TRANSCRIPT OF PROCEEDINGS

CORONERS COURT

RINAUDO, Coroner

ROMA-COR-00000007/04

IN THE MATTER OF AN INQUEST INTO THE
CAUSE AND CIRCUMSTANCES SURROUNDING
THE DEATH OF MARGARET ISABEL HORSINGTON

ROMA

..DATE 04/05/2007

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: Thank you. Good morning, be seated. This is the findings of the inquest into the death of Margaret Isabel Horsington. An inquest was held on the 26th and 27th of October 2006 by the then Coroner at Roma, Mr Costello. Mr Costello became ill and it became clear that the delivery of findings would be delayed, possibly substantially.

By notice dated the 9th of February 2007, the State Coroner transferred the coronial investigation into the death of the deceased to me, pursuant to section 63 of the Coroners' Act 2003. I have reviewed all of the evidence and will shortly publish my reasons in full, however, I make the following comments.

In these findings I have endeavoured to reduce the substantial evidence to arrive at a distillation of the main issues as raised by the family of the deceased. In broad terms, there is no issue about the cause of death, as reported by Dr Guard, as set out in the autopsy report. He is clear, in the evidence he gave, that the death was causative of the underlying heart disease and the effects of the bowel obstruction. When Mrs Horsington presented - are you right? Hello?

MS COMANS: Hello? Yes, I'm sorry, I seem to be having a little bit of difficulty hearing you, your Honour.

CORONER: That's Ms Comans, is it?

MS COMANS: It is, your Honour.

CORONER: Yes, I'm sorry, I should have acknowledged that you were representing the family today and that Sergeant O'Rourke, the police officer assisting the Coroner, is also present, as are some family members. I apologise for not having done that, but can you hear all right?

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MS COMANS: I can now hear you clearly, thank you.

CORONER: Righto. Thanks. Well, I was - you heard what I've said, though, have you?

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MS COMANS: That's right, yes, yes.

CORONER: Yes, all right. When Mrs Horsington presented at the Mitchell Hospital she was properly diagnosed by Dr Tomlinson and a treatment plan was commenced in consultation with Dr Bennett. It is clear, for whatever reason, that Dr Bennett was set on a course of action, that is, to undertake a colonoscopy and ordered that she be prepared for this procedure with the use of Fleet.

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The deceased had already been given a number of enema treatments, including an oral enema and Shores cocktail, as well as other treatments, all designed to clear the constipation/blockage with virtually no effect.

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The Fleet contributed to the mass in her bowel, thereby distending her abdominal area, thereby putting pressure on her diaphragm which, in turn, was pressing on her lungs, making it difficult for her to breathe, causing respiratory problems and

putting pressure on her already weak heart, which eventually gave out.

There is little argument on the evidence that, in broad terms, this was the cause of death. However, there are a number of issues which have been canvassed, particularly by the counsel for the family, about the way the deceased was treated, in both senses of that word, in hospital.

These include the competence of Dr Gujral, the attitude of the nursing staff, in particular, Nurse Maguire, the use of Fleet in the circumstances that existed here, the failure to properly read the X-rays on the morning of the 23rd of November 2004, the failure to obtain further blood tests and to treat accordingly, the failure to take regular observations, leading to distress and discomfort for the deceased, particularly in the use of oxygen, and the failure to observe a deterioration in the state of health of the deceased as the afternoon wore into the evening, something that was all too obvious to Dr Vermeulen when he arrived at 7 p.m.

On the evidence, it seems to me that the family of the deceased have every right to ask these questions. It is clear that the Department has taken them seriously and they have largely been addressed in a fulsome and timely manner. To put it in context, I consider that the events outlined above took place because, as the position then stood, the Roma hospital

and surrounding area was totally reliant on an overworked and fully stretched flying surgeon.

Dr Tomlinson, realising that there was a prospect that surgical intervention may be needed, contacted Dr Bennett. From that point on, the deceased was Dr Bennett's patient. Dr Gujral was not experienced enough, by his own admission, to properly assess her and to advise Dr Bennett that the course of action proposed was not going to be in the best interests of the deceased.

The nursing staff were aware that Dr Bennett was appraised of the situation and would be in later, as it were, to make things right. In a busy hospital, nurses are under a lot of strain and generally, due to the nature of their work, under substantial stress.

It is sometimes easy to misinterpret this pressure as arrogance or a lack of commitment or professionalism, particularly for distressed relatives. These relatives were rightly distressed. Their mother, who hitherto had been lively - indeed, Dr Feint described her as "a lovely, alert, vibrant lady with a quite really minimal past" - was failing in health as the day progressed, with no apparent medical intervention.

Dr Gujral was largely reliant on Dr Bennett who was attending to other things a long way away. If a more senior doctor had been present, a decision could have been made earlier to

transport the deceased to Toowoomba or, indeed, if another surgeon had been present, as will be the case in the future, surgery could have been undertaken earlier in the day.

Dr Bennett was, of course, a very senior surgeon and he had the best interests of the patient in his mind, but it is impossible for him to be everywhere at once or to know all things.

In so far as the use of Fleet is concerned, again, if a more senior doctor had been present, a decision could have been made, subject to looking at the X-rays, assessing them correctly and looking at other signs, including blood. The Fleet was not the correct procedure in this case and the treatment plan could have been altered. Dr Bennett could not do this from his plane.

It should be said that it is by no means certain that the outcome would have been any different. What would have been different is that family would have felt that their loved one had been given the best care and attention.

This is, in my view, the most important thing to come out of this inquest. There is simply no such thing as a half-baked medical system, particularly for the bush. It is trite to say that hospitals need to be adequately staffed and sufficient medical staff needed to be on hand to properly deal with patients as necessary.

In the end analysis, there is no one person at fault. There were clearly systemic problems. As I have said, these have been addressed and changes implemented for the betterment of the system as a whole.

I make the following findings:

a) The identity of the deceased was Margaret Isabel Horsington.

b) Her date of birth was the 28th of April 1921.

c) Her last known address was 93 Mary Street, Mitchell, Queensland, and at that time she was a pensioner.

d) The date of death was the 23rd of November 2004 and she died at the Roma Hospital, Roma.

e) The formal cause of death was cardiac arrest from assumic heart disease, due to or as a consequence of severe triple vessel coronary arthrosclerosis. Other significant conditions were large bowel obstruction from carcinoma of the rectum, assumic bowel disease, due to the carcinoma, emphysema and compression of lungs from raised diaphragm, from gut obstruction, producing respiratory inefficiency.

I make no recommendations or comments pursuant to section 46 of the Act.

My condolences go the family of the deceased. It is always a tragedy to lose a mother and I feel for them. I thank the police officer appearing and assisting in the inquest and the excellent representation given by the other legal practitioners for the parties.

The inquest is now closed. I publish my reasons.

RUTH GOBBERT APPOINTED AS RECORDER