OFFICE OF THE STATE CORONER

FINDINGS OF INQUEST

CITATION:	**Inquest into the death of James Errol TRANBY**
TITLE OF COURT:	Coroner's Court
JURISDICTION:	Townsville
FILE NO(s):	COR 8336/08(3)
DELIVERED ON:	09 June 2011
DELIVERED AT:	Townsville
HEARING DATE(s):	6 August 2010, 6 - 8 June 2011
FINDINGS OF:	Mr Michael Barnes, State Coroner
CATCHWORDS:	CORONERS: Death in custody, Necrotising Fasciites

REPRESENTATION:

Counsel Assisting:	Ms Julie Sharp
Next of Kin:	Mr Greg Lynham (instructed by Hinds Lawyers)
Queensland Health:	Ms Stephanie Gallagher (instructed by Cooper Grace Ward Layers)

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The *Coroners Act 2003* provides in s47 that when an inquest is held into a death in custody, the coroner's written findings must be given to the family of the person who died, each of the persons or organisations granted leave to appear at the inquest and to various officials with responsibility for the justice system. These are my findings in relation to the death of James Errol Tranby. They will be distributed in accordance with the requirements of the Act and posted on the web site of the Office of the State Coroner.

Introduction

James Tranby was a 64 year old Indigenous prisoner when he was admitted to the Townsville Hospital (TH) on 3 December 2008 for treatment of a fish bone which had become lodged in his anal canal.

On 5 December, the fish bone was surgically removed and later that day he was returned to the Townsville Correctional Centre (TCC).

The next day he was brought back to the hospital for further treatment but was not admitted. He was sent back to the correctional centre with instructions about how his condition should be managed.

Mr Tranby did not prosper and on 8 December was again admitted to the Townsville Hospital where he remained until his death on 17 December. During that period he underwent surgery on 10, 12, 13, 14, 15 and 16 December 2008. All treatment proved futile.

These findings:-

- Confirm the identity of the deceased person, how he died, the date, place and medical cause of his death;

- Consider whether the infection which led to Mr Tranby's death might have been prevented by earlier or other treatment;

- Consider whether the treatment provided at the Townsville Correctional Centre and the Townsville Hospital was adequate; and

- Consider whether any changes are needed to the Queensland Corrective Services Policy relating to the notification of next of kin when a prisoner is hospitalised.

The investigation

Officers from Stuart Police Station were advised of the death and attended the hospital soon after it occurred. Mr Tranby was identified to police by his wife, Patricia Tranby.

Statements were obtained from doctors who had been involved in the care of Mr Tranby at the Townsville Hospital and from the Nurse Unit Manager at the Townsville Correctional Centre.

An autopsy was undertaken by Professor David Williams on 19 December 2008.

The matter was then referred to the Office of the State Coroner and an independent clinical review was commissioned.

The police investigation was adequate to negate any suspicions about the death in so far as it excluded foul play or the involvement of a third party. It did not attempt to critique the quality of health care provided to the deceased which was the primary focus of this inquest.

The Inquest

A pre-inquest conference was held in Brisbane on 6 August 2010. Ms Sharp was appointed as counsel to assist me with the inquest. Leave to appear was granted to Mr Tranby's family, Queensland Health, the Department of Community Safety, the operator of the TCC. Submissions were made as to the issues to be investigated and the witnesses to be called.

The Department notified its intention to withdraw from the proceedings once it was determined the issues for investigation would focus on the medical care provided by practitioners at the TH.

During the course of the inquest, all of the statements and other relevant material were tendered and oral evidence was heard from 10 witnesses.

The evidence

I turn now to the evidence. Of course, I cannot even summarise all of the information contained in the exhibits but I consider it appropriate to record in these reasons, the evidence I believe is necessary to understand the findings I have made.

Social history

Mr Tranby was born on 22 April 1944. He met his wife, Patricia, when they were 13 or 14 year old school students on Palm Island. They were friends for a few years and in 2006, met again and were married.

She described Mr Tranby as a good husband who helped her with cooking and cleaning. They were a happy couple who went everywhere together.

Mr Tranby travelled around Australia quite a bit during his adult life. He worked on cane fields in Gordonvale. He had eight children from a previous relationship. One of those children, James, described his father as generally being in good health and very happy.

Mr Tranby's unexpected death has been a terrible blow for Mr Tranby's family and I offer them my sincere condolences.

Custody

Mr Tranby had a relatively lengthy criminal history dating back to 1963 but prior to his imprisonment in 2008 he had not been before the courts since 1999.

On 3 December 2008 Mr Tranby was sentenced to two years imprisonment after pleading guilty to a charge of trafficking marihuana.

Background to fatal incident

After being sentenced on 3 December Mr Tranby was moved to the TCC at approximately 3:30pm that day.

He was seen by a nurse, Angela Greenwood who took a social and medical history from him as part of the usual prison reception process.

With some prompting, Mr Tranby advised her he was diabetic and took insulin twice a day. He brought some insulin with him but had not been able to inject any that day because he was in court. She also deduced from the medications he had with him that Mr Tranby suffered from heart disease. He confirmed this.

As a result of his blood sugar level being elevated it was decided Mr Tranby would be accommodated in the prison medical centre overnight so his blood sugar levels could be monitored.

At about 5:30pm a corrective services officer approached Nurse Greenwood and advised her Mr Tranby was in a lot of pain. She therefore went to the medical cell to examine him.

She found Mr Tranby standing up with his knees bent and his body hunched forward. She says he was guarding his lower abdominal region with his hand. She asked him what was wrong and he replied "*I have a fishbone up my arse*". On querying this he assured her he had felt it with his finger and t it was consistent with him having eaten fish for dinner the previous evening.

Nurse Greenwood sought advice from the nurse unit manager and another colleague who both advised Mr Tranby should be sent to hospital.

An ambulance was summoned and after a short delay that was of no consequence, Mr Tranby was taken to the TH.

First admission to TH

Hospital records show Mr Tranby was seen in the TH emergency department (ED) at around 7:00pm. A medical transfer form accompanied Mr Tranby to the hospital and so the admitting doctor was aware of his complaint, his underlying medical conditions and the medications he had been prescribed.

The doctor who saw him ordered x-rays of his abdomen and examined his rectum. Shortly before 2:00am, in response to a request from the ED staff,

first year surgical registrar, Dr Christian Connors, went to the ED to examine Mr Tranby.

Dr Connors obtained a history from Mr Tranby consistent with that outlined above. He conducted a rectal examination and felt a foreign object lodged transversely across Mr Tranby's sphincter approximately one to one and a half centimetres inside Mr Tranby's anus. He found that Mr Tranby was tender if the object was moved.

Dr Connors also reviewed the x-rays that had been ordered by the ED staff but saw no foreign body on the film. There were no other obstructions or free gas visible. Dr Connors reviewed the blood test results that had been taken in the ED. He noted the white cell count was only mildly increased at 11.

He formed the view that the obstruction should be surgically removed the following day and assessed the need for the operation to be within category B, meaning it should be undertaken within twenty-four hours. He explained he did not consider Mr Tranby's situation warranted him being taken to theatre immediately because he was haemodynamically stable and appeared comfortable. Further, he was not displaying any signs of peritonitis or sepsis.

Later that morning, at approximately 7:30am Mr Tranby was reviewed by another surgical registrar, Dr McCallum, as part of ward rounds. With him was an intern Dr O'Connor.

His examination of Mr Tranby noted nothing significantly different from what had been observed by Dr Connors earlier in the morning. He was aware of the procedure planned for Mr Tranby, namely an examination under anaesthetic for the removal of the foreign body and wrote "+ *or* - *colostomy*" in the notes of his review. Dr McCallum recognised that Mr Tranby's history of diabetes was relevant in that it could make him more susceptible to the risk of an infection, however Mr Tranby appeared comfortable despite having some lower abdominal pain. He denied any nausea or vomiting. He reported that his bowels had not been opened that day but he was passing wind. This, together with the absence of any tenderness of the abdomen when palpated, indicated to Dr McCallum there was no significant bowel obstruction or inflammation sufficient to cause poor bowel function.

It is unclear whether Dr McCallum or Dr Connors caused Mr Tranby's operation to be put on the fast track board, but in any event this occurred. That was a mechanism used to schedule category B cases for the operating theatre.

Dr McCallum stated that in view of there being a foreign body in Mr Tranby's rectum, he was cognizant it was possible there might have been an injury such as a perforation that would warrant the performing of a colostomy in order to divert faecal matter out of the rectum to allow the injury to heal. For that reason he obtained Mr Tranby's consent to that procedure being undertaken if at the time of the removal of the foreign body that was judged to be necessary.

Dr Connors commenced work again at about 10:00pm on 4 December. At some stage early in his shift he became aware Mr Tranby's operation had not yet been performed. Accordingly, he began to make arrangements to ensure it was undertaken. He discussed the procedure with a consultant surgeon, Dr Cameron, whom he was assisting with another operation. He recalls Dr Cameron instructed him that after removing the foreign object from Mr Tranby's rectum he should carefully examine the rectal mucosa to observe if it had been breached. He was told were he to find evidence of that he should perform a colostomy.

The operation was commenced shortly before 3:00am; it proceeded without complication. After the fishbone of approximately 2cm in length had been removed, Dr Connors inserted an instrument referred to as Parkes retractors to obtain more direct vision of Mr Tranby's rectum which he examined closely. He formed the opinion the mucosa was intact and there were no signs of bleeding. He did not detect any other mass or obstruction.

He provided instructions in the chart for Mr Tranby to be returned to the ward and that he could commence eating and drinking. He indicated in the chart that Mr Tranby could go "*home tomorrow*".

Mr Tranby was again seen by Dr McCallum on his ward round a few hours later. He recorded that Mr Tranby told him the pain was not significant; he was tolerating a normal diet; he had no nausea or vomiting and he had no per-rectal bleeding. He assessed Mr Tranby as being fit for discharge because the foreign object that led to his admission had been removed, the examination performed at the time revealed no evidence of any bowel or anorectal injury and therefore no further treatment was necessary. The discharge was authorised at approximately 9:30am, some five and a half hours after the procedure had been completed.

Second admission to TH

The following day, Mr Tranby was brought by a corrective services officer (CSO) to the TCC medical centre. He had told the CSOs he had not passed urine or faeces since his discharge from hospital and he was complaining of abdominal pain when seated or standing. On examination his abdomen was distended. He was taken by ambulance to the TH.

Mr Tranby was seen in the ED and reported abdominal and rectal pain, as well as the inability to pass urine or faeces. Examination revealed he was "*very tender rectally*." A catheter was inserted and Mr Tranby was sent back to the TCC with advice to staff there to remove the catheter in a few days.

On the following day, 7 December, correctional staff contacted the medical centre and stated Mr Tranby was not well and had severe pain which was causing him problems ambulating. Two nurses went to the unit and spoke to Mr Tranby. He was transported to the medical centre in a wheelchair. One of the nurses telephoned the visiting medical officer, Dr Kuen, and explained the situation to him. It was agreed Mr Tranby would stay over night in the medical

centre and would be seen by the Visiting Medical Officer (VMO) the next morning. The VMO gave a telephone order to enable Mr Tranby to receive analgesia. His indwelling catheter was apparently functioning to some extent as the urine bag was emptied three times during that day.

Dr Kuen saw Mr Tranby on the afternoon of 8 December. He complained of being unable to pass urine and was hypertensive with blood pressure of 79/58 but with a normal heart rate of 83 beats per minute. He had an obese distended abdomen.

Dr Kuen telephoned the emergency department of the TH and spoke with a medical officer there to initiate Mr Tranby's urgent transport to the TH for assessment and treatment.

Third admission to the TH

Mr Tranby was presented to the ED of the TH at about 6:30pm on 8 December. Soon after arrival it was established by a scan that his bladder contained 840ml of urine and so a new catheter was inserted. This apparently initially relieved the pain but it quickly returned. His bowels were opened and his stools were normal.

Shortly after midnight, in the early hours of 9 December, Mr Tranby was seen again by Dr Connors. As a result of considering his symptoms and examining his abdomen, Dr Connors concluded there was no basis to suspect peritonitis. He notes abdomen "*not distended, no masses, no peritonitis, no percussion low abdominal pain*". He also noted a highly raised white blood cell count of 23.5.

Dr Connors said in his statement and in evidence that he does not recall whether he was aware a series of abdominal x-rays had been performed soon after Mr Tranby was brought back to the hospital on the evening of 8 December. Nevertheless, having regard to Mr Tranby's history, the test results of which he was aware and the results of the examination he had undertaken, Dr Connors considered the most likely explanation for Mr Tranby's deterioration was a urinary tract infection which was causing urinary retention and dehydration. Accordingly he arranged for him to be referred to a urologist for review.

The urologist, Dr Borjana Barth says in her statement that she saw Mr Tranby on 10 December but the notes of the circumstances indicate this must have actually occurred on 9 December at about 10:00am. As a result of reviewing his history and examining the patient Dr Barth quickly came to the view that the cause or causes of Mr Tranby's deterioration were not urological in nature. Her notes record her differential diagnoses as 1. ischiorectal/perirectal abscess causing AUR (acute urine re-retention) or 2. intra-abdominal/pelvic abscess. The circumstance which she listed as supporting this possible second diagnosis was that Mr Tranby had a tender lower abdomen and was tender on per-rectal examination, the air fluid levels which she presumably saw in the x-rays and the fact there was a likelihood/possibility of the fish bone having perforated the colon or rectum.

Dr Barth suggested Mr Tranby return to the care of the surgical team and he be resuscitated with IV fluids, have his insulin needs maintained, further blood tests be undertaken and he have CT scans of his abdomen performed. She also prescribed a trio of broad spectrum antibiotics.

Dr Bath contacted Dr McCallum to confirm she was transferring the patient back to Dr Hack's surgical team of which Dr McCallum was a member. It seems later that morning Dr McCallum again examined Mr Tranby and read the notes written by Dr Bath. He formed the impression Mr Tranby had an ischiorectal or perirectal abscess but that there may have also been some intraperitoneal pathology present and that the urinary retention was secondary to those conditions.

Dr McCallum decided to implement the plan suggested by Dr Bath and to review the CT scan and blood test results before assessing whether a laparotomy was necessary.

Dr McCallum says on reviewing Mr Tranby's chart and noting he had been prescribed tramadol, paracetamol and morphine in the proceeding twelve hours it was apparent he was suffering considerable pain which reinforced the differential diagnosis of an ischiorectal abscess. However he says he does not recall if he reviewed the x-rays that had been ordered in the evening of 8 December.

Dr McCallum says he does not recall if he discussed the proposed operative procedure with Dr Hack who would need to approve it and indeed Dr Hack has a similar lack of recall.[1]

The CT scan ordered by Dr Barth was performed at approximately 1:00pm on 9 December and Dr McCallum believes he would have reviewed it as soon as it was available immediately after it had been undertaken. He also expects he would have discussed the CT scan imaging with Dr Hack and the staff in the radiology department to obtain a verbal report on what the imaging revealed and what course of action might be required. He says that as the CT scan did not demonstrate any injury within Mr Tranby's gut or a collection there was no clear indication for surgery at that time. He therefore considered the appropriate management of the patient was to continue the course of antibiotics for the treatment of the inflammation he could interpret from the CT scan.

[1] As is unfortunately commonly the case with the coronial investigation of hospital deaths, members of the treating team declined to be interviewed by the investigating officer, electing instead to provide statements prepared with the assistance of lawyers retained by the department. This practice certainly results in more detailed information being provided to the court than is likely to be the case if the medical witnesses were interviewed by a detective but it also results in significant delay and the loss of an opportunity to record the witnesses' version while the events are fresh in their memories. For example, Dr McCallum's statement is dated 26 May 2011. As one firm usually acts for all or most of the medical practitioners and allied health professionals involved and as those lawyers are retained by QHealth, a suspicion may arise that subconsciously or otherwise, pressure is brought to bear on witnesses to give a consistent account.

Mr Tranby was further reviewed by another surgical registrar, Dr Justin Perron, at about 4:30pm on 9 December. He found Mr Tranby slightly distressed, febrile and tachycardic with a tender abdomen and perianal area. However he said in his statement he found no evidence of peritonitis, either as a result of his examination or from looking at the x-rays and CT images.

Work up for first operation

Mr Tranby had a restless night and the nurses obtained an order for further analgesia. When seen by a surgical intern on call overnight he was complaining of abdominal pain and distension. Mr Tranby apparently told that doctor the pain had increased since the afternoon; he had not opened his bowels that day; but he had no nausea or vomiting. He had healthy blood pressure of 110/70 a heart rate of 95 and normal body temperature.

The next morning Mr Tranby was reviewed by the surgical team Dr Hack, Dr McCallum and the intern Dr O'Connor. Dr McCallum said there were a number of clear changes in Mr Tranby's presentation from when he had been reviewed the previous day. These included that he was now anorexic and there was obvious distension of his abdomen on examination.

Following discussion with Dr Hack it was agreed to take Mr Tranby to theatre for a laparoscopy to look at his bowel given the findings of the CT scan were non-specific. The team explained to Mr Tranby that depending on what they found during the laparoscopy it might be necessary to proceed to a laparotomy in order to drain an abscess if one was found. That could also require them to undertake a colostomy. The treating team said Mr Tranby understood this and consented to it.

First operation

The records indicate the laparoscopy commenced at 2:23pm and was completed at 2:34pm. As a result of the large amount of fluid encountered in Mr Tranby's peritoneal cavity which obscured the vision on the laparoscopy that procedure was converted to a laparotomy that then proceeded over nearly two hours.

The evidence of what was encountered in this operation is conflicting. In an operation note made on the day of the procedure Dr Hack recorded that he found a small amount of turbid free fluid and noted a swollen appendix secondary to intra-peritoneal infection and mild peritonitis in the lower abdomen. He also noted lateral oedema in the right iliac fossa, fluid and some pus he considered might be necrotic fat. Accordingly, a sample was gathered for sending to pathology for the growth of cultures. Dr Hack noted he found oedema but no induration (the hardening of tissue due to the accumulation of pus etc) in the mid sacral retro-peritoneal space. He noted that he inspected the rectal mucosa which felt normal. He also opened the ischiorectal fossa wherein he found pus and necrotic fat. He did not find a primary abscess or source of the infection. The note records his plan to be: "*antibiotic support for the next forty eight hours: query further imaging: close abdomen forty eight hours. Await abscess formation*".

In his statement signed on 10 August 2009, Dr Hack said that during the procedure it became apparent "*there was some changes of low grade peritonitis within the abdomen and retro peritoneal oedema but an obvious source of it was not found*". Dr Hack says that an examination of the buttocks showed some local inflammation which was incised and some local dead fat and pus was also removed. He says Mr Tranby was sent to the intensive care unit with the abdominal wall unclosed to allow for further exploration.

These accounts are consistent with the statement of the assisting registrar, Dr McCallum who records that Mr Tranby was found to have an ileus (a non mechanical intestinal obstruction) but there was no evidence of any peritoneal injury and no evidence Mr Tranby was suffering from necrotising fasciitis.

On the other hand, when he gave evidence, Dr Hack said that during the first operation he identified that Mr Tranby had necrotising fasciitis and it had progressed up the retro-peritoneal space to the level of the ribs. He says from that first operation he did not expect Mr Tranby to survive. It was, he said, by that stage probably inoperable because the only option was the removal of all the affected organs which would be grossly disfiguring and unlikely to have been survivable.

Dr Hack's claim that he diagnosed Mr Tranby to be suffering necrotising fasciitis during the first operation is inconsistent with the notes he made at the time, inconsistent with his statement and inconsistent with the evidence of Dr McCallum. It is also inconsistent with his plan to "*await abscess formation*".

I am therefore inclined to the view that Dr Hack is in error: that as a result of the passage of time he has mistakenly concluded he knew on 10 December information he actually learned two days later.

Post operative care

Dr McCallum reviewed Mr Tranby in the ICU on the day following the first operation. He was stable but still septic and requiring cardiovascular support. Dr McCallum also noted there were changes in Mr Tranby's lung function that were consistent with an acute lung injury caused by sepsis. He had been commenced on Vasopressin to increase his blood pressure but the source or focus of the infection had not been controlled or removed at that time. As a result of his review Dr McCallum queried whether Mr Tranby should be taken back to theatre that afternoon. There is no explanation as to why this did not take place.

Sadly, Mr Tranby's wife, Patricia Tranby, did not learn her husband was in hospital until this stage. He was by then of course intubated and incommunicado. I will return to how this happened and how it might be prevented from recurring later in this report.

On 12 December Dr McCallum again reviewed Mr Tranby. His vital signs were slightly improved and he was off the inotropic medication. There had also been an improvement in the extent of this sepsis and it was planned to

take him back to theatre that day to enable Dr Hack to perform a wash out of Mr Tranby's abdomen and if appropriate a closure of the surgical wound.

Second and subsequent operations

When Mr Tranby was taken back to the operating theatre, purulent peritonitis was noticed, as was necrosis of the peritoneum. As a result, the peritoneum was debrided along the lateral and anterior abdominal wall. During this procedure necrotising fasciitis was, according to the notes, positively identified for the first time. Extensive debriding took place in an effort to remove all of the infective tissue. A stoma was formed.

A further laparotomy was undertaken the next day on 13 December and it appeared there may have been some improvement in the pelvic sepsis – the retroperitoneal planes were opened and noted to be less septic. Again some debridement of necrotic tissue was undertaken especially in front of the bladder. The abdomen was irrigated with lots of saline and packs left in the retroperitoneal spaces. However, the improvement was short lived and despite increasingly extensive debridement in procedures undertaken on 14, and 15 December, the sepsis continued to result in necrotic tissue.

Thereafter Mr Tranby became increasingly unstable and it was obvious the fight against infection was being lost. At an operation on 16 December there were findings of purulent exudate and slime enveloping his bowel; there were pockets of pus; the abdominal musculature was ashen and necrotic. During this procedure it was accepted Mr Tranby's disease was unsurvivable. The following day, following consultation with his wife, life support measures were withdrawn and Mr Tranby was pronounced dead at approximately 11:50am.

Autopsy results

An autopsy was performed by Professor David Williams an experienced forensic pathologist on 19 December 2008 who reported his examination revealed no significant bruises, abrasions or lacerations or other injuries not related to surgical intervention.

He also reported the internal examination revealed evidence of intra-abdominal sepsis extending to the soft tissue and the lower pelvic area.

Professor Williams expressed the view there appeared to be no untoward complications of the surgery.

The autopsy also revealed significant coronary atherosclerosis, emphysema and nodular hyperplasia of the thyroid.

Professor Williams suggested the cause of death was

1(a) abdominal sepsis due to
1(b) peritonitis

Independent medical advice

I was greatly assisted by a report from and the evidence of Dr Russell Stitz, an eminent and senior surgeon who has for many years led the colorectal unit at the Royal Brisbane and Women's Hospital. Dr Stitz reviewed Mr Tranby's medical charts and the statements provided by those who treated him.

He expressed the view that the removal of the fishbone from Mr Tranby's anal canal was a "*simple procedure of low priority and short duration*". However, Mr Tranby being an insulin dependant diabetic increased his risk factors and this was also exacerbated by the delay in undertaking the operation to remove the foreign body. Dr Stitz pointed out that this increased the potential exposure to contamination of the perianal tissues by bacteria in the large bowel.

He commented that the possibility of a need for a colostomy should have increased the priority given to Mr Tranby's operation. Dr Stitz opined the delay may have been a contributing factor in the spread of Mr Tranby's infection.

He considered the symptoms observable on 6 December when Mr Tranby was returned to the TH were suggestive of possible sepsis in the anorectal region and pelvis because Mr Tranby should have been largely asymptomatic by the time of the review. While the urine retention may have been an artefact of the surgery he was of the view "*the pelvic septic process had already commenced but was not apparent externally*". Dr Stitz commented that the signs and symptoms Mr Tranby displayed were suggestive of possible sepsis in the anorectal region and pelvis.

He was also of the view the severe lower back pain Mr Tranby complained of on 7 December was probably referred from the pelvic septic process because the indwelling catheter would have relieved pain due to urinary retention.

Dr Stitz considered the low blood pressure recorded when he was taken to the TH on 8 December, 62/43 was also most likely due to the associated systemic affect of the developing pelvic sepsis.

When Mr Tranby was reviewed in the TH in the evening of 8 December and the early hours of 9 December, his white cell count was markedly raised at 23.5. This amounted, in Dr Stitz' view, to documented signs of infection which could have been traced to the operation site as a result of the x-ray which showed small bowel distension with air fluid levels. A UTI was not an unreasonable differential diagnosis but he said in evidence the x-rays clearly showed intra abdominal pathology which warranted urgent investigation.

He also said the x-rays did not indicate a mechanical obstruction of the bowel but most definitely suggested a paralytic ileus, most likely caused by an infection.

Dr Stitz suggested necrotising fasciitis – the infection which subsequently caused Mr Tranby's death – should have been at least considered by this point. Urgent investigation by way of a laparotomy was called for.

Commenting on the laparotomy that took place on 10 December, and accepting that the operation note accurately recorded what had been found, Dr Stitz queried whether Dr Hack sufficiently explored the possible sources of the infection; whether he dissected sufficiently deeply into the pelvis and as far back into the retro-peritoneal space as may have been called for. When asked to comment on what he considers should have been done if the first operation revealed infection to the extent claimed by Dr Hack when he gave evidence in these proceedings, Dr Stitz said in evidence that as much infected tissue should have been excised as could be accessed. He did not accept this would have necessitated the removal of all of the pelvic organs or even the major organs but he acknowledged that aggressive and quite radical excision would be called for. That aside, he believed the ICU care of Mr Tranby and the continuing attemtps to remove the infected tissue were appropriate.

Dr Stitz's view was that by 12 or 13 December the fulminant infection process was so entrenched it was unlikely anything could have been done that would have led to a better outcome.

Conclusions

On the surface, Mr Tranby's death following a minor procedure raises concerns about the adequacy of his treatment at the TH. He presented on 3 December with a fish bone lodged in his rectum and died 14 days later after six operations.

However, as with most things, a valid critique of what occurred requires deeper analysis.

Initial delay?

Was there unreasonable delay in removing the fish bone? Mr Tranby presented at the TH about 7:00pm on 3 December. The operation to remove the fish bone which was known to be present soon after his arrival did not commence for 32 hours.

It is accepted the delay increased the risk of an infection developing and the longer it remained unaddressed the risk of the infection becoming worse increased. As Mr Tranby suffered from diabetes he was at heightened risk in both respects.

There is no evidence to suggest the delay resulted from dilatory conduct by any of the staff of the TH. I accept the evidence indicating Mr Tranby's procedure was appropriately classified as category B but more apparently serious and urgent procedures kept presenting so his was not reached until 3:00am on 5 December. When Dr Connors, the doctor who had first identified the procedure as necessary, became aware it had not been undertaken he expeditiously caused this to be addressed.

Dr Hack described the situation as "terrible." I share his concern. He indicated some improvements have been effected by making more efficient use of slots

in elective surgery lists but that demands for acute or emergency surgery continue to increase. He also indicated new facilities are "on the drawing board." It is hoped this will alleviate the problem.

Resourcing the public health system has been the subject of numerous investigations and reports in recent years. I can add little to that debate.

Should surgery have occurred prior to 10 December?

Mr Tranby's chances of surviving would have been improved had surgical examination of his abdomen occurred sooner. As I understand the evidence, it is now accepted by all parties that the fish bone which lodged in Mr Tranby's rectum on the afternoon of 3 December is likely to have perforated the bowel wall allowing bacteria to escape into the peritoneal cavity, leading to the infection which proved fatal.

Dr Connors, who removed the fish bone, says he was alerted to this possibility by a consultant he spoke to immediately prior to undertaking the procedure. As a result he searched in vain for evidence of the injury we now know must have occurred. The question then becomes when should the treating team have become alerted by the symptoms Mr Tranby subsequently developed to the likelihood an intra-abdominal infection was present.

In reviewing the charts Dr Stitz has identified signs of this infection as early as 6 December when Mr Tranby developed anorectal pain and was very tender on digital examination per rectum despite the foreign body having been removed. He was of the view the urinary retention experienced at this time was also consistent with the developing septic process. The low back pain Mr Tranby reported on 7 December was further evidence. Nevertheless, I accept attempts to resolve the problem by catherterising Mr Tranby were not unreasonable at that stage.

However when he was brought back to the hospital on 8 December he had a markedly raised white cell count of 23.5. X-rays were undertaken which in Dr Stitz' view clearly demonstrated an intra-abdominal pathology of Mr Tranby's problems. In his view the x-rays show quite a lot of gas in the large and small bowel and fluid levels that weren't insignificant. They were, he said, inconsistent with a mechanical obstruction but did suggest a paralytic ileus most likely caused by infection. An ileus was unlikely in Dr Stitz' view to be caused by urinary tract infection (UTI) and when added to the abdominal tenderness and guarding and the exuding of pus in the anus there was sufficient evidence exploration of Mr Tranby's abdomen was urgently needed.

Dr Connors reviewed Mr Tranby at 30 minutes past midnight on 9 December. He is unsure whether he reviewed the x-rays that had been taken some three or four hours previously. Rather than booking Mr Tranby for a laparoscopy or laparotomy the following day, a decision that would either be confirmed or reversed by his supervising consultant during the ward round the next morning, Dr Connors chose to refer Mr Tranby to the urology team.

It was submitted on his behalf that suspecting a UTI was not unreasonable because Mr Tranby had an in dwelling catheter fitted which predisposed him to that condition. But he had also had lodged in his rectum a fine, sharp bone that could not be manually removed despite attempts by Mr Tranby and Dr Connors to do so. It seems so sure was Dr Connors that he had searched for and excluded a perforation he concluded none could exist and the possibility of it was given insufficient consideration when it was clear an infective process was underway. [2]

Much was made of the rarity of intra-abdominal necrotising fasciitis. That may have been more relevant if concern had been raised about the failure of the treating team to correctly identify the pathogens involved in Mr Tranby's infection. In this case the concerns were and remain, that the general site of the infection was not identified sufficiently promptly.

It has been suggested it would be unfair to expect a first year registrar such as Dr Connors to be as insightful in such matters as an eminent consultant like Dr Stitz. That is obviously true and Dr Stitz was very careful to avoid doing that. Indeed, he consciously and explicitly compared the reasonable expectations of a first year registrar, a third year registrar and a consultant. He acknowledged a first year registrar should not be expected to confidently interpret the x-rays and other symptoms of this case as he would, but he was firmly of the view that such a trainee should know enough of his or her own limitations to realise liaison with a consultant was urgently needed.

He was less forgiving of Dr Connors' apparent continuing reluctance to acknowledge the misdiagnosis he had made. It was suggested by his counsel it would be unfair to criticise Dr Connors for not being able to properly interpret the x-rays in the unhelpful confines of the witness box when he held them up to the light. I agree. However, he said in his statement that he reviewed the x-rays while preparing it and still saw no evidence warranting surgical intervention. Of real concern was Dr Connors' refusal to accept Dr Stitz' interpretation of the x-rays and other symptoms and his insistence he would proceed the same way in future. It might be in the best interests of Dr Connors and his patients were he to become a little more self reflective.

As a result of considering all of the evidence, I am of the view Dr Connors made an error of judgement in not seeking an urgent review by his consultant of Mr Tranby's condition, either that night or in the ward round on the morning of 9 December. I note Dr Hack indicated it was unlikely he would have caused any different course to be followed, but I was left with the impression he was seeking to shield his trainee from criticism. In any event the case was not referred to him for another 36 hours.

Alternatively, Dr Connors could have sought an immediate or urgent review from a urology registrar. When the case was referred to them, the urology team quickly concluded Mr Tranby did not need their help and referred Mr Tranby's treatment back to the surgical team, correctly suggesting the

[2] Coroners and other investigators are rightly warned of the misleading effects of hindsight bias. Medical practitioners should perhaps be just as alert to confirmation bias.

evidence indicated an intra-abdominal problem. The unnecessary diversion delayed the laparoscopy by approximately 24 hours. I cannot conclude that had the procedure been undertaken on 9 December Mr Tranby would have definitely survived, but it almost certainly would have improved his chances.

Was the initial operative response adequate?

Dr Stitz suggested the laparotomy should have been sufficiently extensive to identify all possible sources and sites of infection. If necrotising fasciitis was discovered it would then be appropriate to debride all affected tissue. He was of the view this could be undertaken without removing the major pelvic organs.

The difficulty in assessing the adequacy of Dr Hack's surgical response is that he claimed in the witness box for the first time that when undertaking the procedure on 10 December he discovered necrotising fasciitis which was so extensive its removal was not consistent with life or at least any reasonable quality of life. If this was the case, it is difficult to understand why he would not have undertaken more extensive excision at that point and why further surgery was not undertaken for 48 hours. Nor is such a discovery consistent with his noted plan to "*await abscess formation".*

However, I have found Dr Hack is mistaken in thinking he discovered extensive necrotising fasciitis during the first operation. Accordingly, it raises the question of whether Dr Hack was sufficiently thorough in his investigation of the possible infection sites. Based on Dr Stitz' evidence I have concerns about that aspect of the treatment of Mr Tranby. However, Dr Hack is a senior and experienced surgeon and I do not consider I have sufficient evidence to make a finding adverse to him in that regard.

Findings required by s45

I am required to find, as far as is possible, the medical cause of death, who the deceased person was and when, where and how he came by his death. As a result of considering all of the material contained in the exhibits, I am able to make the following findings in relation to the other aspects.

Identity of the deceased – The deceased person was James Errol Tranby

How he died - Mr Tranby died as a result of an intra-abdominal infection which developed following the removal of a foreign object from his rectum.

Place of death – He died in the Townsville Hospital while in the custody of the Queensland Corrective Services.

Date of death – He died on 17 December 2008.

Cause of death – Mr Tranby died from the effects of necrotising fasciitis, precipitated by a fishbone perforating his rectum.

Comments and recommendations

Section 46, insofar as it is relevant to this matter, provides that a coroner may comment on anything connected with a death that relates to public health or safety, the administration of justice or ways to prevent deaths from happening in similar circumstances in the future.

The only issue raised by the evidence in this case which may warrant consideration from that perspective is the failure of the authorities to alert Mrs Tranby to her husband's predicament in a timely manner.

As I have already mentioned, Mrs Tranby was not notified of Mr Tranby's hospitalisation until 11 December 2008 by which time he was in a coma in the ICU. He did not regain consciousness before dying and accordingly they had no opportunity to say goodbye, a significant exacerbation of the grief Mr Tranby's wife and family naturally suffered as a result of his sudden and unforeseen death.

According to John Harrison, General Manager of the TCC at the relevant time, he notified Mrs Tranby personally once he was made aware of the seriousness of Mr Tranby's condition. Mr Harrison does not recall who made him aware, or precisely when he was informed. He responded appropriately and compassionately by going to Mrs Tranby's house to inform her, and by later arranging a family meeting at the hospital. Mrs Tranby was authorised unlimited visits from that point.

The Queensland Corrective Services procedure relating to the admission of prisoners to external medical facilities provides -

11. Advising an offender's primary contact or other person of admission to an external medical facility

Where an offender is admitted to an external medical facility and the medical condition indicates a serious threat to the offender's health and/or an extended period of admission, the following must occur-

a. the offender should be asked whether they would like contact to be made with their primary contact/s to make them aware of the offender's admission to an external medical facility;

b. where the offender is not able to be asked permission for contact to be made with the offender's primary contact/s the general manager or nominee must consider the nature of the offender's medical condition, expected duration of the offender's admission to an external medical facility, relevant security/escape related information and determine whether the offender's primary contact/s should be advised of the offenders admission.

The general manager or nominee will be responsible for making contact with the offender's primary contact/s where consented to under a) or determined necessary under b).

The difficulty in consistently applying this policy is well demonstrated by this case. Mr Tranby arguably faced a serious threat to his health when, on 10 December 2008, he underwent abdominal surgery with the attendant risk of a colostomy. Mr Harrison however was not made aware the procedure was planned and frankly said even had he been he would have awaited the outcome of the procedure before considering whether Mr Tranby's wife needed to be contacted. In all of the circumstances I do not find the policy was breached.

However, the subjective nature of the test to be applied - is the prisoner facing a "serious threat" to his/her health; the unpredictability of many health procedures; and the ad hoc information sharing between hospitals and correctional centres militate against consistent and reliable notification of prisoners' families in a timely manner.

I acknowledge there are a number of competing policy objectives that need to be accommodated. I do not have sufficient evidence before me to attempt that. Accordingly, I will only recommend a review.

Recommendation – Notification of prisoners' NoK

The facts of this case highlight the inadequacy of the current Queensland Corrective Services (QCS) policy governing when a prisoner's nominated contact person should be advised the prisoner is to undergo a medical procedure. The sad consequences of a failure to do so in a timely manner, when a sudden death results, should be avoided. Accordingly, I recommend QCS review the policy to ensure as far as is possible it accommodates the unexpected outcomes of relatively minor procedures and cases involving a progressive deterioration.

I close this inquest.

Michael Barnes
State Coroner
Townsville
9 June 2011