QUEENSLAND COURTS

OFFICE OF THE STATE CORONER

FINDINGS OF INQUEST

CITATION:	**Inquest into the death of Nerida Ann Parry**
TITLE OF COURT:	Coroner's Court
JURISDICTION:	Toowoomba
FILE NO(s):	COR 2011/465
DELIVERED ON:	6 September 2012
DELIVERED AT:	Brisbane
HEARING DATE(s):	14, 15 and 16 May 2012, 25 June 2012
FINDINGS OF:	O Rinaudo, Coroner
CATCHWORDS:	Laparoscopic cholecystectomy surgery, medical record keeping, contact with on-call Doctors, Hospital communication
REPRESENTATION:	
Counsel Assisting:	Mr Minnery of Counsel
For Nurses Wann & Davies:	Mr G Rebetzke of Counsel, instructed by Roberts and Kane Solicitors
For St Andrews Hospital:	Ms JE Farr of Counsel, instructed by Minter Ellison Lawyers
For Dr Antoun:	Ms M Zerner of Counsel instructed by Moray and Agnew Solicitors
For Dr Egerton	Ms Rosengren of Counsel instructed by Avant Law

This is the inquest into the death and circumstances of death of Nerida Ann Parry.

1. I must deliver my findings pursuant to the provisions of the *Coroners Act 2003*. I do so, reserving the right to revise these reasons should the need arise.

2. The purpose of this inquest, as of any inquest, is to establish, as far as practicable:-

    - Whether or not a death happened;
    - The identity of the deceased person;
    - How the person died;
    - When the person died;
    - Where the person died; and
    - What caused the person to die. [Section 45 (1) and (2)]

3. It should be kept firmly in mind that an inquest is a fact finding exercise and not a method of apportioning guilt. A Coroner must not include in the findings any statement that a person is, or may be guilty of an offence or civilly liable for something. [Section 45(5)]

4. The procedure and rules of evidence suitable for a criminal trial are not suitable for an inquest. The Coroners Court is not bound by the rules of evidence and may inform itself in any way it considers appropriate. [Section 37]

5. In an inquest there are no parties; there is no charge; there is no prosecution; there is no defence; there is no trial. An inquest is simply an attempt to establish facts. It is an inquisitorial process, a process of investigation. These observations were confirmed by Justice Toohey in *Annetts v McCann* (1991) 65 ALJR 167 at 175.

6. A Coroner's inquest is an investigation by inquisition. It is not inclusive of adversary litigation. Nevertheless, the rules of natural justice and procedural fairness are applicable. Application of these rules will depend on the particular circumstances of the case in question.

7. A Coroner may, whenever appropriate, comment on anything connected with the death that relates to:-

    a) Public health or safety; or
    b) The administration of justice; or
    c) Ways to prevent deaths from happening in similar circumstances in the future. [Section 46 (1)]

8. If, from information obtained while investigating a death, a coroner reasonably suspects a person has committed an offence, the coroner must give the information to:-

    a) for an indictable offence – the Director of Public Prosecutions; or

b) for any other offence – the chief executive of the department in which the legislation creating the offence is administered.

9. A Coroner may give information about a person's conduct in a profession or trade, obtained while investigating a death, to a disciplinary body for the person's profession or trade if the coroner reasonably believes the information might cause the body to inquire into, or take steps in relation to, the conduct, [Section 48].

10. All proceedings before this Court are sad proceedings. At this stage I express my sympathy and condolences, and that of the court, to the family of the deceased for their sad loss, in the tragic death of Nerida Ann Parry.

Introduction

11. Ms Nerida Ann Parry was sixty three years old at the time of her death at the St Andrews Hospital in Toowoomba in the early hours of the morning on 6 February 2011. Ms Parry was recovering from surgery. Dr Michael Egerton had performed a laparoscopic cholecystectomy (removal of her gall bladder), on 4 February 2011.

12. A pre-inquest conference was held in Brisbane on 27 February 2012, and the inquest proceeded over the course of four days of evidence – 14, 15 and 16 May 2012 in Toowoomba, and 25 June 2012 in Brisbane.

13. The inquest was convened to examine, the matters required by section 45(2) *Coroners Act 2003*, and the quality of the medical care provided to the deceased, including whether any deficiencies in that care contributed to her death.

Findings section 45(2)

14. Pursuant to section 45(2) *Coroners Act 2003*, I make the following formal findings:

a) the deceased was Ms Nerida Ann Parry; and

b) Ms Parry died at St Andrews Hospital, in Toowoomba, in Queensland; and

c) Ms Parry died at approximately 4:35am on Sunday 6 February 2011; and

d) Ms Parry died from bile peritonitis, as a complication from a laparoscopic cholecystectomy.

Other matters arising during the course of the evidence

15. Evidence was given by a number of witnesses about the surgery and various matters relevant to the circumstances surrounding the death. I do not propose to summaries all of the evidence but will refer to a number of persons in the context of their role in the event leading up to the death, and the evidence will be considered in that context.

16. I am grateful for the written submissions provided by Counsel assisting and much of the summary of evidence in each instance is taken from that submission. I am also grateful for the written submissions of Counsel for each of the parties. I will refer to those parts of them which are relevant to each of the persons or entities referred to.

17. In broad terms the Inquest raised a number of issues for consideration and I intend to address each in turn. These are, the role of Dr Michael Edgerton, the surgeon who performed the Laparoscopic cholecystectomy, The role of Dr Iman Antoun the on call surgeon, nurses RN Jamie Wann and RN Avril Davies, Dr Geytenbeek an anaesthesiologist who was consulted to insert a cannula, and the role of the hospital including consideration of its reporting and recording processes. Each of these main persons were represented at the Inquest. Some others, who will be referred to, were involved to varying degrees, of a lesser nature.

18. Expert evidence was given by Dr Gary Hall and Dr Michael O'Rourke and Dr David Gotley

Dr Michael Edgerton

19. Dr Michael Edgerton is an experienced specialist general surgeon. He performed the surgery on Ms Parry after referral by Dr Richard Grundy, (general practicioner). The surgery was designed to assist with the treatment and management of Ms Parry's cholecystitis. There was nothing in Ms Parry's prior medical history of concern.

20. Ms Parry was reviewed by Dr Edgerton on 31 January 2011. A recent ultrasound performed on Ms Parry gave Dr Edgerton assistance in deciding the best surgical option was laparoscopic cholecystectomy. This surgery and the risks involved was explained to Ms Parry with some written information provided as well, and Ms Parry signed a consent form in relation to the surgery[1].

21. Ms Parry was admitted to hospital on 3 February 2011, and the surgery was performed on that day by Dr Edgerton. Dr Edgerton in his statement[2] described the surgery as difficult, in that Ms Parry had quite significant gall bladder disease and there were a lot of adhesions between the abdominal wall and the omentum. There were also significant adhesions stuck to the wall of the gall bladder, making it difficult to remove the gall bladder, and separation of the gall bladder

[1] Exhibit C2 in the proceedings, page thirty-seven to thirty-nine
[2] Exhibit B5 in the proceedings, at paragraph six

from the duodenum was also difficult.

22. Notwithstanding the difficulties Dr Edgerton successfully completed the surgery. As stated Dr Edgerton was very experienced in this type of surgery and he did not identify any injuries or problems in the surgery. Importantly[3] there was no bleeding or leakage at the time of the surgery being completed, so a drain was not inserted as it was thought unnecessary.

23. The death was as a result of a known surgical complication of the laparoscopic cholecystectomy surgery. The complication is considered rare, on the literature and on the evidence of Dr O'Rourke and Dr Gotley. It is reportedly difficult to detect and difficult to diagnose.

24. Dr Edgerton reviewed Ms Parry on Friday 4 February 2011. At this point Ms Parry reported she did not feel comfortable enough to go home, although had observations were within expected limits and she reported pain scale of 0[4].

25. Dr Edgerton had no involvement in Ms Parry's care after handover to Dr Antoun (see below), and was saddened to hear of her death.

26. Dr Edgerton's role in this death does not require any further consideration.

Dr Antoun and the nurses Wann and Davies

27. As he was to be away over the weekend, Dr Edgerton left the care of Ms Parry, to a colleague Dr Iman Antoun. Dr Antoun became responsible for the care of Ms Parry from the point of the handover at approximately 5pm Friday 4 February 2011[5]. The handover itself was unremarkable[6]. Ms Parry remained in hospital under observation

28. Dr Edgerton had confidence that Dr Antoun would care for Ms Parry carefully and competently[7].

29. For purely social reasons Dr Antoun decided to keep Ms Parry in hospital for a further day.[8] As Ms Parry lived alone, she felt unready to return home when examined by Dr Antoun on Saturday morning 5 February 2011.

30. Nurses employed at the St Andrews Hospital took care of Ms Parry. RN Beth Richie was the team leader of the nursing shift from approximately 7am to 3:30pm 5 February 2011.

[3] Exhibit B5 in the proceedings, at paragraph seven
[4] Exhibit B5 in the proceedings, at paragraph eight
[5] Second statement of Dr Antoun, exhibit B2.1 in the proceedings, paragraph six
[6] Refer transcript day one of inquest, page 13, line 52 to page 14, line 23
[7] Exhibit B5 in the proceedings, at paragraph eight
[8] Refer transcript, day one of the inquest, page 104 line 47 to page 105, line 38

31. RN Karen Le Gay Brereton was the team leader of the nursing shift from approximately 2:30pm to 11:00pm 5 February 2011, and RN Jamie Wann was the nurse with the care of Ms Parry during this shift.

32. In his review of this matter, Dr Gary Hall notes there was reason to be concerned about Ms Parry's condition commencing at approximately 10am 5 February 2011. This is because[9] she had an elevated heart rate (120 to 135 bpm) from approximately 10am 5 February 2011 until when she passed away. She had a low blood pressure on three occasions between 10am, 5 February 2011 and when she passed away. She was noted to be tachycardic during this period.

33. Ms Ava Emery visited Ms Parry[10] at approximately 11:30am 5 February 2011. Ms Parry reported to Ms Emery an amount of pain as well. Ms Rebekah Kenos visited Ms Parry[11] at about 12 noon 5 February 2011. Ms Parry reported to Ms Kenos significant pain earlier that day, and Ms Parry was reportedly extremely clammy and had difficulty mobilising.

34. It does not appear that any action was taken by the morning shift nurses about the deterioration of Ms Parry's condition.

35. By approximately 7pm that evening RN Wann became concerned enough about Ms Parry's condition to call Dr Antoun, who was at home.

36. There is competing evidence about the contents of this phone call. Essentially, there are two versions of how this phone call went.

37. RN Wann recalls "*I told her the specific observations I had available to me, specifically, the blood pressure, pulse and respirations. I also told her that I had performed an ECG which showed sinus tachycardia which had been reviewed by ICU staff who confirmed it showed sinus tachycardia. I told her the patient was a bit clammy*."

38. This version is corroborated by the note RN Wann made at the bottom of the clinical pathway[12]. It is also corroborated by RN Brereton who recalls that, during the phone call, RN Wann told Dr Antoun the specific observations of Ms Parry[13].

39. Dr Antoun disagrees and says in her evidence that she was not told the specific observations by RN Wann[14].

40. It was accepted evidence that Dr Antoun ordered IV fluid, monitoring overnight, and continue with pain medication as already prescribed.

[9] Exhibit C3, page two, first full paragraph
[10] Exhibit D2 in the proceedings
[11] Exhibit D1 in the proceedings
[12] Exhibit C2 in the proceedings, page 58.
[13] Exhibit B12 in the proceedings, paragraph 24 to 27.
[14] Exhibit B2.1 in the proceedings, at paragraph 17

41. For the following reasons, I prefer the evidence of RN Wann that Dr Antoun was given the specific observations by RN Wann during the phone call. I reject the evidence of Dr Antoun on this point.

(a) Dr Antoun's recollection is uncorroborated. RN Wann's evidence is corroborated by RN Brereton;

(b) RN Wann's recollection is confirmed in a note written by him at the time of the call or shortly thereafter. Dr Antoun has no such note; and

(c) RN Wann's recollection is consistent with nursing practice – being concerned about the condition of the patient means the nurse contacts the on-call doctor and provides the observations and other information. Dr Antoun's recollection is inconsistent with good practice – she confirmed in her evidence that giving the amount of fluid she ordered without knowing specifics of the vital signs of the patient would be unsafe[15].

(d) RN Wann and RN Brereton appeared to me to be witnesses of credit and their answers were forthright and credible. Dr Antoun's evidence lacked credibility. Some of her answers were inconsistent and evasive.

42. Ms Parry's condition did not improve as a result of the treatment prescribed by Dr Antoun in the phone call. It is not surprising that nurses persisted with the treatment ordered by Dr Antoun. They had every right to rely on the orders of the Doctor in charge. From about 10.45pm Ms Parry was cared for by RN Avril Davies and EEN David McLeod.

43. Regular observations of Ms Parry continued. A spontaneous resolution of her pain and some improvement in her observations were reported, however her fluid intake and output remained of concern. Consideration was given to calling Dr Antoun again however at about 4am Ms Parry was found unresponsive and a MET call was made. All efforts to resuscitate Ms Parry were unsuccessful. I am satisfied that the conduct of EEN McLeod, RN Davies and the MET response were all appropriate.

44. Ms Parry passed away at approximately 4:30am Sunday 6 February 2011.

45. Dr Antoun agreed that had she been told the observations of Ms Parry, the treatment she ordered would have been entirely inappropriate[16]. The evidence of Dr O'Rourke did not go as far as this.

46. Counsel for Dr Antoun submitted in paragraph 104 and following, of her written submission that;

[15] See the transcript of day three of the inquest, at page seventeen.
[16] Transcript of day one of the inquest, page 111, line 54 onwards

"*It is submitted that whilst there may have been a number of failings with respect to clinical judgement, documentation and patient assessment by a number of health practitioners (i.e. both nursing staff and doctors) involved in the case of Miss Parry, no one health professional can ne singled out for misconduct (unprofessional or professional misconduct in accordance with the HP&RNL Act) in regards to the events leading up to Miss Parry's death. Considering all of the circumstances of this case, Miss Parry's clinical deterioration was not identified due to a number of system issues and clinical misjudgement, not misconduct. Further, in evaluating whether to refer any health practitioner in this case, the circumstances surrounding the health practitioner's conduct must be viewed in the context (i.e. within the framework of a treating team). It would be inappropriate to consider a health practitioner's conduct in isolation. Specifically in relation to Dr Antoun, it is not clear exactly what information or observations were conveyed to her by RN Wann in the telephone conversation at around 1900hrs however we know for certain Miss Parry's earlier observations and other symptoms from 1000hrs onward (as identified in paragraph 51 herein) were not communicated to her. In this regard, all the experts agree that a different clinical picture presents if this further information had been communicated (see paragraph 52 herein). Dr Antoun is genuine in her belief that she was not informed of Miss Parry's tachycardia based on the clinical interventions she ordered. Additionally, this is not a case where there is any deficiency of knowledge or skill on the part of Dr Antoun. She is clear in her evidence that had certain information been communicated to her (in particular Miss Parry's pulse rate) she would have acted differently.*

47. In those circumstances it was submitted that I would not refer any person under section 48 of the Act.

48. Whilst I accept the force of this argument, having made findings that Dr Antoun was given full observations; it seems to me in that context that she did not fulfil her professional obligations in this case.

49. In all the circumstances I consider there is sufficient evidence to refer Dr Antoun's conduct to the Australian Health Practitioner Regulation Agency for investigation into her professional conduct, pursuant to section 49 (4) *Coroners Act 2003*.

Dr Geytenbeek

50. As part of the treatment ordered by Dr Antoun a cannula was required to administer the intravenous fluids. Dr Geytenbeek was consulted to assist in placing the cannula.

51. It was suggested that because Dr Geytenbeek attended upon Ms Parry at a time when she was still unwell, and that he had the opportunity to review the ECG showing tachycardia, he ought to have assessed Ms Parry's condition. It is suggested that if he had, then he may have

ordered some other treatment which might have been life saving.

52. I reject this contention. I am fortified in this view by the evidence of the experts Dr O'Rourke and Dr Gotley. It seems clear it was not the role of Dr Geytenbeek to undertake such an assessment when inserting the canula (or, in this case, two cannulas). I accept his evidence that he did not assess Ms Parry[17] except in the most limited conversational or observational sense[18], nor did he review the chart[19], and he did not see anything about her which caused him to intercede – had there been anything like that, to make him concerned, he would have acted[20].

53. I make no unfavourable comment about discrepancies between what was said to Dr Geytenbeek by nurses in the nurses' recollection, and in Dr Geytenbeek's recollection. I am satisfied, having regard to the *Briginshaw* test, that there is insufficient evidence to establish whether Dr Geytenbeek was told about Ms Parry's observations which he ought to have acted upon, out of concern for her condition.

THE HOSPITAL

54. It is not unreasonable to say that the entries on the observation charts made it extremely difficult to extract exactly what observations were taken of Ms Parry at key times, particularly on 5 February 2011. The observations chart (exhibit C2, page 60) was quite frankly a mess and not conducive to good patient management, particularly in hindsight. It was most difficult to reconcile times written at the top with observations, since there are observations which do no correspond with a time, and there are times for which there do not appear to be full observations. The form appeared to be extremely inefficient. It is noted that the form has been revamped, and hopefully will be much more efficient and effective.

55. The hospital conducted a review of this serious event. After determining that deficiencies existed in the recording of observations, changes were made. The review took the form of a Critical Systems Analysis. The statement of Ms Fiona Brown details the process of review.

56. The Critical Systems Analysis determined some matters relating to documentation and training which could be improved. I am satisfied the review was thorough and detailed and succeeded in identifying issues for improvement particularly about, nursing conduct, documentation and training. I am satisfied the response to the matters identified in the analysis have been appropriate.

[17] Transcript of day two of the inquest, page 25
[18] Transcript of day two of the inquest, page 30, line 5, and page 31, line 27
[19] Transcript of day two of the inquest, page 25
[20] Transcript of day two of the inquest, at page 26, line 5

57. However, the hospital was lacking when it came to a willingness to review actions of doctors, particularly Dr Antoun. The reason for this appears to be that the hospital does not employ doctors. As a result it appears there has been a lack of surgical audit of Ms Parry's death, which might have been of assistance.

58. I am concerned about this apparent deficiency. The hospital must have some review process for those doctors who operate within the hospital.

59. RN Wann gave evidence that the hospital's policy was that nurses were not to write in progress notes – this was for doctors. Ms Brown and others did not agree with this. However what cannot be disputed is that the quality of documentation in this case was almost universally considered to be poor. Ms Brown reported on the steps the hospital has taken to rectify this. I am satisfied the hospital has fully understood the issues relating to documentation and has made a genuine effort to rectify the position.

60. One of the key issues in this death was the apparent deficiency in the process for escalation of what appeared to be deterioration of Ms Parry's condition to a doctor. Was this because the doctor was only on call and not at the hospital? Nurses need to be able to escalate concerns to doctors. In this instance nurses did contact the doctor which as it turned out was of little help.

61. Ms Brown outlined steps taken to improve the process of escalation of concerning signs or observations in a patient.

62. I accept that the steps taken by the hospital, as outlined by Ms Brown, about improvement in documentation, and improvement in escalation of concerning signs or observations, are sufficient and appropriate.

63. I am mindful of the rarity of the surgical complication, which occurred in this instance. I am satisfied that looking out for this particular complication is routine in aftercare, and accordingly no further recommendations are necessary as to education or training of surgical staff.

RECOMMENDATION

Pursuant to section 49 (4) *Coroners Act 2003*, I refer the conduct of Dr Iman Antoun in this matter to the Australian Health Practitioner Regulation Agency, for their consideration.

I close the inquest.

Ray Rinaudo
Coroner
BRISBANE
06 September 2012