call with Dr Anderson soon after this decision confirming the transfer and that he would be in within half an hour.

31. RN Poddubecki then spoke to Dr Gabruseva who said there was little point in transferring Mr Plumb to the CCU as there was nothing else they could do that was not happening on the ward and the transfer was double handling. RN Poddubecki says this appeared to be justifiable and she did not question this. She recalls discussing this turn of events with RN See who would document this in the notes. RN See largely confirms this version in her statement.

32. Dr Gabruseva in her first statement says she personally contacted Dr Anderson after he had not been contacted and expressed her serious concerns regarding Mr Plumb. She also said there was a nursing staff shortage in CCU that night and she was unable to transfer him straight away.

33. In her second statement Dr Gabruseva noted that on the evening of the 19 September 2014 there were 79 patients in total admitted to the hospital with four patients in the CCU. Two of the CCU patients were critical but stabilising during the course of the night and the other two patients had fluctuations in their conditions during the course of the night. All four CCU patients required review, interventions, adjustments to treatment and management by her for the duration of the shift.

34. Dr Gabruseva stated that although there were five unoccupied beds in the CCU there were not enough CCU trained nurses to look after any patients in addition to the four patients already admitted. One nurse who had been rostered to work that night had called in sick and another nurse, who would otherwise have been on-call, was already working at the hospital.

35. Dr Gabruseva states she was not initially requested to review Mr Plumb by nursing staff or Dr Anderson. Between midnight and 02:00 she recalls RN Poddubecki requested she review Mr Plumb. Dr Gabruseva does not recall there being any sense of urgency in the request. She saw Mr Plumb within two hours. When she reviewed him at 02:15 she had not seen the formal report of the abdominal CT scan but had been told by the ward nurse that the verbal report given to her by Dr Anderson indicated a query perforation of CBD and/or duodenum. The hospital file contained limited information and very little medical history. The operation report was very short. The blood test results taken at 18:55 on 19 September 2014 indicated an elevated lipase, high white cell count and a high neutrophils. However, there were no pre-operative blood test results in the file for comparison. Her interpretation of the pathology results in combination with the clinical signs was that Mr Plumb was developing early biliary sepsis and/or pancreatitis, although he was not febrile. She was unable to locate the formal report of the CT scan. She noted Mr Plumb still had pain, which was worse in the right upper side. She noted that his blood pressure had remained about the same

but his heart rate had steadily increased and that he was clinically very dehydrated.

36. Mr Plumb's abdomen was very tender, with pain out of proportion to what would be expected. There was possible rigidity in the right upper quadrant. The findings at that time would have been consistent with the perforation of the biliary tree and bile leak.

37. In Dr Gabruseva's analysis, Mr Plumb's condition was not straightforward because he presented with a number of possible problems. She said she was reassured by the fact that Dr Anderson was aware of the CT scan results and had subsequently provided verbal orders to the nursing staff. Her plan was to rehydrate Mr Plumb and commence appropriate antibiotics. She escalated the antibiotic therapy and ordered intravenous fluid to be commenced. She also prescribed Maxolon for nausea and buscopan for abdominal pain in addition to the paracetamol and morphine already prescribed. Her plan was to escalate conservative treatment with stronger antibiotic therapy and fluid boluses to see if that improved his clinical state and clarified his diagnosis.

38. Dr Gabruseva asked RN Poddubecki to inform Dr Anderson of Mr Plumb's condition at her earliest convenience. It was her intention that this call should be made as soon as possible and she states she did not indicate a timeframe and did not ask her to wait until 05:00. She states she said words to the effect 'please let Dr Anderson know that I had to review the patient, that he has low urine output and is tachycardic and that I am giving him fluid boluses and escalating antibiotics'. RN Poddubecki says this is incorrect. Dr Gabruseva's reasoning for requesting nursing staff to contact Dr Anderson rather than contacting him herself was she did not have his telephone number and she also was concerned about other patients in the CCU and wanted to return to check on them. She had spent about one hour on this assessment.

39. Dr Gabruseva stated she spoke to the CCU nurse team leader and stated that transfer of Mr Plumb was not imminently required but could become a necessity later in the shift. She was contacted by nursing staff at 04:15 to say that Mr Plumb's urinary output had only been 10mls over an hour. Dr Gabruseva increased albumin over the telephone. She reviewed him at approximately 04:40. Mr Plumb showed no signs of improvement. His abdomen was very rigid and tender. Her plan was to provide IV albumin and further fluid boluses and she ordered urgent pathology tests.

40. Dr Gabruseva states there were not sufficient nurses in the CCU to look after Mr Plumb. She asked if any communication had been made with Dr Anderson with a negative reply. She accordingly went back to the CCU to look up his number and contacted him personally at about 05:30 and informed him of her serious concerns. Dr Anderson said he was aware of the issue and would come to review the patient promptly. She then told RN Poddubecki that Dr Anderson was coming to review Mr Plumb before he was moved to CCU. Dr Gabruseva was informed that RN Poddubecki had been told by Dr Anderson that in accordance with a discussion with the CCU consultant, Mr Plumb's transfer to the CCU had been agreed to. She was not present when Dr Anderson arrived and reviewed Mr Plumb on the ward or the CCU. Dr Gabruseva recorded this later discussion in the notes at 06:15.

41. Dr Gabruseva stated in evidence that in hindsight she regrets not making the earlier telephone call herself. She states she has learned from her experience with Mr Plumb and now personally contacts the admitting specialist if she has

any concerns about a patient's deterioration or is uncertain whether the specialist is aware of the patient's current clinical status.

42. There was some minor contention about whether RN See made the telephone call to Dr Anderson and then transferred the call through to Dr Gabruseva. It seems more likely the call was made by Dr Gabruseva and RN See may have confused the call with another. It appears there may have been two calls to Dr Anderson at this time but resolving this issue is of little importance. At least one call was made and certainly Dr Gabruseva spoke to Dr Anderson but it is a bit unclear when. Dr Anderson said he had a shower and came straight in and arrived between 06:30 and 07:00. Dr Gabruseva did not see Dr Anderson arrive and given she wrote a note in the record at 06:15 and provided a handover at 06:30 and then left after her shift, it seems the call was made after 05:30 and before 06:15.

43. Dr Ian Walker-Brown was a locum medical officer on his first shift in the CCU. He says he received a handover at about 06:30 from Dr Gabruseva about Mr Plumb, who had yet to arrive in the CCU. He was told Mr Plumb was peritonitic and hypotensive. On arrival in the CCU he was reviewed by Dr Hermann Wittner. Discussions were held with Dr Anderson and Wesley Hospital for transfer. Dr Walker-Brown placed a number of lines and started inotropic support, fluid resuscitation and fentanyl infusion for pain relief.

44. Blood tests showed acute renal failure, and a CT scan showed evidence of a bile duct or duodenal perforation. Mr Plumb was referred to the Wesley Hospital in Brisbane for urgent surgical management. Discussions took place at 09:25 hours, and he was transferred via Careflight later that day.

Transfer to the Wesley Hospital

45. The family have expressed no concerns with respect to the care and treatment provided to Mr Plumb at The Wesley Hospital and this was confirmed in a medical review of the records.

46. Upon arrival at the Wesley Hospital, Mr Plumb was taken straight to the operating theatre (OT) for an exploratory laparotomy that found 2-3 litres of bile in the peritoneum, and a perforation at the junction of the common bile duct, pancreatic duct and duodenum. Following repair, peritoneal washout and insertion of drains, Mr Plumb returned to ICU ventilated and sedated, and required inotropic support to maintain adequate haemodynamic status.

47. Throughout the following month, Mr Plumb remained acutely unwell. He developed pancreatitis and then systemic inflammatory response syndrome due to sepsis. He remained sedated and ventilated, required ongoing multi-system support, and received aggressive antibiotic treatment under the guidance of the infectious disease specialists.

48. Mr Plumb returned to OT on two further occasions for peritoneal washouts and in order to look for a source of ongoing sepsis. No collections were found, but he was found to have progressive retroperitoneal and fat necrosis with a large duodenal defect and extensive adhesions.

49. Despite full active treatment, Mr Plumb remained critically unwell, suffered ongoing complications and progressively developed multi-organ dysfunction. The family were kept appraised of his condition throughout this time and were aware of the gravity of his prognosis.

50. On the 17 October 2014 the decision was made, in consultation with the family, that, as there were no other active treatment options available, Mr Plumb was not for escalation of treatment, and in the event of a deterioration, he was not for resuscitation.

51. Over the following days, there was some concern that Mr Plumb's family were administering homeopathic remedies, as there were no other active treatment options available. Some of this contained arsenic, however consent was given by an ICU Registrar. This was addressed by medical staff and tests showed negligible levels of arsenic in his urine. A full list of the homeopathic remedies were contained in the medical notes, and a review considered it does not appear that this impacted his condition in any way.

52. Mr Plumb failed to improve, and on the 21 October 2014 active treatment was withdrawn and palliative care was commenced with a focus on pain relief and dignity. Mr Plumb passed away at 23:40hrs on the 23 October 2014.

Evidence of Dr Pitre Anderson

53. Dr Anderson only provided his first statement to the coroner in March 2016 after a pre-inquest hearing took place. He has since provided two further statements. Dr Anderson had provided letters to support the RCA process. In a letter dated 27 October 2014 he noted that sphincterotomy perforation and leakage is a well confirmed complication of ERCP and sphincterotomy, but is usually a small perforation and low risk and most cases are treated conservatively. Other perforations are more extensive and required drainage, and some are very significant injuries requiring duodenal exclusion procedures. Dr Anderson considered there was no technical fault in the procedure or equipment failure, which could have avoided or remedied to prevent this complication occurring.

54. Dr Anderson stated in his letter the procedure was straightforward. Mr Plumb developed pain post operatively. A CT showed he had sustained a retroperitoneal leakage. The next day his situation worsened and it was evident that conservative treatment could not be maintained and he was transferred to Wesley Hospital.

55. Dr Anderson's first statement noted he had been in practice since 1971 and had performed several hundred of these ERCP procedures in Bundaberg. He retired from medical practice in January 2015 due to ill health. Dr Anderson has not maintained his registration as a medical practitioner.

56. Dr Anderson noted he was the only surgeon in Bundaberg who performed ERCPs. He first saw Mr Plumb in September 2014. The only treatment option available to Mr Plumb was an ERCP. Mr Plumb's health status at the time did not put him at any greater risk of developing complications, than usual. He was otherwise a fit and healthy man, with no comorbidities.

57. Dr Anderson states he provided Mr Plumb with an information sheet explaining the procedure although this information sheet does not provide information about the risks and complications. He states he did discuss these complications with Mr Plumb and explained these to him, including pancreatitis, bleeding, infection and perforation, as is his usual practice. He obtained an informed and written consent from Mr Plumb. It was his usual practice only to document concerns the patient has and as Mr Plumb had no concerns he did not document any.

58. Dr Anderson stated the ERCP/sphincterotomy and gall stone extraction was uneventual and straightforward. He met with Mr Plumb in recovery and informed

him he would experience some discomfort for a few hours and he would be given oral analgesics and antibiotics.

59. Dr Anderson noted he was in recovery for a little longer than usual as there was a delay with a room being available in the ward. His observations remained stable during this time.

60. Mr Plumb then developed abdominal tenderness, pain and tachycardia. Mild-to-moderate pain is common but severe progressing pain is a sign of a complication.

61. Dr Anderson then reviewed Mr Plumb prior to transfer to the ward and noted he was experiencing slight abdominal pain and discomfort and continued him on morphine as ordered by Dr Thomas, and decided it was prudent to keep him ”nil by mouth”[2].

62. Dr Anderson states he was contacted by the Resident Medical Officer (this was Dr Low) at 16:00 hours and Dr Anderson stated he was informed that the pain was resolving but there was an inability to void his bladder. Dr Anderson was happy with the plan of management put in place by Dr Low and agreed that he would review Mr Plumb later that day. Dr Anderson did not consider that an urgent review was warranted at the time.

63. Dr Anderson reviewed Mr Plumb at about 18:00 hours. He inserted an IVC and drained 400mls of urine, indicating there was urinary retention rather than renal failure. Dr Anderson states Mr Plumb’s observations were stable and on clinical examination his abdomen was soft but slightly tender. He had no signs of peritonism at that stage, with no rigid abdomen, guarding or rebound tenderness.

64. However, Dr Anderson ordered a CT scan to be performed urgently and for blood investigations. He conveyed his management plan to nursing staff. He did not document the details of this review in the records, as it is his usual practice for the nurses to document the verbal orders he provides.

65. Dr Anderson stated that at 21:25 hours he was contacted by the radiologist Dr Matar informing him of the results of the CT scan that showed a sealed perforation but no free gas in the abdomen or retroperitoneal emphysema. In addition there was no leak of contrast from the duodenum. Dr Anderson says he considered the CT findings were favourable and suggestive of a sealed perforation and an indication to embark on conservative management. As per the Victorian Surgical Consultative Council guidelines he ordered nil by mouth, a nasogastric tube to be inserted if he was nauseated or vomited, IV fluids, antibiotics, hourly urine output measures and analgesia as required. Dr Anderson notes that his verbal orders were recorded accurately in the medical records by nursing staff at 21:55. In his experience the majority of cases of ERCP perforation respond to conservative treatment.

66. Dr Anderson states that when he received the call from Dr Matar he was told there was no free intraperitoneal fluid and all the inflammatory changes were retroperitoneal and contained within the retroperitoneal tissue planes. Dr Anderson says the written report (which he did not have) is ambiguous and does not state exactly where the tracking fluid is i.e. intraperitoneal or retroperitoneal. Dr Anderson stated in evidence that upon reading the CT report there was nothing contained in it of any significance that was not conveyed verbally to him.

[2] Essentially an instruction to withhold food and fluids through the mouth

67. Dr Anderson states free peritoneal fluid would indicate a free perforation requiring immediate surgery, but this is not what he understood was the case.

68. In his evidence he stated the outcome of the complication is usually a small perforation. Dr Anderson stated in evidence he found it difficult to understand the extent of the injury as described by the surgeon at Wesley Hospital Dr Cavallucci being 'the bile duct and pancreatic duct had been partially disconnected from the duodenal wall and were freely leaking into the abdomen'. It was suggested to Dr Anderson that the extent of the injury had likely progressed and Dr Anderson commented that for instance dry retching could do this. This was a proposition that Dr Lockie disagreed with.

69. Dr Anderson states he contacted Mrs Plumb at 21:30 hours to inform her of the situation and the management plan.

70. In his statement Dr Anderson notes that according to the records Mr Plumb's condition deteriorated over the next few hours. He notes that at 02:15 hours, Dr Gabruseva reviewed the patient and requested a review by the hospital coordinator and for him to be contacted at the earliest convenience. He was not contacted at that time. He states that if he had been contacted he would have gone to the hospital and reviewed Mr Plumb, as is his usual practice. Of significant concern at that time was that peritonism had developed in the right abdomen indicating an extension of bile leakage.

71. Dr Anderson was also not contacted at 04:40 hours when there was discussion and issues about availability of beds in the CCU.

72. Dr Anderson states he was first contacted at 06:15 hours by Dr Gabruseva (it is likely this was earlier at between 05:30 and 06:00) and informed of Mr Plumb's status including a reduced urine output, increased tenderness and rigid abdomen. He provided verbal orders for pathology tests, a central venous line, an arterial line and fluid resuscitation. He also contacted the cardiologist in charge of CCU to request an urgent transfer. Dr Anderson states he immediately presented to the hospital but acknowledges that he did not record the time in the records. It would have been about 07:00 hours. In light of the CT results and the symptoms of increased pain and peritonism he considered it highly likely that Mr Plumb's sealed perforation had not resolved and had progressed to a duodenal-bile duct perforation that warranted urgent treatment and surgery. It became evident that conservative treatment was not working and he considered a transfer to Brisbane was warranted.

73. Dr Anderson acknowledges there was a lack of documentation in the case notes but on this occasion there were two telephone calls made at home and he did not have access to the case notes and these details were not documented. In retrospect, he acknowledges he should have documented these details when at the hospital.

74. Dr Anderson also stated that lack of communication/notification to him by the hospital in the early hours of 20 September 2014 was a factor that contributed to the delay in reviewing Mr Plumb.

75. In this case Dr Anderson stated the lack of communication to him; no availability of an ICU bed; no intensivist available for an opinion on an urgent review; are management issues, which have resulted in delay in treatment of Mr Plumb, which may have been detrimental to his condition and outcome.

76. Dr Anderson does not agree with Dr Lockie's comments that it would have been desirable that Mr Plumb had been transferred to Brisbane at about 21:30 hours. This would have been ideal if he had been made aware earlier of his deteriorating state after review at 18:00 hours. At that time he considered Mr Plumb's condition relatively stable. Any transfer would have been dependent on the earlier availability of the retrieval service and an available bed at the Wesley Hospital.

77. He states that at 02:15 hours, if he had been made aware of Mr Plumb's situation, he would have arranged for immediate transfer at that time.

Independent expert opinion of Dr Phil Lockie

78. Dr Phil Lockie is a specialist general surgeon specialising in laparoscopic, upper GI and bariatric surgery. He was requested to provide a report to the coroner after reviewing the medical records. In summary, he believed Dr Anderson's decision to perform an ERCP was entirely appropriate. Dr Lockie has concerns regarding the post-operative of care received at the Friendly Society Private Hospital at Bundaberg and believes Mr Plumb's transfer to The Wesley Hospital could have occurred some hours earlier than it did.

The appropriateness of the ERCP procedure conducted by Dr Pitre Anderson on 19 September 2014

79. Mr Plumb was referred to Dr Anderson by Dr DeLacy following a cholecystectomy and the development of further abdominal symptoms. Subsequent radiological investigation revealed evidence of a gallstone in the distal common bile duct. In those circumstances Dr Lockie opined the retrieval of this gallstone at ERCP is entirely appropriate and correct.

The appropriateness of the post-operative care provided to Mr Plumb at the Friendly Society Hospital Bundaberg.

80. Dr Lockie found Mr Plumb had what appears to be a routine ERCP and stone retrieval performed and his immediate post-operative recovery was uneventful.

81. Dr Lockie believes there are significant deficiencies on Mr Plumb's post-operative care at FSPH once Mr Plumb's condition started to deteriorate at approximately 17:00 hours on 19 September 2014 and was therefore at a medical standard below what would reasonably be expected.

82. Dr Lockie stated it is apparent Dr Anderson assumed Mr Plumb had post ERCP pancreatitis, which is not unusual and can be self-limiting and fixes itself in 48 hours. Dr Lockie noted that post-operative pain is also not unusual but it was not settling and Dr Anderson made the appropriate decision to obtain a CT scan and blood tests.

83. In evidence, Dr Lockie also agreed that retention of urine post procedure is not uncommon and the insertion of a catheter was appropriate.

84. In his report Dr Lockie stated the consultant radiologist apparently informed Dr Anderson at approximately 21:25 hours on 19 September 2014 that Mr Plumb had a suspected perforation of his duodenum or common bile duct, with free fluid in his abdomen.

85. Dr Lockie said in evidence he considered the CT scan was a *"game changer"* in that the CT scan showed a perforation and retroperitoneal fluid and the case was now in a different category from that of pancreatitis. He disagreed with the

assertion that it would be reassuring that the CT scan showed no free intraperitoneal fluid. Medical studies have shown that retroperitoneal fluid can also be a problem that needs management.

86. Dr Lockie noted there had also been a rise in Mr Plumb's lipase level, which indicated an injury to the duodenum. He stated the description of the injury found at surgery at the Wesley Hospital was consistent with an injury occurring at the ERCP and consistent with the rise in lipase and the CT results.

87. Having received this information, Dr Lockie stated that not only did Dr Anderson fail to institute any changes to Mr Plumb's management, he did not review him in the hospital at that time. Dr Lockie noted the plan was for conservative management and to wait for it to resolve. With this information of CTscan/lipase rise, Dr Lockie stated it was likely further intervention would be required and there should have been a plan put in place considering what further interventions may be required, which usually would need to be performed at a specialist unit.

88. Dr Lockie also noted that when Mr Plumb's condition continued to deteriorate, at 02:15 hours on 20 September 2014, assuming that he was contacted, Dr Anderson again failed to attend a deteriorating patient. As there were no statements from Dr Anderson at the time Dr Lockie provided his report, it was unclear as to whether Dr Anderson was told about this deterioration. Dr Lockie was later provided with further statements recently received from medical and nursing staff. Dr Lockie stated in evidence this confirmed there had been a communication breakdown and it is apparent Dr Anderson was not told of the deterioration at 02:15.

89. Dr Lockie stated that obviously, Dr Anderson cannot be held accountable for lack of action, if he was not in fact contacted by the medical/nursing staff. In which case, the failure of the resident medical officer and/or the nursing staff to contact a consultant surgeon when a patient's condition is deteriorating, requires further investigation by the appropriate regulatory authorities.

90. In Dr Lockie's opinion, there was a significant delay in transferring Mr Plumb to the CCU for appropriate resuscitation and observation when his condition had significantly deteriorated at approximately midnight on 19 September 2014. This transfer did not take place until after Dr Anderson attended Mr Plumb early on the morning of 20 September 2014. The time of this attendance is not recorded in the nursing notes. According to Mrs Plumb, she contacted the hospital at approximately 05:00 hours, however Dr Gabruseva has written a note in the medical records dated 06:15 hours and Dr Anderson's note is written after this. Mrs Plumb then attended the hospital after her phone call.

91. In Dr Lockie's opinion Dr Anderson's note keeping is inadequate and below an acceptable standard expected. He attended the ward on a number of occasions and performed an invasive procedure and did not record this procedure, nor his attendance in the medical notes. Investigations were ordered and this was not recorded in the medical notes, nor were the results of these investigations.

The timeliness of the transfer of Mr Plumb from the Bundaberg Hospital to the Wesley Hospital

92. At 21:25 hours on 19 September 2014, Dr Anderson was aware that he had an ill patient post ERCP with probable perforation of the distal common bile duct and/or duodenum and free fluid within the abdominal cavity. Dr Lockie suggests that given the facilities available to Dr Anderson in Bundaberg, it would have been appropriate at that time to have at least discussed Mr Plumb's case with a

Consultant Hepatobiliary Surgeon. Perforation is a rare complication post ERCP. At the very least, having contacted a Hepatobiliary Surgeon, Dr Anderson could have been reassured that his approach to the situation was appropriate, or it would have facilitated an earlier transfer to a specialist unit.

93. Furthermore, even if the Consultant Hepatobiliary Surgeon had been happy with the initial management, when Mr Plumb deteriorated at 02:15 hours on 20 September 2014, Dr Lockie would strongly suggest, that at this time, had the Hepatobiliary Surgeon been contacted again, the decision would have been made to transfer Mr Plumb to a specialist unit. Thus the transfer would have been made between 11-16 hours earlier, well before Mr Plumb's clinical condition had critically deteriorated. Dr Lockie stated it is impossible to state whether or not Mr Plumb would have survived his perforation had he been transferred to the Wesley Hospital at an earlier time, but the significant delay and consequential critical deterioration of his clinical condition compromised his initial treatment at the Wesley Hospital.

Clinical reviews conducted by Friendly Society Private Hospital

94. The FSPH conducted various internal reviews. Nurse Unit Manager Donna Stallan prepared an incident report. In accordance with FSPH Sentinel & Adverse Event management policy the incident was referred to Dr Michael Moreny, the hospital medical advisor. Dr Moreny prepared a Clinical Review. He later commissioned a Root Cause Analysis.

95. Dr Florian Grimpen, gastroenterologist and heptalogist also provided a review. Dr Grimpen stated it was difficult to say what led to the complication as there is limited information regarding the procedure itself. Perforation of the junction between the bile duct and duodenum is a recognised complication of ERCP and it is usually caused by the sphincterotomy. The standard ERCP consent form used by public facilities in Queensland states the risk of perforation with ERCP is about 1%.

96. The consent form signed by the patient in this case is of general nature and does not document the specific risks of ERCP, but does state that the signatory understands the risk of the procedure. A consent form should detail indications, details of the procedure, treatment alternatives, and the most important possible complications. The form should also be signed by the medical officer.

97. Dr Grimpen stated the management post procedure could have been better. Ongoing severe pain for many hours after ERCP raises concern for a serious complication to have occurred and mandates review by a senior medical officer, not just the intern. After the intern review at 16:00 and the surgeon at 18:30, there was no medical review until 02:15, despite clear signs of the patient being gravely ill and the suspected perforation of bile duct or duodenum having been communicated to the surgeon in the evening by the radiologist. The diagnosis of perforation was strongly suspected after the CT report, and one could argue that some time delays occurred until the transfer to the Wesley hospital was arranged at 9:25 AM the next day.

Root Cause Analysis

98. The RCA noted five causal statements and seven recommendations were made.

99. *Causal Statement 1*: Due to peri-operative sphincterotomy choledocochograms not been reviewed by radiologist at the time of ERCP. It was recommended that these be reviewed as a matter of peri-operative practice and reported to the surgeon immediately. It was further recommended that scheduling of ERCPs be

undertaken in conjunction with a radiologist for reporting and emergency ERCPs to be scheduled with radiologist consultation where out of hours.

100. *Causal statement 2*: Due to the care/perforation not recognised until 11 hours post-surgery. It was recommended that unresolved pain post ERCP (up to three hours) is to have a timely CT scan and immediate reporting to surgeon.

101. *Causal statement 3*: Due to the deteriorating patient response being delayed. It was recommended for the development and/or to adjust current tools to provide greater clarity and triggers for action in management of the deteriorating patient.

102. *Causal statement 4*: Due to delay in transfer to CCU/Wesley. It was recommended to enforce mandatory communication to the Director of CCU or Hospital Nurse Unit Manager/Hospital Coordinator to determine required resources availability for patient care.

103. *Causal statement 5*: Due to limited number of ERCPs. It was recommended there be a review of the level of procedures/cases required to maintain competency.

104. The Director of Nursing–Compliance is a role that focuses on quality outcomes and clinical risk. DON-Compliance Yvonne McChesney reported on the response to the recommendations of the RCA. Principally a decision was made that since November 2014 ERCPs are no longer performed at FSPH. Currently there are no accreditation requests to undertake ERCPs at FSPH. At the time of Mr Plumb's death Dr Anderson was the only accredited practitioner undertaking ERCPs and he resigned from his practice in December 2014. It is considered that any application in the future would be treated with utmost caution and only approved with the right supports in place.

105. It was also apparent that there would be difficulty in having a radiologist present to report on any review of images post-procedure or to attend any emergency after-hours procedure, which contributed to the decision to cease the performance of ERCPs at FSPH. Both Dr Anderson and more particularly Dr Lockie disagreed with necessity for this recommendation on the basis surgeons are well able to interpret cholangiograms. Apart from this issue Dr Lockie stated that the other recommendations that have been implemented are consistent with current widespread adoption of similar policies throughout Queensland Health and private health systems.

106. In June 2015 an Acute Pain Management policy was developed to ensure pain management principles and management expectations were clear and applied clinically throughout the hospital. It was noted during the inquest that a number of staff were unclear about this policy and in submissions Counsel for the FSPH stated this had been noted by management attending the inquest and would be addressed.

107. The FSHP had in place a track and trigger observation chart (*Adult General Observation Chart*). A second version of the chart providing greater clarity about triggers for further action and more specifically required responses was drafted in 2015 and trialled and fully implemented in March 2016. Although nursing staff had identified the concerns to the medical officers throughout this admission, the form has resulted in an increased responsiveness from the medical team and an increased awareness in the nursing team on what is acceptable and what signals an emergency or rapid response attendance.

108. *The Recognising and Responding to Clinical Deterioration Policy* had been implemented since June 2013 but has since been revised, including use of the updated *Adult General Observation Chart*. Further education for nurses was conducted over that period. In 2016 the *Speak up for Safety–Cognitive Institute Program* was introduced and close to 200 members of staff were educated with aims to empower staff to raise any concerns they may have about patient safety.

109. Nursing and medical staff at the inquest consistently referred to their knowledge of and training in the use of the abovementioned policies and tools.

110. It has also been reiterated that hospital policy requires that resourcing decisions affecting intra-hospital transfer of patients is to be made by the Director of CCU/NUM CCU/Hospital Coordinator. A memorandum was issued to all staff on 17 December 2014 to ensure appropriate managers were contacted in relation to any concerns about a deterioration in the patient's condition so that appropriate decisions could be made about additional care supports or intra-hospital transfers and coordinated as necessary. An updated intra-hospital transition of care policy was also updated to add as a key principle that all transfers are appropriate and timely, consistent with patients' condition or needs.

111. A Patient Communication Board has also been placed in each room, in order to improve communication amongst the entire care team, the patient and their family. The hospital has also introduced a *One-on-One Nursing Care of Patients (Specialling)* policy to assist with identification of patients requiring additional care and ensure consistency of relevant practice.

112. A training plan for critical care has also been developed for resident medical officers (RMO) to ensure a clear and consistent understanding by employed medical staff of their role expectations within the hospital and also the ongoing clinical competency.

Conclusions

113. 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.

114. If, from information obtained at an inquest or during the investigation, a coroner reasonably believes that the information may cause a disciplinary body for a person's profession or trade to inquire into or take steps in relation to the person's conduct, then the coroner may give that information to that body

115. 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.

116. 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. Some of those factors are evident in this

case and these resulted in a number of missed opportunities to diagnose the deterioration in condition being suffered by Mr Plumb.

117. This case also emphasised the importance of systems being in place to recognise and manage a deteriorating patient. It has been recognised that warning signs of clinical deterioration are not always identified or acted upon. As a result there is a specific component for Recognising and Responding to Clinical Deterioration contained in Standard 9 of *The National Safety and Quality Health Service Standards*. As the Standard states, serious adverse events are often preceded by observable physiological and clinical abnormalities and early identification of deterioration may improve outcomes and lessen the intervention required to stabilise a patient's condition if it deteriorates in hospital.

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

119. The evidence, consistent with the opinion of Dr Lockie, suggests that it was appropriate for Dr Anderson to perform the ERCP on Mr Plumb. As with all surgery and anaesthesia there are known complications, which if they occur are not necessarily conclusive that something has gone wrong or that reasonable care has not been given by the medical team completing the surgery. It would appear that the risk of a perforation in an ERCP is in the region of 1-1.3% with a mortality rate if a perforation occurs at a considerably higher level of 18%.[3]

120. There is no evidence that Mr Plumb and his wife were not aware generally of such risks, although it is evident the generic Consent Form signed by Mr Plumb does not set out or list such risks .This was noted by Dr Lockie and Dr Grimpen and in that respect it was considered it would be better practice to detail those matters in the form itself. It has been my experience that the use of generic consent forms with little detail as to risks and complications remains very common and is most undesirable in this current medico/legal environment.

121. Mr Plumb was managed adequately post operatively in recovery and subsequently on the ward, with pain relief being provided and sufficient observations being performed and plans put in place. Dr Anderson was provided with an update by Dr Low. There was nothing provided in that update that suggests other action should have been taken then. Dr Anderson reviewed Mr Plumb after 18:00. Dr Anderson appropriately ordered a CT scan in response to ongoing abdominal pain.

122. The 'game changer' was the results of the CT scan, which were communicated to Dr Anderson at 21:25 on 19 September 2014. Dr Anderson decided to keep to a conservative management plan. Dr Lockie considered that what should have occurred is for Dr Anderson to review Mr Plumb again as it was evident to Dr Lockie there needed to be plans for alternative management or interventions, including radiological or surgical, to be considered over and above conservative measures. The CT scan effectively ruled out pancreatitis as the cause of the pain and a perforation was at this time to be highly suspected. This was a missed opportunity to consider alternative management plans, which could have led to an earlier transfer for further intervention at a specialist unit such as the Wesley.

[3] Report of Dr Grimpen exhibit C2 and Victorian Surgical Consultative Council guidelines attached to C4.

123. Dr Anderson agrees it would have been prudent for him to have physically reviewed Mr Plumb at that time but did not concede this was a time when a transfer should have been considered. Dr Lockie agrees to the extent that such a decision may not have been made then but there should have been put in place a plan where alternative arrangements may have been highlighted.

124. If that had been the case, and a less conservative approach was noted, then it may have resulted in nursing staff being made aware of the features to be considered and monitored for deterioration in such cases and escalated accordingly. In this case Mr Plumb's vital observations were within a normal range, albeit perhaps trending up, but the confounding issue remained the abdominal pain he continued to experience notwithstanding the use of analgesia and morphine for relief and the increasing abdominal tenderness. Nursing staff, notwithstanding that no particular plan other than conservative measures had been communicated, did request a review from Dr Gabruseva. There was no urgency communicated about the review, given the vital signs were normal, and the review took place within two hours.

125. It is apparent from evidence heard at the inquest that there were no cultural or practical impediments to nursing or medical staff in being able to contact Dr Anderson or other consultants conducting their practice at FSPH to discuss patients or any concerns.

126. As well, Dr Gabruseva, who reviewed Mr Plumb at 02:15 would have been comforted by the fact that Dr Anderson was aware of the CT scan results and had proceeded with conservative management, which management she then escalated after she reviewed Mr Plumb.

127. It is apparent the time of the review at 02:15 was another missed opportunity to escalate concerns. Dr Gabruseva, not unreasonably delegated responsibility to the Hospital Coordinator to contact Dr Anderson. Dr Gabruseva concedes that with retrospect, she should have done that herself, and would do so in the future if faced with a similar scenario. Dr Anderson was not contacted at the time or at all until Dr Gabruseva made the call after 05:30. Dr Anderson agrees that at 02:15 a review and transfer for specialist care at another hospital would have been considered. It is unclear why Dr Anderson was not contacted earlier by the Hospital Coordinator or nursing staff.

128. I am less concerned with the delay in transfer to the CCU at FSPH for an hour or so. Mr Plumb was receiving one-to-one nursing care at the time and Dr Gabruseva had been with Mr Plumb for some time as well and it is unclear what more would have been done in the CCU compared to the ward.

129. There are no concerns with respect to the time it took for Mr Plumb to be transferred by air to Brisbane. It is apparent that the transfer took place within expected time frames and according to available resources.

130. The main missed opportunity was in Dr Anderson not reviewing Mr Plumb after the CT Scan or at least flagging to nursing and medical staff the need to be vigilant in monitoring Mr Plumb for deterioration consistent with the effects of a perforation. That may have resulted in an escalation of action many hours earlier before Mr Plumb's serious deterioration set in. It is unclear if earlier intervention as provided by Wesley Hospital would have made a difference to the outcome

for Mr Plumb but at a common sense practical level the earlier attention is given the better the prospects must be.

Findings required by s. 45

Identity of the deceased – Mark Anthony Plumb

How he died – Mark Plumb attended Friendly Society Private Hospital for an elective procedure to remove a gall stone. Soon after the procedure Mr Plumb began to experience severe abdominal pain. A CT Scan later noted a suspected perforation of his duodenum or common bile duct, with free fluid in his abdomen. No action beyond implementing conservative treatment was taken by the surgeon Dr Pitre Anderson on being provided with this information. There was no escalation of treatment despite Mr Plumb's deterioration being noted for over 11-16 hours during which time Mr Plumb became septic. By the time of transfer to Wesley Hospital in Brisbane, and despite maximal treatment being provided to him, Mr Plumb had a poor prognosis and subsequently died. An earlier recognition of deterioration and transfer for appropriate care would likely have improved Mr Plumb's chances of survival from his perforation.

Place of death – Wesley Hospital AUCHENFLOWER QLD 4066 AUSTRALIA

Date of death– 23 October 2014

Cause of death –

1(a)	Multiple organ failure
1(b)	Sepsis with peritonitis and pancreatitis
1(c)	Perforation of the junction of common bile duct, pancreatic duct and duodenum
1(d)	Elective endoscopic retrograde cholangiopancreatography (ERCP) and sphincterotomy
1(e)	Biliary calculi

Comments and recommendations

Given the findings and recommendations arising from the Root Cause Analysis I do not consider it necessary to make any further recommendations. ERCPs are no longer conducted at FSPH. A number of improvements have been made regarding assisting nursing staff in recognising a deteriorating patient, improving communication and the management of pain at the hospital. It is noted that generally hospital staff were aware of the changes to policy and procedures and had received training on them. The exception appears to be with respect to the pain management policy, which the hospital administration has acknowledged and I accept will take some further action on.

It was noted that a number of medical and nursing staff did not contribute directly to the Root Cause Analysis and Ms Callaghan suggested that this should be considered. This is an issue identified by me previously in relation to a number of Queensland

Health public hospital cases[4]. I agree, consistent with my previous recommendations that wherever possible the Friendly Society Private Hospital ensure that Root Cause Analysis processes should be conducted such that relevant members of the treating team, if they wish to participate, are provided an opportunity to be interviewed and are provided with feedback as to the outcome of the RCA.

It is also noted that Dr Anderson has since retired and is unwell. I do not intend to make any referral to a disciplinary body as a result. A copy of my finding is routinely forwarded to the Office of Health Ombudsman and Australian Health Practitioner Regulation Agency and can be considered in the event of any application for re-registration.

I close the inquest.

John Lock
Deputy State Coroner
Brisbane
19 August 2016

[4] Inquest into the death of Patient A delivered 5 July 2012; Inquest into the death of Preston Paudel delivered 25 October 2012