



A combined Victorian Institute
of Forensic Medicine
and Victorian State
Coroner's Office publication.

CORONIAL COMMUNIQUÉ

VOLUME 7 ISSUE 4.
December 2009

ISSN 1834-2221

CONTENTS

Editorial	1
New Format for the Medical Deposition	1
Open Days	2
Recently Closed Cases	2
Beware the Patient Who Re-presents	3
Readers' Feedback	3
Medication Maladministration – Adding up the Errors	4

PUBLICATION TEAM

Editor in Chief: Dr. Nicola
Cunningham
Editorial Team: Dr. Joe Ibrahim
Dr. Adam O'Brien
Designer: Caroline Rosenberg

Address: Clinical Liaison Service
Coronial Services Centre
Victorian State Coroner's Office
L1, 436 Lonsdale St
Melbourne 3000

FREE SUBSCRIPTION

The Clinical Liaison Service
will publish **CORONIAL
COMMUNIQUÉ** on a quarterly
basis. Subscription is free of charge
and will be sent electronically to
your preferred email address.
If you would like to subscribe to
CORONIAL COMMUNIQUÉ,
please email us at: cls@vifm.org

EDITORIAL

Welcome to our final issue for 2009. The most significant event since our last issue is the introduction of the new *Coroners Act 2008(VIC)* on the 1st November 2009. Two key changes are the stronger focus on prevention; and the obligation for the Coroners Court to publish their findings, comments and recommendations following an inquest. Detailed information about the Act is available at –
<http://www.coronerscourt.vic.gov.au/wps/wcm/connect/Coroners+Court/Home/Case+Findings/>

This issue describes two cases where systemic errors resulted in delays of recognition and treatment of a clinical situation. A schedule for 2010 Open Days and an update on the electronic medical deposition are also provided.

We wish all our readers a safe and festive New Year season!

OPEN DAYS

Due to the overwhelmingly positive response in 2009 to our Open Days, we have scheduled four for next year. These will be hosted at the Victorian Institute of Forensic Medicine on:

- Monday 8th February, 1:00pm till 4:30pm
- Thursday 13th May, 9:30am till 1:00pm
- Monday 16th August, 1:00pm till 4:30pm
- Thursday 18th November, 9:30am till 1:00pm

The "Open Days" provide an insight into the legal investigation of healthcare-related deaths conducted by the State Coroner's Court and Victorian Institute of Forensic Medicine. Health professionals should email cls@coronerscourt.vic.gov.au to register.

NEW FORMAT FOR THE MEDICAL DEPOSITION

The Coroners Prevention Unit is implementing a new electronic format for the Medical Deposition. The deposition is completed with every death reported to the Coroner in Victoria.

Most of the information required to complete the Medical Deposition is similar to the existing hard copy version. The new version requires greater detail about medical procedures. If a medical practitioner considers the circumstances of the death "potentially reportable" they will continue to telephone and discuss the case with the Coroners Court. If the death is deemed reportable, the medical practitioner will be directed to a website where the Medical Deposition is to be completed on-line. The exact details of the new on-line resources and contact phone numbers will be released to hospitals early in the New Year.

It is hoped that this will enhance the transfer of information and assist coroners, pathologists, hospitals and clinicians to contribute to public health and patient safety.

Next Edition: November 2009

CONNECTING CLINICIANS AND COMMUNITY WITH CORONERS

FEEDBACK

The CLS team is keen to receive feedback about this communication especially in relation to changes in clinical practice.

Please email your comments, questions and suggestions to: cls@vifm.org

REPRODUCTION

This document may be reproduced in its entirety for the purposes of research, teaching and education and may not be sold or used for profit in any way. You may create a web link to its electronic version. Permission must be obtained for any modification or intended alternative uses of this document.

If referring to this publication, the following citation should be used: Coronial Communiqué [electronic resource]: Clinical Liaison Service, Connecting Clinicians and Community with Coroners. Southbank, Vic. State Coroners Office; Victorian Institute of Forensic Medicine. Available at: <http://www.vifm.org/communiqué.html>

Other publications including the Residential Aged Care Coronial Communiqué and WORKWISE can be found on our website at <http://www.vifm.org/n961.html>

RECENTLY CLOSED CASES

235/05 A 91 year-old female was admitted to hospital for surgery following dislocation of a prosthetic hip joint. While waiting for theatre, a large haematoma formed over the hip. A blood transfusion was commenced but the haemoglobin continued to fall from 9.0 to 5.9 g/dL leading to a cardiac arrest. The cause of death in the absence of a full autopsy was "hypovolaemic shock post-repair of a dislocated hip".

4769/06 A 29 year-old female with a past medical history of headaches and a normal CT Brain scan, presented to hospital complaining of a headache associated with dizziness, nausea and photophobia. This was diagnosed as a migraine and she was discharged home for follow-up by the general practitioner. Over the following three weeks she presented twice to the hospital and on several times to the general practitioner with severe headache. On each occasion she was diagnosis with migraine. Eventually she collapsed at home and died of a severe catastrophic subarachnoid haemorrhage.

3576/07 An 84 year-old male with a past medical history including end-stage renal failure, atrial fibrillation treated with clopidogrel and warfarin, and lung cancer was transferred to hospital after tripping at home. He sustained facial bruising, shoulder and hip injuries and was discharged home after x-rays of his shoulder and hip.

The following day he was readmitted to hospital for investigation of periods of altered consciousness. On admission he was alert and was investigated for possible cardiac causes in view of an elevated troponin level. Later, he developed limb weakness and a CT Brain scan performed two days after the fall showed a large subdural haemorrhage. Palliative care was instigated and he died three days later.

903/08 An 85 year-old female was admitted to hospital with fever and atrial flutter. Treatment was initiated with intravenous metoprolol and digoxin. Three days later she developed complete heart block and a dual chamber pacemaker was inserted. The following day she collapsed and had a cardiac arrest. Cause of death was a perforated right atrium.

4233/07 An 84 year-old female with a past medical history of peripheral vascular disease and diabetes mellitus had community nursing services attend for care of leg ulcers. In the past when the ulcers had been infected there were documented episodes of spontaneous bleeding. On the day of death, the wounds dressings had been changed and the nurse noted the presence of serous ooze with no bleeding. Several hours later, she was found unresponsive with evidence of haemorrhage at the scene and blood-soaked bandages. It appeared that the leg ulcer began to bleed while she was having a wash. Cause of death was haemorrhage from a lower leg ulcer.

4993/08A A 25 year-old obese female with a past medical history of congenital heart disease that required cardiac surgery including repair of an atrial septal defect presented to hospital with leg pain following a motor vehicle accident. Initial assessment indicated low oxygen saturations and a trans-oesophageal echocardiogram revealed a large mass adherent to the atrio-septal defect patch with associated severe pulmonary regurgitation. The cause of the mass was unclear and treatment with antibiotics and anticoagulation was instigated. Subsequently cardiac surgery was required to excise the mass and replace the pulmonary valve. While being weaned from the bypass machine after the long operation it was noted she fixed dilated pupils. The cause of death was a large acute intracranial haemorrhage probably due to a ruptured aneurysm.

BEWARE THE PATIENT WHO RE-PRESENTS

CASE NUMBER: 2932/04

Case Précis Author: Carmel Young RN,, CLS

CLINICAL SUMMARY

Mr S was a 47 year-old male with a mild intellectual disability who lived with his mother.

In July 2004 Mr S attended a general practitioner complaining of an ulcerated mouth, chest pain, sore ears and vomiting. A tooth abscess was diagnosed and treated with antibiotics and analgesia.

Two days later and still unwell with similar symptoms Mr S rang for an ambulance to transport him to the local rural hospital. Mr S' mother explained to the nurse that he had been taking antibiotics, that his tongue had become swollen and there was difficulty with swallowing and neck movement. The clinical record documents that Mr S "is a poor historian", vital signs within normal limits, and no respiratory distress and triage category 5.

Within an hour of attending, Mr S was examined by a doctor, the diagnosis altered to a fungal infection of the throat, the treatment changed and he was discharged home. Later that evening

the symptoms worsened, so Mr S rang for an ambulance and re-presented to the Emergency Department. On this visit he was a triage category 4, the diagnosis altered to glandular fever associated with gastroenteritis. Treatment was intravenous fluids and then he was discharged home for review by his general practitioner.

The following day he presented again to the Emergency Department this time unable to walk, with severe chest pain and very sore ears. On this visit he was a triage category 5. The clinical record documented "return for review of sore throat", no obvious distress, heart rate was slightly tachycardic and temperature was recorded no higher than 37.6C. After waiting over 5 hours, he left before seeing a doctor.

The next day at the general practice clinic, the general practitioner noted Mr S was pale, short of breath and had pleuritic chest pain. An ambulance transfer to hospital was organised. On this fourth presentation, no triage category was recorded. Documentation in the clinical record indicated he was febrile with a tachycardia 133bpm and rapid, shallow breathing (oxygen saturation 89% on room air). One-half hour later it was noted he had left the emergency department with his mother.

The next morning Mr S was found dead at home.

PATHOLOGY

An autopsy was conducted and the cause of death was reported as Streptococcal sepsis secondary to extensive mediastinitis resulting from tracking of infection from a pharyngeal abscess.

INVESTIGATION

An inquest was held to determine the events that led to Mr S' death.

The emergency department doctors stated that Mr S had no signs or symptoms of an abscess in the throat; and there was not a hoarse voice. The coroner examined the Australasian Triage Scale during the inquest and found that the recommendations by the Australasian College for Emergency Medicine were not adhered to in this case.

CORONER'S FINDINGS

The Coroner made three recommendations. Firstly, that triage guidelines are included in education/training courses. Secondly, "that an assessment be made of the effectiveness of existing hospital protocols and procedures regarding the follow-up of patients who after admittance to the emergency department, elect to leave without first having been seen by a doctor". Thirdly, "that it be clearly recorded in the emergency department records that a patient is suffering from an actual or suspected mental impairment."

READERS' FEEDBACK

Case 792/07 (FEBRUARY 2009 RECENTLY CLOSED CASES)

Raises a number of questions about prophylaxis of venous thromboembolism (VTE). It seems that everything was done correctly (including the use of clexane) and despite this, the complication occurred in someone who is considered very low risk. One asks:

1. Were there risk factors (apart from the surgery itself) which predisposed this woman to VTE?
2. For how long post-operatively would it be normal practice to continue the anticoagulant (either clexane or warfarin) and was this done in this particular case?
3. If short-term therapy is considered adequate, should this advice be reconsidered?

4. Are there any lessons that could be learnt from this case (apart from the obvious one that "low risk" is not "zero risk", and if something can happen, then sooner or later it will)?

These questions are not just academic – as an obstetrician gynaecologist, the issue of VTE is constantly in one's mind, especially when a young woman dies. It causes one to consider "What else could have been done?" Anticoagulants have significant complications, and one has to make a judgment on the risks and benefits of treatment. Fortunately, these events are rare but the fact that a complication is rare does not help the person to whom it happens. Recent publications may help to address some issues surrounding VTE prophylaxis.

See: [Clinical Practice Guide: For the Prevention of Venous](#)

Thromboembolism in Patients Admitted to Australian Hospitals

Sweetland S, Green J, Liu B et al. Duration and magnitude of the postoperative risk of venous thromboembolism in middle aged women: prospective cohort study. *BMJ* 2009;339:b4583.

Cohen A. Prevention of postoperative venous thromboembolism (Editorial) *BMJ* 2009;339:b4477.

EDITOR'S COMMENTS

In this case, the patient did not have any other risk factors for VTE. Clexane was prescribed and administered until the day of discharge. No other anticoagulation medication was prescribed on discharge. The woman was asymptomatic and mobilising with crutches at discharge and two weeks later at the outpatient review (4 days prior to death).

The reader's comments highlight the ongoing challenges for preventing VTE.

MEDICATION MALADMINISTRATION – ADDING UP THE ERRORS

CASE NUMBER: 3662/03

Case Precis Author: Dr Nicola
Cunningham FACEM, CLS

CLINICAL SUMMARY

Ms B was an 89 year-old female with a past medical history of chronic obstructive airways disease, congestive cardiac failure and dementia, who resided in a low-level care facility. The medications at the facility were dispensed in a Webster Pack and provided by the staff each morning.

On the morning in question, Ms B was administered her medications, and shortly afterwards staff realised the Webster pack belonged to another resident. Amongst the medications ingested were nifedipine 10mg, tramadol 50mg, telmisartan 40mg and atenolol 75mg.

The error was reported to the care coordinator and the manager who contacted the general practitioner within 90 minutes of the error occurring. The General Practitioner advised that Ms B have bed rest and for staff to monitor for headaches and dizziness.

Two hours later, Ms B was looking pale and weak. The paramedics were called and on arrival noted the presence of a bradycardia and hypotension (systolic blood pressure 65 mmHg). Ms B was taken to hospital and died there three days later.

PATHOLOGY

An autopsy was conducted and the cause of death was reported as acute myocardial infarction in a woman with ischaemic heart disease due to coronary artery atherosclerosis following administration of nifedipine, atenolol, tramadol, caltrate, aspirin and telmisartan.

INVESTIGATION

Statements were obtained from the staff involved in Ms B's care to explore the circumstances surrounding medication administration and the subsequent clinical management.

The case proceeded to an Inquest where the coroner heard that usually a pharmacy dispensed the Webster Packs on Fridays. On Sunday nights, staff would prepare the packs for Monday by affixing the resident's named photograph from an old pack onto the front of the new pack.

On this occasion, the Sunday evening routine was not followed because of staff sick leave. On Monday morning, a Personal Care Attendant and a work-place student commenced the medication round with the old packs on the trolley.

The student was given the task of transferring the photographs from the old packs to the new packs. Ms B was in room 23 and a new pack was placed in slot "23" on the trolley. The Personal Care Attendant checked the photograph but not the name, and administered the medications. Moving on to the next room, the student could not locate the pack for room "24" and found a second pack (identified as belonging to Ms B) attached to the pack in slot "22".

This had led to Ms B given the medications charted for the resident in room "24".

Oral evidence from the facility staff revealed that much of the training for the administration of medication was "on-the job", and most of the staff were not trained or equipped to perform pulse or blood pressure checks.

Evidence from the General Practitioner revealed there was no specific request that Ms B's blood pressure or heart rate be taken as he had assumed that no one at the facility had appropriate training to perform the task. The General Practitioner stated that he had not requested an immediate transfer to hospital and deferred attending the hostel because he was led to believe her clinical state was relatively stable.

A toxicologist and a pharmacist were both called to provide expert opinions on the degree of nexus between the administration of wrong medications and the death. Both agreed that in a patient with significant underlying cardiac and respiratory disease, the administration of the antihypertensive medications were likely to have had a profoundly negative effect on the Ms B's cardiovascular function.

CORONER'S COMMENTS AND FINDINGS

The coroner found that there was a logical and proximate link between the administration of anti-hypertensive medication and Ms B's death, and that the event occurred as a consequence of systemic procedural shortfalls.

Issues identified included failure of staff to check names against photographs, a delay in contacting the General Practitioner, failure by the General Practitioner to advise staff of the potential side effects of the medications or need for blood pressure checks, and a delay in medical assessment or referral to hospital.

The coroner noted that despite a lack of training and regulations for personal care attendants, the responsibility of swapping Webster Packs fell on them rather than the pharmacy. Therefore, when circumstances changed, systems failed. It was recognised however, that at the time of the case, the facility was not recognised as a "health service", the definition of which changed in 2006, allowing for greater regulation of training and credentialing of staff at low-level care facilities.

The coroner also stated that the General Practitioner alone held the knowledge of Ms B's medical history, and the potential for adverse consequences of the medications, and was critical of his management.