IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: 4508/07

FINDING INTO DEATH WITH INQUEST[1]

Form 37 Rule 60(1)
Section 67 of the ***Coroners Act 2008***

Inquest into the Death of DAVID CRISFIELD

Hearing Dates:	3-4 December 2009
Appearances:	Leading Senior Constable G. McFarlane, SCAU[2] - Assisting the Coroner Ms F. M. Ellis of Counsel - on behalf of Dr Gyi Mr A. N. Murdoch of Counsel- on behalf of Kyabram & District Health Service Dr S. L. Keeling of Counsel - on behalf of Dr Young
Findings of:	AUDREY JAMIESON, Coroner
Delivered On:	6 February 2012
Delivered At:	Coroners Court of Victoria Level 11 222 Exhibition Street Melbourne

[1]The Finding does not purport to refer to all aspects of the evidence obtained in the course of the Investigation. The material relied upon included statements and documents tendered in evidence together with the Transcript of proceedings and submissions of legal representatives/Counsel. The absence of reference to any particular aspect of the evidence, either obtained through a witness or tendered in evidence does not infer that it has not been considered.

[2] SCAU = State Coroners Assistant Unit (now Police Coronial Support Unit (PCSU))

I, AUDREY JAMIESON, Coroner having investigated the death of DAVID CRISFIELD

AND having held an inquest in relation to this death on 3 & 4 December 2009

at Shepparton

find that the identity of the deceased was DAVID REGINALD CRISFIELD

born on 3 December 1963

and the death occurred on 7 November 2007

at Goulburn Valley Health Service, Graham Street, Shepparton, Victoria 3630

from:

1a. SEPTIC SHOCK
1b. STREPTOCOCCUS PNEUMONIAE SEPSIS
1c. STREPTOCOCCUS PNEUMONIAE PNEUMONIA
2. IMMUNOSUPPRESIVE THERAPY FOR CROHNS DISEASE, CIGARETTE SMOKER

in the following summary of circumstances:

1. Mr David Reginald Crisfield died in the Goulburn Valley Health Emergency Department (ED) after being transported by ambulance from his home in Kyabram. He had presented at Kyabram District Health Services Accident & Emergency Department on the previous day, 6 November 2007, with complaints of a compromised respiratory state and was sent home. On the day of his death, 7 November 2007, he was seen at Kyabram Regional Clinic and permitted to return to his home to make his own arrangements to attend hospital in Shepparton after his general practitioner was unable to secure his admission at the local health service, Kyabram Hospital.

BACKGROUND CIRCUMSTANCES:

2. Mr David Reginald Crisfield lived at 1/8 Oswald Street, Kyabram. He was 43 years of age at the time of his death. He had married twice and had a son, Tyrone, born 14 April 1999, with his second wife, Theresa Scerri. The couple had been separated for approximately 5 years.

3. Mr Crisfield had a medical history which included Crohn's disease treated with immunosuppressive therapy, oesophagitis, Non Insulin Dependent Diabetes Mellitus and chronic obstructive pulmonary disease (COPD). He was a heavy drinker of alcohol and smoked approximately 2 packets of cigarettes per day. Mr Crisfield received ongoing treatment for his Crohn's Disease from St Vincent's Hospital in Melbourne and he regularly attended the Kyabram Regional Clinic (the Clinic) for treatment of aliments related to his COPD.

4. Kyabram & District Health Services[3] (Kyabram Hospital) is a small rural hospital without a full-time doctor. It is serviced by a visiting local medical officer. It is not gazetted/funded for an Accident & Emergency (A&E) Department and the attending medical officer, but it does maintain an equivalent area where people attending for emergency treatment are assessed by nursing staff on ward duty. A triage system/policy was developed in conjunction with the doctors and nursing staff[4] where patients are rated 1 to 5 with 5 being the least urgent. Patients that fall into Categories 1 & 2 are all seen by the

[3] At the time of the Inquest, the Services' website indicated that it was comprised of 39 acute hospital beds, a 42 bed Aged Care Residence and provided a range of services to the community including Diagnostic, Accident & Emergency, Primary Health, District Nursing and Community & Allied Health. It employed 264 staff and had many volunteers assisting in a broad range of roles.

[4] Transcript (T) @ p56

doctor who is on call. A doctor is consulted on the telephone for a Category 3 patient and the doctor may attend the hospital to review the patient at their discretion. Patients triaged as Category 4 or 5 are seen only by nursing staff and referred to the general practitioner's clinic during normal hours.

SURROUNDING CIRCUMSTANCES:

5. On 6 November 2007, at approximately 7:45pm, Mr Crisfield presented at the Kyabram Hospital A&E with a history of a persistent cough that was distressing him[5] and had worsened over the past few days. In addition, he complained of being unable to take a deep breath.[6] He also complained of excessive sweating and of a general ache in the chest and back. Registered Nurse (RN) in Division 1 (Div 1), Alexia Kell attended to Mr Crisfield's vital signs recording his blood pressure at 94/58, pulse at 98 beats per minute (bpm), temperature at 36.4°C and respirations at 28 breaths per minute. His oxygen saturation levels obtained with the use of a pulse oximeter, ranged between 88-92% on room air. RN Kell handed over to the in-charge nurse, RN Div 1 Bev Bird and left the A&E soon after. Dr Robert Young was present in the A&E attending to another patient with RN Bird. As Dr Young and RN Bird returned to the nurses station/desk area, Dr Young saw Mr Crisfield within the A&E, about 10 feet away,[7] from across the other side of the desk. He reviewed Mr Crisfield's recorded observations and without physically examining him, formed the opinion that his presenting history of symptoms,[8] appearance and oxygen saturation levels were consistent with his COPD. Dr Young considered that Mr Crisfield's presentation more appropriately fell into triage Category 5 and declined to see him. RN Bird subsequently reviewed Mr Crisfield's oxygen saturation, recording the same to be 83%. She administered oxygen at 6 litres per minute (lpm) via a mask and triaged Category 3.[9] Observations taken at 9:15pm by RN Div 2 Sharon Matthews, who had been called into the hospital to assist, indicated a rise in oxygen saturation to 90%, blood pressure 90/57 and pulse 90bpm. At 9:30pm, Mr Crisfield was discharged from A&E and advised to see his general practitioner the following day.

6. On 7 November 2007, at approximately 12:00pm, Mr Crisfield presented to the Clinic with a history of cough of about 1 week duration, shortness of breath with a respiratory rate of 32 breaths per minute and wheezing. He was seen by Dr Aung Gyi who found Mr Crisfield's oxygen saturation to be 83-84% on room air and on auscultation, found that he had basal crepitations to both lungs. Dr Gyi assessed Mr Crisfield's condition as serious[10], requiring admission to hospital for treatment of infective exacerbation of his COPD and probable pneumonia in the left lower lobe. He treated Mr Crisfield with 4 puffs of Ventolin CFC Free 100mcg/dose inhaler with spacer. Dr Gyi planned to have Mr Crisfield admitted to Kyabram Hospital, which was situated next door to the Clinic, and arrange for him to have a Chest X-ray, blood work-up and treatment with follow-up with his regular GP. When Dr Gyi contacted the nursing sister in-charge at the hospital to arrange Mr Crisfield's admission, he was advised that there were no beds available. Consequently, Dr Gyi advised Mr Crisfield that he would need to immediately be transferred to Goulburn Valley Health (GVH) hospital in Shepparton for assessment and probable admission. However, due to previous experiences at GVH, Mr Crisfield told Dr Gyi that he would prefer to go home. He reported improvement in his symptoms since the delivery of Ventolin and on reassessment by Dr Gyi, Mr Crisfield had clinically improved including a rise in his oxygen saturation to 94% on room air. At Mr Crisfield's insistence and with a degree of negotiation,[11] Dr Gyi prescribed a Ventolin inhaler and the antibiotic Rulide on the undertaking that Mr Crisfield would return home in the

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[5] T @ p91 (Alexia Kell)

[6] Exhibit 5 - Statement of Alexia Kell

[7] Exhibit 12 - Statement of Dr John Young & T @ p 125 (Dr John Young)

[8] T @ p127 (Dr John Young)

[9] Exhibit 3 - Statement of Maxine Brockfield, & T @ p65

[10] T @ p99 (Dr Aung Gyi)

[11] Exhibit 7 - Statement of Dr Aung Gyi & T @ p110

first instance, take the prescribed medication and if he had not improved within 30 minutes he would make arrangements and advise relatives and friends that he was going to hospital and that he would contact an ambulance to take him to GVH. Mr Crisfield left Kyabram Regional Clinic at approximately 12:33pm. Dr Gyi advised Mr Crisfield that he would prepare a letter of referral to the Admitting Officer at GVH, Shepparton. On his way home, Mr Crisfield arranged for his father, Robert, to collect his medications and the letter of referral.[12]

7. At approximately 2:30pm Robert Crisfield arrived at his son's unit with the letter of referral which he had collected from the Clinic.[13] Mr Crisfield was on the telephone to the ambulance service. Paramedics arrived a short time later and found Mr Crisfield to be cyanosed and capable of speaking in short phrases only. His skin was cold and moist. His heart rate was 140 bpm. Mr Crisfield was transported to GVH, arriving at approximately 3:11pm.

8. In the Emergency Department at GVH, Mr Crisfield was noted to be cyanosed, tachycardic and hypotensive. Blood examination indicated severe metabolic acidosis, hypoglycaemia and renal failure. He underwent an urgent CT scan of the chest which revealed complete consolidation of the left lobe of his lung and multiple areas of consolidation throughout the other lobes. He was placed on BIPAP ventilation support. At approximately 3:40pm, Mr Crisfield suffered a cardiac arrest. He was resuscitated but suffered a second arrest at approximately 5:00pm from which he could not be revived. Mr Crisfield was declared deceased at 6:46pm. His death was reported to the Coroner.

JURISDICTION:

9. At the time of Mr Crisfield's death, the *Coroners Act 1985* (the Old Act) applied. From 1 November 2009, the *Coroners Act 2008* (the new Act) has applied to the finalisation of investigations into deaths that occurred prior to the new Act commencement.[14]

10. In the preamble to the new Act, the role of the coronial system in Victoria is stated to involve the independent investigation of deaths for the purpose of finding the causes of those deaths and to contribute to the reduction of the number of preventable deaths and the promotion of public health and safety and the administration of justice. Reference to preventable deaths and public health and safety are referred to in other sections of the Act.[15]

11. Section 67 of the new Act describes the ambit of the coroner's findings in relation to a death investigation. A coroner is required to find, if possible, the identity of the deceased, the cause of death and, in some cases, the circumstances in which the death occurred.[16] The 'cause of death' generally relates to the *medical cause of death* and the 'circumstances' relates to the *context* in which the death occurred.

12. A coroner may also comment on any matter connected with the death, including matters relating to public health and safety and the administration of justice.[17] A coroner may also report to the Attorney-General and may make recommendations to any Minister, public statutory authority or entity, on any matter connected with a death which the coroner has investigated including recommendations

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[12] Exhibit 10

[13] Statement of Robert Henry Crisfield - Inquest Brief pp8-12

[14] Section 119 and Schedule 1 - Coroners Act 2008

[15] See for example, sections 67(3) & 72 (1) & (2)

[16] Section 67(1)

[17] Section 67(3)

relating to public health and safety or the administration of justice.[18]

INVESTIGATIONS:

13. The identity of David Reginald Crisfield was not in dispute and required no additional investigation.

The medical investigation:

14. Mr Crisfield's body was not transferred to the Victorian Institute of Forensic Medicine (VIFM) for post mortem examination. An autopsy was not performed. A death certificate was issued by the hospital at the time of Mr Crisfield's death. The cause of death was attributed to:

1(a) Overwhelming chest sepsis - 1 week minimum
1(b) Immunosuppression secondary to medications - years
1(c) Chronic smoker
1(d) Crohns - years
2 Alcoholic liver disease

15. Blood cultures taken on the day of Mr Crisfield's death grew streptococcus pneumoniae in both aerobic and anaerobic culture.

16. Dr Angela Sungaila, Forensic Physician with VIFM reviewed Mr Crisfield's medical records from Goulburn Valley Hospital, Kyabram Regional Clinic, Kyabram Hospital and St Vincent's Hospital and reported to the coroner that a reasonable cause of death in the circumstances could be attributed to:

1(a) Septic Shock
1(b) Streptococcus pneumoniae sepsis
1(c) Streptococcus pneumoniae pneumonia
2 Immunosuppressive therapy for Crohn's Disease, Cigarette smoker

17. Mr Crisfield's death was subsequently registered, as per Dr Sungaila's formulation, with the Registrar of Births Deaths & Marriages.

18. The Clinical Liaison Service (CLS)[19] was requested to review the medical management of Mr Crisfield on behalf of the Coroner. Statements were sought and obtained from a number of health professionals involved in Mr Crisfield's care. The investigation into the circumstances surrounding Mr Crisfield's death identified issues related to:

- the functionality of Kyabram Health Services Accident & Emergency Department
- the application of triage to Mr Crisfield and whether his significant medical history was taken into consideration.
- Dr Young's decision not to see Mr Crisfield in the Kyabram A&E.

[18] Section 72(1) & (2)

[19] The role of the CLS was to assist the Coroner's investigation into the nature and extent of deaths, which occurred during the provision of healthcare, and identify potential system factors in healthcare related deaths. CLS personnel were comprised of practising Physicians and Clinical Research Nurses who drew on their medical, nursing and research experiences, skills and knowledge to independently evaluate clinical evidence for the investigation of reportable and reported healthcare deaths and to assist in identifying remediable factors that may assist in prevention and risk management in health services settings. The CLS was replaced with the Health and Medical Investigation Team (HMIT) in 2010. HMIT sits within the Coroners Prevention Unit, which was established in 2008 to strengthen the prevention role of the coroner. The unit assists the coroner in relation to the formulation of prevention recommendations, as well as assisting in monitoring and evaluating the effectiveness of the recommendations.

- Whether nursing staff can/should escalate concerns about an attending medical officer.

19. An Inquest was held pursuant to section 17(2)[20] of the old Act.

INQUEST:

Viva voce evidence was obtained from the following witnesses:

- Beverley BIRD, Registered Nurse Division 1, Kyabram & District Health Service
- Maxine BROCKFIELD, Director of Clinical Services, Kyabram & District Health Service
- Dr Craig WINTER, Director of Medical Services, Kyabram & District Health Services
- Alexia KELL, Registered Nurse Division 1 (Associate Charge Nurse), Kyabram & District Health Services
- Sharon MATTHEWS, Registered Nurse Division 2, Kyabram & District Health Service
- Dr Aung GYI
- Dr John YOUNG

FINDINGS, COMMENTS & RECOMMENDATIONS:

Mr Crisfield's presentation to A&E on 6 November 2007

20. RN Beverley Bird has 39 years experience as a nurse. She was rostered as the Grade 5 - Kyabram Hospital supervisor and person responsible for the A&E presentations on the afternoon of 6 November 2007. She took on the role as the Grade 5 reluctantly as she found it generally stressful added to by her experience that *most of the doctors are reluctant to come in and see patients unless they are triaged 1 or 2.*[21]

21. RN Bird recalled the day as an extremely busy day - it was the Melbourne Cup public holiday and the hospital had 35 of its 39 beds full. There were 6 other staff members on duty which included two (2) Div 1 nurses, two (2) Div 2 nurses, one (1) Graduate Nurse and one (1) Midwife. There were 14 presentations, 4 ambulance presentations and 4 admissions. Mr Crisfield was brought into the A&E by RN Div 1 Alexia Kell and seated in front of the desk because there were no cubicles available at the time. RN Bird first noticed Mr Crisfield as she came out of Cubicle 1 where she had been assisting Dr Young. She was immediately concerned about his colour which she described as *quite florid.*[22] Dr Young also noticed Mr Crisfield at the same time, pointing at him from behind the desk and according to RN Bird, stated that he would not see Mr Crisfield because he had seen him before and he was a heavy smoker and drinker and non-compliant. Nevertheless, RN Bird placed Mr Crisfield in a cubicle when one became available, took his observations and oxygen saturation level and in response to the low level (83%)[23], sat him upright and administered oxygen by mask at 6 lpm. RN Bird stated that she

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[20] s17. **Jurisdiction of coroner to hold inquest into a death**

(1) A coroner who has jurisdiction to investigate a death must hold an inquest if the body is in Victoria or it appears to the coroner that the death, or the cause of death, occurred in Victoria and-

(a) the coroner suspects homicide; or

(b) the deceased was immediately before death a person held in care; or

(c) the identity of the deceased is not known; or

(d) the death occurred in prescribed circumstances; or

(e) the Attorney-General directs; or

(f) the State Coroner directs.

(2) A coroner who has jurisdiction to investigate a death may hold an inquest if the coroner believes it is desirable.

[21] Exhibit 1

[22] Exhibit 1 & Transcript (T) @ p10

[23] T @ p13, 14, 24

would have triaged Mr Crisfield as Category 3 but was influenced by Dr Young having seen Mr Crisfield from behind the desk[24] and his comments about Mr Crisfield, and instead triaged him as a Category 4. She did not telephone Dr Young with this reading of 83% due *to past abuse over ringing over* triage matters at the hospital. She did not take a thorough history from Mr Crisfield other than that he had a cough and was having difficulty breathing.[25] RN Bird subsequently called in another staff member, RN Div 2 Sharon Matthews to assist with the volume of work being experienced at the hospital that evening. She gave a brief handover of Mr Crisfield to RN Matthews including mentioning Dr Young's comments,[26] and did not see Mr Crisfield again before his discharge. RN Bird worked one hour beyond her rostered shift, which concluded at 10:00pm, in order to complete her paperwork.

22. I found RN Bird to be an honest and consistent witness. Minor inconsistencies identified by Dr Keeling in cross examination were no more than that and did not detract from the overall impression that the shift she worked on 6 November 2007, was clearly imprinted in her memory. Her reluctance upgrading into the position of Grade 5, in charge of the hospital, in part arises from the infrequency of her need to step into the role which she stated occurred approximately once every 6 months to cover for somebody else for example, to cover for someone on sick leave[27] and because she predominately worked as a Midwife. In addition, she had no specific training in the application of the triage system. The influence that Dr Young exerted on RN Bird's decision making, whether real or perceived, was palpable.[28]

23. Dr John Young was one of the doctors at Kyabram Regional Clinic who had treated Mr Crisfield for multiple medical conditions over the years. He had seen Mr Crisfield on eleven occasions at the Clinic between 18 October 2006 and 28 August 2007 for a range of complaints requiring investigations, prescriptions and referrals for specialist opinions. Dr Young was familiar with this patient and recalled his usual facial colour to be *plethoric and quite red.*[29] His recollection of the evening of 6 November 2007, was *somewhat blurred* but he did recall having seen Mr Crisfield and remembers seeing his observations which had placed in front of him.[30] His clinical judgement that Mr Crisfield was fit to be seen in the Clinic the following day was based on these two factors plus his *knowledge of his health as his doctor.*[31] Dr Young accepted the recorded oxygen saturation levels of 88-92% as being within a normal range for a person with COPD however he conceded that he had never taken Mr Crisfield's oxygen saturation level in the Clinic and as such had no baseline specific to Mr Crisfield[32] - the assumption was a generalised or *educated*[33] assumption. The diagnoses of COPD was itself never transcribed into Mr Crisfield's medical record at the Clinic but one based on his long standing respiratory problems/presentations.[34]

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[24] Exhibit 1 & T @ p14

[25] T @ p24

[26] T @ p15

[27] T @ p52

[28] T @ pp40-41

[29] T @ p144 (Dr JohnYoung)

[30] T @ p144 (Dr John Young)

[31] T @ p145 (Dr John Young)

[32] T @ p154 (Dr John Young)

[33] T @ p154 & 160 (Dr John Young)

[34] T @ pp154-155 (Dr John Young)

24. Of significance to this inquiry is whether the outcome would have been different for Mr Crisfield if he had been assessed and admitted on the evening of 6 November 2007, when he presented himself to Kyabram Hospital. Dr Young was clearly irritated on that evening. He was irritated about the reason(s) for seeing a staff member in the A&E and this is reflected in his statements and *viva voce* evidence and in RN Bird's evidence of her interpretation of his comments and orders. His jaded approach may in part be explained by factors including his view that Mr Crisfield had had ample opportunity in the previous few days to present to the Clinic in normal working hours and his frustrations *per se* about the work load for doctors working in rural Victoria. However, **I find** Dr Young's clinical judgement not to examine Mr Crisfield on the night was fraught. He made a number of cursory assumptions about Mr Crisfield and the observations of others such that he left me with the impression that it was unlikely that he could have provided a thorough and objective assessment on that evening even if he had proceeded to perform an examination. I was not convinced that even if Dr Young had examined Mr Crisfield that it would have led to his admission and the implementation of treatment in the form of antibiotics. What is known is that Dr Young did not examine Mr Crisfield, he was not admitted and he did not receive the administration of antibiotics which I have heard would have commenced to have an immediate effect. Nevertheless, I am unable to find to the requisite standard, that admission and treatment with antibiotics on that evening would have prevented Mr Crisfield's death on the following day. I do however, **find** that a significant opportunity was lost on 6 November 2007. A significant opportunity for a possible earlier diagnosis and for timely and appropriate medical intervention and the implementation of a treatment. An opportunity lost with consequences including the prolongation of Mr Crisfield's compromised respiratory state and necessitating the involvement of a number of health professionals in the delivery of emergency care.

AND I further **find** that this opportunity lost was at the behest of Dr Young only and not related in any way to the application of triage in the hospital's A&E.

I find that Dr Young made an error of judgement on that evening.

The triage system at Kyabram Hospital

25. Dr Craig Winter stated that the triage system was fundamentally put in place for nurses to know when to call a doctor or not.[35] The triage category of Mr Crisfield was not really relevant

> *...because the medical practitioner who knows the patient well, can make a judgement at the time based on their experience with the patient and that really means that the triage process has been bypassed and the decision about what to do with the patient has been made at that time.*[36]

> *And I think that's probably one of the reasons why the nurse involved became a little confused about what triage number to give, because you don't triage with a doctor standing with you.*[37]

26. Dr Winter acknowledged that when triaging it was important to be aware of underlying conditions and any nurses involved in triaging should be provided with training.[38] He also agreed that it was likely that Mr Crisfield's pneumonia was already in existence on 6 November 2007, when he

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35 T @ p82 (Dr Craig Winter)

36 T @ p68 , 82-83 (Dr Craig Winter)

37 T @ p82 (Dr CraigWinter)

38 T @ p71 (Dr Craig Winter)

presented to Kyabram Hospital A&E[39]

27. The introduction of the triage system at Kyabram Hospital approximately 5 years earlier was with the aim of reducing the burden or evenly sharing of the after hours work on the individual doctors in the area. Retaining doctors in regional Victoria has been a long term problem for the State. According to Dr Winter, the benefit for nursing staff is that the triage system increases their competencies.[40] Overall, Dr Winter felt that it was an improvement on the delivery of services to the community and the doctors and nurses were happy with it. He said that the triage system had been introduced in many rural communities in Victoria and *anecdotally at Kyabram it has significantly reduced the conflict between the expectations of the medical staff and the expectations of the nursing staff in dealing with the patients that present.*[41]

28. Dr Gyi agreed that the system had relieved the burden on the local general practitioners receiving out-of-hours calls to attend to patients. He estimated that he was required to do the on-call duty doctor work once per week, that the system helped in enabling the doctors to manage their own lives and agreed that it played a role in servicing the community's medical needs. Dr Gyi also spoke highly of the nursing staff at Kyabram Health Services and of the organisation's culture.[42]

29. **I accept** the evidence and opinion of Dr Winter that the management of Mr Crisfield at Kyabram Hospital on 6 November 2007, was not influenced by the triage process. Dr Winter defended the triage process at Kyabram, describing it as being very good and he emphasised on a number of occasions, that it did not need to be applied to Mr Crisfield because the medical practitioner was present in the A&E at the time. Medical management decisions thus rested with that practitioner, Dr Young, and were not based on the knowledge or application of the triage process by nursing staff. Mr Crisfield's processing through the A&E was determined by and driven by Dr Young.

Conflict between health professionals

30, Dr Winter stated that although there had been a reduction to conflict it had nevertheless not been eradicated. Dr Winter considered that Kyabram Health Services had a number of mechanisms in place to deal with concerns, such as expressed by RN Bird. But finding a solution/managing personality factors in conflict situations when the Kyabram Health Services relied solely on the medical services of one practice, with one group of doctors, was a great challenge.[43]

31. At the time, RN Bird was not aware of her ability to escalate any concerns and/or disagreements with the visiting medical officer.[44] There was however no specific policy in place at the time but an *understanding* that nursing staff could contact either the Director of Clinical Services or the CEO.[45] RN Bird did not become aware of Mr Crisfield's death until in/or around August 2008. At some later date, she made a request to her employer for a review of the circumstances surrounding Mr Crisfield's attendance at the hospital on the evening of 6 November 2007, but this did not occur.

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[39] T @ p72 (Dr Craig Winter)

[40] T @ p74 (Dr Craig Winter)

[41] T @ p75 (Dr Craig Winter)

[42] T @ pp115-116 (Dr Aung Gyi)

[43] T @ pp78-79 (Dr Craig Winter)

[44] T @ p15

[45] T @ pp59-60 (Maxine Brockfield)

Mr Crisfield's presentation on 7 November 2007

32. **I find** that Dr Gyi's examination of Mr Crisfield at the Clinic on 7 November 2007, was thorough and appropriate. He was unaware that Mr Crisfield had been at Kyabram Hospital the previous evening.[46] Following auscultation of Mr Crisfield's lungs and on obtaining an oxygen saturation of 83% Dr Gyi treated Mr Crisfield immediately, referring to the National Prescribing Service Prescribing Practice Review on interventions for COPD,[47] as a guide. He considered Mr Crisfield's condition serious and attempted to admit him immediately to the local hospital. This was Dr Gyi's preferred course of action and one that Mr Crisfield was apparently agreeable to but in the absence of an available bed and Mr Crisfield's reluctance to go to GVH, Dr Gyi negotiated a plan with his patient that he felt Mr Crisfield would adhere to. Dr Gyi permitted him to return home in the first instance to accommodate Mr Crisfield's reluctance, not because he considered that Mr Crisfield would improve.[48] Dr Gyi did believe that Mr Crisfield would follow the agreed plan. He did not believe that Mr Crisfield would improve and because of his past experience in treating Mr Crisfield he had the confidence to accept his undertaking. With the plan in place, it was not unreasonable for Dr Gyi to allow Mr Crisfield the flexibility to advise his family of his impending admission and to obtain and administer further Ventolin if necessary. Dr Gyi wrote a comprehensive referral letter to the Admitting Officer at GVH which confirmed that an appropriate physical examination had been performed and although there was inconsistency between the statement of Mr Robert Crisfield and the evidence of Dr Gyi as to whom the referral letter was given, **I find** that Mr Crisfield had it in his possession at the time he was transported by ambulance to GVH. In the absence of hearing from Mr Robert Crisfield I am unable to reconcile this inconsistency but attach little weight to it in my overall findings related to Dr Gyi's management of Mr Crisfield. Dr Gyi was a credible and compelling witness.

33. I commend Dr Gyi's acknowledgment that with the benefit of hindsight, he should have insisted that Mr Crisfield be transferred to GVH immediately[49] however, compulsion of a patient who is competent is generally considered an approach to the provision of health care from days past which has been replaced by inclusion and consent and I accept that it was the latter Dr Gyi was seeking to achieve in the overall management plan. Of equal significance in assessing whether Dr Gyi should have secured Mr Crisfield's transfer to GVH at the time Mr Crisfield was with him, is whether immediate transfer would have made any difference to the outcome. Mr Crisfield was in a perilous state when the Ambulance arrived at his home and more so on arrival at GVH.

34. Dr John Stanton, whose expert opinion report was accepted into evidence by the parties without question, considered that the treatment provided by Dr Gyi *to be of a high standard* and in particular, that:

> *The delay of two hours in Mr David Crisfield reaching hospital probably made little difference. He was a very sick man with severe pneumonia. If intravenous antibiotics had been commenced two hours earlier, it is unlikely that it would have altered the outcome.*[50]

CONCLUDING COMMENTS & FINDINGS:

35. The functionality of Kyabram Health Services A&E and the application of the triage system are inter-related and addressed within the body of the Finding. The taking of a past and immediate medical history could indeed be relevant to the management of patients presenting illnesses however, apart from

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[46] T @ p 113 (Dr Aung Gyi)

[47] Exhibit 8 and T @ p111 (Dr Aung Gyi)

[48] T @ p113 (Dr Aung Gyi)

[49] T @ p 114 (Dr Aung Gyi)

[50] Report of Dr John Stanton dated 14 November 2009 - Exhibit 13 - Balance of Inquest Brief

agreeing that it is good practice to take a past history, I make no further comment or findings about the lack of a history taken from Mr Crisfield on 6 November 2007, as I have accepted and found that the triage system was bypassed by the presence of Dr Young who was very familiar with Mr Crisfield's medical history. The triage policy appears on the face of it, to be a considered and workable document for a rural community hospital and I accept that its implementation has improved the working conditions for doctors in the community and improved the delivery of services to the people of that community.

AND I make no adverse comment against RN Bird for not contacting Dr Young with an oxygen saturation result of 83%, taken at a time subsequent to Dr Young's assessment of Mr Crisfield's health. His opinion about spurious oximeter readings would have, in all probability, not affected his original assessment and orders to nursing staff.

AND in respect to the issue that arose about who authorised Mr Crisfield's discharge, I rely on the contemporaneous entry by RN Bird in the Progress Notes that states that Mr Crisfield was discharged at 21:30. It is understandable that with the passage of time, detail about who authorised discharge is forgotten however, in the absence of a specific reference to leaving without authorisation, I do not accept that Mr Crisfield has discharged himself. His discharge was authorised and consistent with the orders of Dr Young.

36. Training in relation to triage was also identified as an issue to the extent that although training is available, it is not mandated for nursing staff who may only occasionally find themselves working in the A&E. Kyabram & District Health Services needs to provide support to its staff, through appropriate training, to enable individuals to *step up* as required and take on the role and responsibilities with confidence.

37. The issue initially identified about a nurse's ability to escalate concerns about a medical officer was addressed through witnesses in particular, RN Bird and Dr Winter. In so far as the issue is relevant to Mr Crisfield's death, the evidence of RN Bird supports a conclusion that the Kyabram & District Health Services needs to improve its approach to supporting nursing staff to feel empowered to escalate concerns and seek an alternative opinion about patient care in circumstances as identified through this investigation. A policy, and education to staff about its existence and application is of course, a starting point, but means little if the staff do not feel empowered enough to enforce it and the administration of the Hospital is not prepared to confront its attending medical officers when issues arise. While I accept that in such a small community with a small group of doctors servicing the Hospital it may not be workable[51] for staff to be seeking a "second opinion" from one of the other doctors, access to the Directors of Clinical and Medical Services must be a viable option.

38. As such **I recommend** that Kyabram & District Health Services review and revise its policy and procedures on the reporting and escalation of issues/concerns that nursing staff have in their dealings with attending medical officers and that the revised policy and procedure outline alternative means of addressing the particular reported issue/concern and include a process for reporting back to the staff member the action taken in response to the reported issue/concern.

39. Dr Young and in particular, all the nursing staff were working under very busy and difficult circumstances. The willingness of all these health professionals to develop a system to provide access to doctors at all times, to *act up* into positions they are not familiar or comfortable in and to come into work when the need demands, is a reflection of their commitment to the delivery of health services to their community. I accept and acknowledge that rural Victoria has and continues to experience great difficulty in obtaining and retaining adequate numbers of health professionals and I accept that Dr Young's expression of his concerns in this regard were *bona fide.*

[51] T @ p187 - submissions of Mr Murdoch

40. I accept and adopt the medical cause of death as articulated by Dr Angela Sungaila and supported by Dr James Lynch,[52] and **find** that David Crisfield died from septic shock arising from streptococcus pneumoniae sepsis arising from streptococcus pneumoniae pneumonia. Contributing to his death but not directly related to the cause, was the immunosuppressive therapy he received for the underlying condition of Crohn's disease, and his cigarette smoking.

AND save for the findings I have made in relation to a loss of opportunity to treat at an earlier stage, I am unable to make a finding on whether Mr Crisfield's death was preventable.

41. Pursuant to section 73 of the *Coroners Act* 2008, this Finding will be published on the internet.

Signature:

AUDREY JAMIESON
CORONER

Date: 6 February 2012

I direct that a copy of this finding be provided to the following:

- Ms Dianne Wilson on behalf of the family
- Director of Clinical Services, Kyabram & District Health Service
- Director of Medical Services, Kyabram & District Health Service

[52] Report dated 10 November 2009 - Exhibit 13 (remainder of Inquest Brief)