



OFFICE OF THE STATE CORONER

FINDING OF INQUEST

CITATION: **Inquest into the death of Vivian Bexley ZIMITAT**

TITLE OF COURT: Coroner's Court

JURISDICTION: Rockhampton

FILE NO(s): ROCK-COR- 53 / 2004

DELIVERED ON: 28 July 2006

DELIVERED AT: Rockhampton

HEARING DATE(s): 24 May 2006

FINDINGS OF: Ms Annette Hennessy, Coroner

CATCHWORDS: **Regional Neurology Services Availability; Maintenance of appropriate records regarding regional and remote medical contact with specialty units in tertiary hospitals**

REPRESENTATION:

Queensland Police Service
Officer Assisting: Constable C Gnech, Police Prosecutor

Family: Mr R Zimitat (Son of Deceased)

Other Appearances:
For QHealth, Dr Coleman
& Dr Renton-Power: Mr J MacDougall instructed by Tresscox
Lawyers

TRANSCRIPT OF PROCEEDINGS

CORONERS COURT

HENNESSY, Coroner

COR-53 of 2004

IN THE MATTER OF AN INQUEST INTO THE
CAUSE AND CIRCUMSTANCES SURROUNDING
THE DEATH OF VIVIAN ZIMITAT

ROCKHAMPTON

..DATE 28/07/2006

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: My findings in relation to this particular inquest
are that Mr Zimitat was admitted to the Rockhampton Hospital
on the 17th of July 2004. At the time, he was unconscious and
had a scalp laceration, a bruise over his eye, and tenderness
~~over the left side of his ribs. He was, at that time, under~~
the influence of alcohol, and the indications were that he had
a blood alcohol reading of .42 per cent and that he had fallen
over outside of his house during the night, lying undiscovered
for up to five hours.

1

10

A CAT scan was taken on the 18th of July which showed that
Mr Zimitat was suffering from a right subdural haematoma. At
autopsy, a skull fracture was detected which did not show on
the CAT scan results. There was at the time, and is still, no
neurosurgeon resident in Rockhampton, Dr Baker having left in
2004. In fact, the evidence indicated that the only
neurologist situated outside the south-east corner of the
state is in Townsville.

20

30

Dr Ramsay nee Coleman, the Registrar treating Mr Zimitat,
contacted the neurology department at the Royal Brisbane
Women's Hospital to inquire about transferring Mr Zimitat to
Brisbane for treatment. The neurological Registrar advised
that, at the time, Mr Zimitat would not require surgery and he
should be kept under observation, with repeat CAT scan to be
conducted in a week if his condition changed.

40

50

Mr Renton-Power, the senior staff surgeon at the Rockhampton
Hospital, gave evidence that he had been told by Dr Ramsay

that Brisbane had not approved Mr Zimitat's transfer due to a shortage of beds. Mr Renton-Power thought this a scandalous situation and thought that Mr Zimitat should have been transferred to Brisbane for specialist neurological care. He continued, during the course of Mr Zimitat's stay in

1

Rockhampton, to assert that he be transferred to Brisbane as Mr Renton-Power was of the opinion that surgery was appropriate, although he admitted that neurology was not his area of specialty.

10

The notes in the medical file contain no mention of the bed shortage issue and Dr Ramsay denied that this was said to or by her. She proposed that there may have been a misinterpretation of something she said regarding Brisbane not wanting to use a bed for a patient who would not be operated on. There were no records regarding the conversation at the Royal Brisbane Women's Hospital.

20

30

Dr Nuwitsky, Director of Neurosurgery at the Princess Alexandra Hospital gave evidence that the decision not to transfer on the basis of there being no need for surgery, was a valid decision, although he did make some comments regarding the making of that decision on another basis.

40

On the 21st of July, Mr Zimitat became drowsy and difficult to rouse and had a repeat CAT scan. Dr Ramsay contacted Brisbane again and sent both CAT scans for review. No change was evident in the subdural haematoma. The recommended treatment advice did not change although the Registrar in Brisbane

50

advised that they would consider transferring Mr Zimitat to Brisbane when a bed was available, as his condition was not improving.

1

~~The medical evidence before me was clear that Mr Zimitat was~~

10

unlikely to have survived even if he had been transferred to

Brisbane, given his cardio pulmonary condition. Mr Zimitat

died on the 24th of July 2004. He had previously undergone

heart surgery with graphs being implanted. The autopsy

revealed that Mr Zimitat was slightly hypertensive but that

20

the graphs were clear. A pulmonary embolus was identified.

The subdural haematoma and fractured skull was indicative of a

significant trauma from a fall, on the evidence. There was

also evidence of secondary haemorrhages in the brain stem.

The immobilisation of Mr Zimitat, initially after his fall,

30

and also later during his hospital stay, likely led to the

development of a clot in the legs which detached, resulting in

the pulmonary embolus placing pressure on the heart which

likely failed.

40

Dr Buxton's conclusion as to the cause of death, which I

accept, was pulmonary embolism secondary to immobilisation as

a result of a subdural haemorrhage following a fall, with the

coronary artery atheroma and fracture of the skull also

contributing.

50

Whilst it is always preferable for specialist medical

personnel to have direct access to patients to make diagnoses

and treatment decisions rather than making decisions on

relayed information, the practicalities are that all major specialities may not be available to be serviced, even in major rural centres such as Rockhampton.

1

~~It is clear from the evidence, however, that from both the~~
point of view of the patient and medical practitioners, Mr Zimitat would have been best cared for in a neurosurgery unit, whether that be in Rockhampton or, if not available, then Brisbane.

10

Whilst the evidence indicates that the outcome may not have been different for Mr Zimitat if such a service had been available, there is expert evidence before me that accessibility to a specialist neurology service in Rockhampton will save lives.

20

With a view to ensuring that there is no future loss of life in similar circumstances, I make the following recommendations:

30

1. That Queensland Health ensure that proper and complete records be maintained in all specialist units of referral phone calls from regional hospitals or medical practitioners, including record of any opinion and/or decisions regarding transfer of the patient provided to the referring practitioner; and

40

50

2. That Queensland Health ensure that a neurological or neurosurgery service or access to such a service, be provided for the community of Rockhampton and district in whatever form is considered to be most appropriate ~~following a prompt analysis of the needs of the region~~ and that sufficient resources be provided for that purpose.

1

10

I do not consider that there are any other recommendations that I can usefully make. I have made the findings required under the Coroner's Act, and, unless there is anything further, I will now close the inquest.

20

...

CORONER: All right, thank you. I will make those findings available - the transcript of today's proceedings available to each of the parties. Thank you.

30

40

50