FORM 37

Rule 60(1)

FINDING INTO DEATH WITH INQUEST

Section 67 of the ***Coroners Act 2008***

Court reference: 3593/08

Inquest into the Death of BARRY WILSON HOWROYD

Delivered On:	31 August, 2011
Delivered At:	Coroners Court of Victoria Level 11, 222 Exhibition Street MELBOURNE 3000
Hearing Dates:	28 & 29 March, 2011
Findings of:	Coroner Paresa Antoniadis SPANOS
Representation:	Senior Constable Kelly RAMSEY, Police Coronial Support Unit (PCSU), to assist the Coroner Mr A. MURDOCH appeared on behalf of Dr A. THORNTON and Dr T. FRYER Ms D. FOY appeared on behalf of Frankston Hospital/Peninsula Health Mr HALLEY appeared on behalf of Dr Basil SHER Ms S. McPHERSON on behalf of Direct Endoscopy

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Section 67 of the ***Coroners Act 2008***

Court reference: 3593/08

In the Coroners Court of Victoria at Melbourne

I, PARESA ANTONIADIS SPANOS, Coroner,

having investigated the death of:

Details of deceased:

Surname:	HOWROYD
First name:	BARRY
Address:	9 Denholm Street, Rosebud, Victoria 3939

AND having held an inquest in relation to this death on 28th-29th March, 2011
at Melbourne

find that the identity of the deceased was BARRY WILSON HOWROYD
born on 19th November, 1929

and that death occurred on the 15th August, 2008

at Mornington Peninsula Hospital, 12-32 Hastings Road, Frankston, Victoria 3199

from: 1(a) COMPLICATIONS OF BOWEL SURGERY

in the following circumstances:

INTRODUCTION & PERSONAL CIRCUMSTANCES

1. Mr Howroyd was a seventy-eight year old married man and father of five adult children. He had a significant past medical history which included hernia repair, splenectomy, diverticular disease and diet-controlled diabetes. As he was a Jehovah's Witness, Mr Howroyd would not accept the transfusion of blood or blood products. Twelve years prior to his death he had been diagnosed and treated for gastric non-Hodgkin's lymphoma which had been in longstanding remission. As at August 2008, Mr Howroyd's wife June had her own pressing health issues. It fell to his daughter Ms Gayle Gray who held a medical power of attorney for her father, to care for him and to assist him to access medical treatment.

GASTROSCOPY & COLONOSCOPY - 7 AUGUST 2008

2. On 7 August 2008, Mr Howroyd was booked in for gastroscopy and colonoscopy at Direct Endoscopy, Bayside Day Procedure and Specialist Centre (the Centre). Polyps had been discovered and treated at a colonoscopy three years earlier, and he was due for routine follow-up. Mr Howroyd attended the Centre for a pre-operative anaesthetics review on 30 July 2008, accompanied by Ms Gray. Dr Tim Fryer assessed him as "fit" from an anaesthetics perspective.[1]

3. Mr Howroyd returned to the Centre on 7 August 2008 for the scheduled procedures. According to the procedural list, Consultant Gastroenterologist Dr Aaron Thornton, he had a pre-procedure consultation with Mr Howroyd, which included the taking of a full history, and the procedures proper were undertaken without any obvious problems.[2] Following a period of over an hour and a half observation in the recovery room, Mr Howroyd was discharged to the waiting room.[3] Before they left the Centre, Dr Thornton discussed his findings with Mr Howroyd and Ms Gray, in particular the suspected carcinoma of the bowel. He referred Mr Howroyd to an appropriate surgeon and arranged for a prompt staging CT, as is his usual practice following such a diagnosis.[4]

4. Disregarding the discrepancies in the evidence about who initiated contact and the sense of urgency conveyed or communicated, Mr Howroyd was in pain on the evening of 7 August 2008, and his daughter took him to the Emergency Department of Mornington Peninsula Hospital (Frankston ED). They arrived at about 9.00pm and left after a wait of some one and a half hours. Mr Howroyd spent the time sitting uncomfortably on a chair, apparently without being triaged, or receiving any medical attention, or even his presentation being recorded in any hospital records.[5]

STAGING CT SCAN - 8 AUGUST 2008

5. The following morning, 8 August 2008, Ms Gray spoke to Dr Thornton by telephone advising that her father was still experiencing abdominal pain and that their presentation to Frankston ED the previous night had been futile. Again, disregarding some discrepancies in the evidence, it is clear that Dr Thornton advised Ms Gray to call an ambulance to transport her father to Frankston ED.[6] When Mr Howroyd awoke, he wanted to have a shower and felt slightly better, and they decided to keep the 12.15pm appointment at MIA Frankston Private

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1 Statement Exhibit "C" Dr Tim Fryer's statement and transcript pages 35 and following.

2 See note 2 above and Exhibit "G" and transcript page 78 and following.

3 See "Endoscopy Unit Record", part of Exhibit "C" and transcript page 41. The records note that Mr Howroyd was nauseous, vomited once and passed flatus+++ whilst in the recovery room.

4 Exhibit "G" and transcript page 82 and following. Other findings at colonoscopy were - another polyp which was removed, moderate diverticular disease; at gastroscopy - a small hernia, some reflux, mild changes in the stomach, multiple biopsies were taken and later found positive/ consistent with gastric lymphoma. See also Melbourne Pathology report at page 128 of the inquest brief - Exhibit "L".

5 Statement of Dr Choo Leong Goh Exhibit "J" and transcript page 125 and following.

6 Exhibit "A" and transcript pages 10-11.

Radiology (MIA) for a staging CT scan which had been organised the day before.[7]

6. Mr Howroyd arrived at MIA about 11.40am for a CT scan scheduled for 1.30pm. The referral from Dr Thornton was for an oncology staging CT with no level or urgency or reference to a suspected bowel perforation. Ms Gray, who accompanied her father, told a staff member of the colonoscopy the previous day and the concern about a perforated bowel. This information does not appear to have been passed on to the Radiologist, Dr Basil Sher, either while Mr Howroyd was within the premises or subsequently.[8]

7. When Dr Sher reviewed the CT scans at about 2.15pm he suspected a bowel perforation, made enquiries of office staff and was then told that Mr Howroyd had undergone a colonoscopy the previous day. Dr Sher then contacted the Centre, spoke to Dr Thornton and caused a member of his office staff to contact Mr Howroyd, advise him that he had a suspected bowel perforation and needed to go to Franskton ED immediately.[9] It was this call which resulted in Mr Howroyd's second presentation to Frankston ED.[10]

SECOND PRESENTATION TO FRANKSTON EMERGENCY DEPARTMENT

8. According to hospital records, Mr Howroyd arrived at Frankston ED at 3.56pm on 8 August 2008 and was triaged Category 3 "to be seen by a doctor within 30 minutes" and the assessment made that he had "worsening abdominal pain since gastro/colonoscopy, had CT today and advised to present". Nursing observations taken at 4.10pm, 5.15pm and 6.15pm were satisfactory and stable. Mr Howroyd continued to be in pain. He was first seen by a doctor at 7.36pm when he was moved to a cubicle. Hospital Medical Officer Dr Azhar Rakhmetova ordered pathology and radiology and intravenous fluids were commenced at 8.45pm.

9. At 11.00pm Mr Howroyd was assessed by Surgical Registrar Dr Xie who obtained a history from Dr Thornton and documented that the chest xray revealed free gas under the diaphragm and the abdominal CT showed intraperitoneal free gas. Mr Howroyd was commenced on triple antibiotics, made nil by mouth and admitted to a general surgical ward at 0.44am on 9 August 2008 with surgery booked for theatre later that day. He remained afebrile and stable overnight.[11]

10. When reviewed by Consultant General Surgeon Professor Jonathon Serpell at 10.00am Mr Howroyd was significantly tender in the abdomen but otherwise had satisfactory vital signs and remained afebrile. The procedure commenced at 11.00am and is described in some detail

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7 Transcript page 11. Also see discussion at paragraph 29 and following.
8 Exhibit "F" and transcript pages 14, 68. Also see discussion at paragraph 31 below.
9 Exhibit "F" and transcript page 73. Furthermore, Dr Sher's evidence is that Dr Thornton indicated that he would contact the patient immediately, advise him to go to the Frankston ED immediately and would call ahead to Frankston ED to advise them of Mr Howroyd's condition and impending arrival. Dr Thornton could not explain at inquest the absence of any mention in the medical records that he had done so, but stated that it was "inconceivable" that he would not have made the calls in the circumstances - transcript page 88.
10 Exhibit "A" and transcript page 15.
11 Exhibit "J"

below. Suffice to say that the surgery was uncomplicated and Mr Howroyd made good progress in the early post-operative period and until the fourth post-operative day 14 August 2008, when although he remained pain free, he developed an elevated temperature.[12]

11. On the fifth post-operative day 14 August 2008, chest xray and physical examination indicated right and left sided basal lower lobe pneumonia necessitating a change in antibiotics and an intensive care referral. A Medical Emergency Team call was made in the afternoon when Mr Howroyd was hypoxic with a respiratory rate of 26, thought secondary to pneumonia. At that stage there was no evidence of intra-abdominal sepsis.

12. Mr Howroyd was transferred to the Intensive Care Unit (ICU) where he was intubated and commenced on inotropic support. Some abdominal distension was noted consistent with a degree of resolving ileus (bowel distension). Further investigations showed pulmonary emboli and inflammatory consolidation within the lungs. ICU management was directed at ongoing sepsis but Mr Howroyd continued to deteriorate despite all interventions and died at 6.50pm on 15 August 2008.

THE PURPOSE OF A CORONIAL INVESTIGATION

13. The primary purpose of a coronial investigation of a *reportable death*[13] is to ascertain, if possible, the identity of the deceased person, the cause of death and the circumstances in which the death occurred.[14] The practice is to refer to the *medical* cause of death incorporating where appropriate the *mode* or *mechanism* of death, and to limit investigation to circumstances sufficiently proximate and causally relevant to the death, and not merely circumstance which might form part of an open-ended narrative culminating in the death.[15]

14. Coroners are also empowered to report to the Attorney-General on a death they have investigated; the power to comment on any matter connected with the death, including matters relating to public health and safety or the administration of justice; and the power to make recommendations to any Minister, public statutory authority or entity on any matter connected with the death, including recommendations relating to public health and safety or the administration of justice.[16] These powers can be invoked to advance another purpose of the

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12 This is amply documented in the medical records Exhibit "M" but more accessible in Prof Serpell's statement Exhibit K" and transcript pages 149 and following.

13 Section 4 of the Act requires certain deaths to be reported to the coroner for investigation. Apart from a jurisdictional nexus with the State of Victoria, the definition of a reportable death includes all deaths that appear *"to have been unexpected, unnatural or violent or to have resulted, directly or indirectly, from accident or injury"* and perhaps more pertinently, deaths that occur *"following a medical procedure where the death is or may be causally related to the medical procedure - and a registered medical practitioner would not, immediately before the procedure was undertaken, have reasonably expected the death."*

14 Section 67 of the Act.

15 See for example *Harmsworth v The State Coroner [1989] V. R. 989; Clancy v West (Unreported decision of Harper, J in the Supreme Court of Victoria, 17/08/1994.*

16 Sections 72(1), 72(2) and 67(3) of the Act regarding reports, recommendations and comments respectively.

coronial investigation, previously accepted as implicit, now explicitly articulated in the legislation, that is, the *prevention* of similar deaths in the future.[17]

15. It is important to stress that the coroner's role is not to determine criminal or civil liability arising from the death under investigation. Coroners are specifically prohibited from including in a finding or comment any statement that a person is, or may be, guilty of an offence. Somewhat paradoxically, if a coroner *believes* an indictable offence *may* have been committed in connection with the death, the matter must be referred to the Director of Public Prosecutions, and the fact of this referral may be referred to in a finding.[18]

THE EVIDENCE

16. This finding is based on the totality of the material, the product of the coronial investigation of Mr Howroyd's death, that is the statements and materials in the inquest brief compiled by Senior Constable Ramsey from the PCSU, the statements and testimony of those witnesses who testified at inquest and any documents or other material tendered through them, and the submissions of Counsel. All this evidentiary material, together with the inquest transcript, will remain on the coronial file. I do not purport to summarise all the evidence in this finding, but will refer to it only in such detail as is warranted by its forensic significance and the interests of narrative clarity.

UNCONTENTIOUS MATTERS

17. Prior to the commencement of the inquest and based on the material in the inquest brief, it was apparent that a number of the matters required to be ascertained by the coronial investigation of Mr Howroyd's death were uncontentious. These were the deceased's identity and aspects of the circumstances in which he died. I formally find that the deceased was Barry Wilson Howroyd born on 19th November 1929, late of 9 Denholm Street, Rosebud, Victoria 3939 and that he died at Mornington Peninsula Hospital (Frankston Hospital) at 6.50pm on 15 August 2008.

CONTENTIOUS CIRCUMSTANCES - THE FOCUS OF THE INQUEST

18. The focus of the broader coronial investigation of Mr Howroyd's death, including the inquest, was on the medical cause of death and, not unrelated, on aspects of the circumstances in which he died. Framed as questions, the issues for determination were -

- Was the colonoscopy procedure undertaken on 7 August 2008 and/or resultant bowel perforation causally related to Mr Howroyd's death, and/or what were the complications of surgery to which he succumbed?

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17 The Preamble of the Act includes the following - *"... to contribute to the reduction of the number of preventable deaths ..."* while the Purposes in section 1 include *" (c) to contribute to the reduction of the number of preventable deaths ... through the findings of the investigation of deaths ... and the making of recommendations by coroners;"*

18 See sections 69 and 49(1).

- Were the family's complaints about delays experienced in accessing medical treatment well-founded and/or causally related to Mr Howroyd's death?

THE MEDICAL CAUSE OF DEATH

19. Forensic Pathologist Dr Melissa Baker, from the Victorian Institute of Forensic Medicine (VIFM), performed an autopsy, reviewed the medical records and medical deposition and postmortem CT scanning of the whole body, provided a detailed autopsy report and testified at inquest.[19] Dr Baker's summary of anatomical findings included *"Evidence of recent abdominal surgery. Anastomosis between small and large bowel intact"* as well as ascites, cardiomegaly, coronary artery atherosclerosis, bilateral pulmonary thromboemboli, chronic obstructive airways disease [emphysema] and pleural adhesions and diaphragmatic plaques. Dr Baker formulated Mr Howroyd's medical cause of death as *"complications of surgery for perforated bowel post colonoscopy"* and made a number of comments by way of explanation of this formulation.

20. Dr Baker commented that Mr Howroyd had evidence of multi-organ failure clinically, which was not responding to treatment, and that the most common cause of multi-organ failure is sepsis. In terms of the likely source of sepsis, Dr Baker noted that postmortem CT scanning showed a consolidation of the right lung base and, although not confirmed histologically in sections from the right lung, Methicillin resistant *Staphylococcus aureus (MRSA)*[20] was isolated on a postmortem swab from the right lung. She noted that three sets of antemortem cultures were negative, however, this is ambiguous in the context of intravenous antibiotic therapy which Mr Howroyd was receiving.[21]

21. Also of relevance to the issue of infection, Dr Baker commented in the autopsy report about the results of gastric biopsies taken during the gastroscopy procedure on 7 August 2008 which revealed recurrent MALT lymphoma, a condition which may impair an individual's immunity predisposing them to the development of infections.[22]

22. As regards perforation of the bowel, Dr Baker commented that there was evidence of ischaemic colitis in the caecum with a markedly thinned wall on the point of imminent perforation. Further, that *"Although a definite site of perforation was not identified, the presence of free gas under the diaphragm on chest xray, and intraperitoneal free gas on abdominal CT scan indicates that perforation had occurred".*[23] At inquest, Dr Baker clarified that these comments were based on the Melbourne Pathology report[24] of specimens taken during the

19 Exhibit "D" and transcript pages 49-65.
20 Commonly referred to as golden staph.
21 Exhibit "D" page 11-12, transcript pages 53, 61-63. Mr Howroyd had been commenced on triple antibiotic therapy whilst in the Frankston ED - cephalozin, gentamicin and metronidazole. Exhibit "K" Professor Serpell's statement and the medical records Exhibit "M".
22 MALT = mucosa-associated lymphoid tissue. Prior to this finding, Mr Howroyd was considered to be in longstanding remission following diagnosis of non-Hodgkins gastric lymphoma in the mid 1990s and chemotherapy. Exhibit "D" and transcript page 51.
23 Exhibit "D" page 12.
24 This report, attached to the autopsy report, is at page 128 of the inquest brief Exhibit "L". Also transcript pages 53-54, 64.

surgery, and not on autopsy findings. She agreed that the bowel perforation may have been within the section of bowel removed during surgery, but not within the pathology specimens, or may have been so small as not to be seen, in which case one would still expect to see the indicia of perforation such as pus on the surface of the bowel, or evidence of peritonitis or inflammation within the bowel itself.[25]

23. The fact of a bowel perforation having occurred during the colonoscopy was not really an issue during the inquest. Diagnostic Radiologist Dr Basil Sher who reported on the staging CT scans undertaken at MIA Frankston Private on 8 August 2008, provided a statement explaining the relevant processes and protocols and his findings. He also testified at inquest that, in the absence of prior/recent laparoscopy or surgery, free air within the peritoneal cavity generally means a bowel perforation.[26]

24. While Dr Baker made a temporal connection between the colonoscopy and bowel perforation, and Mr Howroyd's death, she was not prepared to go further, recognising that surgery to repair the bowel perforation merely expedited the right hemicolectomy for removal of the bowel carcinoma, which would presumably have been undertaken at some time in the near future.[27]

25. Dr Baker was cross-examined by Mr Halley about real causality as opposed to proximity in time. She agreed that chest infection is a common post-operative complication, that Mr Howroyd was even more susceptible as he had a recurrence of lymphoma and no spleen, and that the onset of post-operative chest infection was dependent on predisposition or co-morbidities, and the fact of bowel surgery, not its timing as such.[28] Dr Baker also agreed that *if* the antecedent cause of death was sepsis, the chest infection noted on the third or fourth post-operative day, was the most likely source of sepsis. While she could not entirely exclude the possibility that infection associated with the bowel perforation played a role, it was unlikely as a source of sepsis in the absence of some evidence of an extant infection, either at surgery at autopsy or both.[29]

26. Professor Jonathon Serpell who performed the laparotomy/right hemicolectomy, provided a statement and testified at inquest about matters pertinent to the medical cause of Mr Howroyd's

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25 Transcript pages 53-55.

26 Exhibit "F" and transcript page 69 and following. See also pages 30-34 of the inquest brief, Exhibit "L".

27 "...So does the time sequence suggest anything to you in terms of the cause of the multi organ failure? It's difficult to be certain. The factors to consider are that he had the bowel perforation. At surgery he didn't have a raging peritonitis. At autopsy he didn't have a raging peritonitis. Clinically he had evidence of pneumonia which, as you said, happened four days after the operation, and it seems that in that time there was never any concern about his abdomen or that he may have had peritonitis, his abdomen seemed, from reading the clinical notes, his abdomen was soft and there didn't seem to be a concern about that so it would appear that the sepsis arising from his abdomen resulting to [sic] the perforation would be less likely but impossible to determine with absolute certainty." Transcript pages 57-78.

28 Transcript pages 60-61.

29 Transcript pages 58-60.

death.[30] He confirmed the occurrence of a bowel perforation by reference to a report of the CT scan undertaken at MIA Frankston Private on 8 August 2008 and the chest and abdominal xrays undertaken at Frankston ED, all of which showed free intraperitoneal gas. When he examined Mr Howroyd at 10.00am on 9 August 2008, he found him significantly tender in the abdomen but with satisfactory vital signs. He agreed with the decision which had been taken for exploratory abdominal surgery.[31]

27. The surgery which was undertaken by Prof Serpell at about 11.00am on 9 August 2008, involved - *"A full laparotomy was performed through a midline abdominal incision. The findings were of a minimal amount of free fluid in the peritoneal cavity, which was neither purulent nor faeculent [emphasis added], a serosal tear in the ascending colon, and a large palpable mass in the caecum/ascending colon region. There was no faecal contamination. There was no macroscopic perforation of the colon evident. The remainder of the colon in particular, and the rest of the laparotomy, including the small bowel and stomach, were normal. There were no liver secondary metastases. A right hemicolectomy with primary anastomosis was undertaken."*[32]

28. Both in his statement and at inquest, Prof Serpell expressed the view that Mr Howroyd's post-operative clinical course, and in particular his rapid deterioration from being relatively well until the fourth post-operative day to being virtually moribund 24 hours later, was indicative of a fulminant, rapidly evolving sepsis causing multiple organ failure which suggested "overwhelming post splenectomy infection" (OPSI). He agreed that there was no evidence of intra-abdominal sepsis, that there was some evidence of pneumonia which wasn't extensive but "it became an overwhelming one in the setting of a patient such as this with an absent spleen".[33]

CONCLUSION AS TO CAUSE OF DEATH

29. The standard of proof in a coronial matter is the civil standard of proof on the balance of probabilities with the *Briginshaw* gloss or explication.[34] The effect of the authorities is to

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30 Professor Serpell's qualifications are M.B.,B.S., F.R.A.C.S., F.A.C.S. He holds the position of Professor and Director of General Surgery, Alfred Hospital and is Head of Unit and Consultant General Surgeon, Frankston Hospital.

31 Exhibit "K" page 2, transcript pages 142-144. At transcript page 147 Prof Serpell expressed the opinion that "...there was no identifiable hole or perforation that one could see, however, there must have been a hole presumably in the region of that caecal serosal tear that had allowed the gas to escape into the abdominal cavity which had subsequently sealed over."

32 Exhibit "K" page 2 paragraph 13.

33 Transcript page 156. See also statement of Dr John Botha, Director of Intensive Care, Frankston Hospital at pages 110-112 of the inquest brief, Exhibit "L". Dr Botha was not involved in clinical management of Mr Howroyd but reviewed the medical records, consulted with treating medical staff and concluded that Prof Serpell's diagnosis of OPSI as a plausible explanation for the sepsis which appeared to be the final cause of death.

34 *"The seriousness of an allegation made, the inherent unlikelihood of an occurrence of a given description, or the gravity of the consequences flowing from a particular finding, are considerations which must affect the answer to the question whether the issue has been proved to the reasonable satisfaction of the tribunal. In such matters "reasonable satisfaction" should not be produced by inexact proofs, indefinite testimony, or indirect inferences..."* Briginshaw *v* Briginshaw *(1938) 60 CLR 336 esp at 362-3.*
Re State Coroner; ex parte Minister for Health *(2009) 261 ALR 152 at [21]*

require a coroner to consider the seriousness of the matters alleged and the consequences of an adverse finding for any person, in reaching a reasonable satisfaction that a matter is proven. I have applied that standard to the totality of the evidence before me in order to determine the medical cause of Mr Howroyd's death and the causal significance of the colonoscopy and resultant bowel perforation.

30. I am satisfied that Mr Howroyd's bowel was perforated during the colonoscopy procedure undertaken by Dr Thornton on 7 August 2008 and that the perforation accounts for the free intraperitoneal gas seen on the CT scans taken at MIA Frankston Private the following day and the xrays taken in the Frankston ED later that night. While the possibility that the bowel perforation caused some infection cannot be excluded, there is insufficient evidence to support a coronial finding that this caused or even contributed to Mr Howroyd's death. I note in this regard that bowel perforation is a known risk of colonoscopy and Dr Thornton's complication rates are in line with the accepted complication rate for this procedure.[35]

31. I find that the evidence does support a finding that Mr Howroyd died from "complications of bowel surgery", as an appropriate description for the laparotomy undertaken on 9 August 2008, to identify and redress the bowel perforation and the right hemicolectomy to remove the bowel carcinoma identified during colonoscopy. I further find that the complications involved a clinical deterioration on the fourth post-operative day involving a chest infection and rapid deterioration thereafter to sepsis and multi-organ failure, consistent with but not necessarily indicative of, an overwhelming post splenectomy infection.[36]

THE SIGNIFICANCE OF DELAY

32. It follows from my findings above, that any delay experienced by Mr Howroyd and his family in accessing medical treatment cannot be said to have caused or contributed to his death. That is not tantamount to finding that Mr Howroyd's access to medical treatment was optimal - far from it. There are a number of areas of concern which highlight scope for improvement to public health and safety.

33. Mr Howroyd's futile presentation at Franskton ED on 7 August 2008 provides a snapshot of a public health system in crisis. Ms Gray recognised that the waiting room was full and the ED very busy. I accept that she explained that her father had a colonoscopy that day, was in a lot of pain and a bowel perforation was suspected. Mr Howroyd's name was taken down on a piece of paper, and nothing else done for him. There was nowhere for him to lie down and he was forced to sit on a chair in pain. Not surprisingly, they left after about an hour and a half, but not before Ms Gray approached the desk and advised staff they were leaving.[37]

Anderson v Blashki [1993] 2 VR 89 at 95
Secretary to the Department of Health & Community Services v Gurvich ;1995] 2 VR 69 at 73-74

35 Exhibit "G".

36 This change to the cause of death will be notified to the Registrar of Births, Deaths and Marriages.

37 Exhibit "A" and transcript page 13 and following.

34. And yet, the hospital had no record of his presentation at all.[38] Having ascertained that the computer system was working at the time, Dr Goh, Clinical Director of Emergency Medicine, could only point to how busy the ED was at the time when Mr Howroyd was there by way of explanation.[39] Ms Shamala Jones, Operations Director of Frankston ED, provided statistical evidence indicating that Frankston ED was one of the busiest emergency departments in the State, not only in terms of absolute number of presentations, but also their acuity. She also provided details about the number of presentations and their relative acuity on 7 and 8 August 2008.[40] Accepting that the ED was busy, even very busy, it is wholly unacceptable that a patient with Mr Howroyd's known presenting complaint was not triaged within 90 minutes of arrival, and that his presentation was not even recorded. The practice of writing patient's names on a piece of paper pre-triage, and only entering their details on the computer once triaged, is obviously fraught and has been proscribed.[41]

35. Not so much a matter of delay but more a missed opportunity, was the flow of patient information at MIA. Dr Sher provided an insight into how a fuller clinical picture would have changed the way he dealt with Mr Howroyd and might have allowed a more seamless delivery of health care across the private and public health systems. If he knew of the colonoscopy the day before and the suspected bowel perforation, he would not have used contrast, he would have conducted a non-contrast CT scan immediately, kept Mr Howroyd on the table, and reviewed the images on the CT scan console. Upon confirmation of the presence of free gas, he would have called an ambulance, immediately dictated a report to accompany Mr Howroyd to hospital and alerted Dr Thornton that his patient was en route to hospital.[42] I stress that I make no adverse finding against Dr Sher and intend no criticism of him at all.

37. The decision to attend a scheduled appointment with MIA around midday 8 August 2008, despite Dr Thornton's advice that they should call an ambulance and go the Frankston ED, was as ill-advised as it was understandable. It is not surprising that a patient who had waited for 90 minutes without even being triaged the night before, would be reluctant to return, particularly as he felt a little better, and that Ms Gray would want to go back armed with some hard evidence by way of CT scans. However, the resultant delay in re-presenting to Frankston ED was of the order of six hours, and could have been critical in different circumstances. Having heard evidence from both Dr Thornton and Ms Gray about the telephone discussion on the morning of 8 August 2008, and recognising that Ms Gray was a stalwart and tireless advocate for her father, I find it unlikely that she would have disregarded Dr Thornton's advice if he had clearly conveyed the potential urgency of the situation. In such circumstances the responsibility for good communication rests with the health professional.

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38 Exhibit "J" and transcript page 126.

39 "...we have been able to establish that at the time ... the ED had 55 patients in the department, there were 4 ambulances waiting to have their patients triaged and 13 patients were waiting to be see after being triaged. The hospital went on bypass at 21:10 and again at 23:55 ... Triage can take 10-15 minutes for each person; it may take more than an hour to reach the top of the queue ... On this evening it may have taken over 90 minutes for all 13 patients to be triaged by the triage nurse." Exhibit "J".

40 Exhibit "I" and transcript page 95 and following.

41 transcript page 98.

42 Exhibit "J" and transcript page 68.

COMMENTS:

Pursuant to section 67(3) of the **Coroners Act 2008**, I make the following comment(s) connected with the death (including any notification to the Director of Public Prosecutions under Section 69(2) of that Act):

1. I was provided with detailed evidence of changes made since, but not necessarily as a direct consequence of Mr Howroyd's death, aimed at improving processes and waiting times in Frankston ED.[43] Those most pertinent to this enquiry are -

1.1 The introduction of a ward clerk co-located with the triage nurse who is required to register any presenting patients not triaged within ten minutes of arrival.

1.2 The introduction of a Waiting Room Nurse available 24 hours per day, to monitor patients awaiting triage and to escalate in the event of any deterioration in their condition, such nurse not to be deployed to any other part of the hospital.

1.3 Increased staffing with two triage nurses working during the day and afternoon shifts, and a night duty clinical support nurse who can help in triage or any other part of the ED when required.

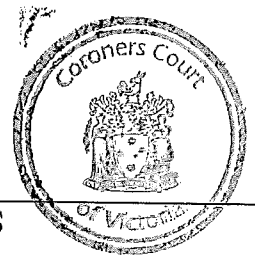
1.4 Changes to the physical environment so that patients awaiting triage are within the direct line of sight of the triage nurse

2. These, and the other changes about which I was advised, should improve access to the public health system via Frankston ED and, had they been in place on 7-8 August 2008, should have facilitated Mr Howroyd's access to treatment.

DISTRIBUTION OF FINDING

The Howroyd family
Dr David Badov, Medical Director, Bayside Day Procedure & Specialist Centre
Dr Aaron Thornton c/o Direct Endoscopy, Bayside Day Procedure & Specialist Centre
Mr Guy Bednarz, Practice Group Manager, MIA Victoria
Dr Basil Sher c/o MIA Frankston Private Radiology
Peninsula Health

Signature:



Paresa Antoniadis SPANOS
Coroner
Date: 31st August, 2011

43 Exhibit "I" and sixteen attachments and transcript pages 98 and following.