IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2009 002381

FINDING INTO DEATH WITH INQUEST

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

Inquest into the Death of: Joan COUTTS

Delivered On:	4 February 2015
Delivered At:	Coroners Court of Victoria 65 Kavanagh Street Southbank Victoria 3006
Hearing Dates:	19 November 2013
Findings of:	Coroner Paresa Antoniadis SPANOS
Representation:	Mr D. WALLIS of Counsel, instructed by Mr C Sykes of Health Legal, Lawyers, appeared on behalf of Ballarat Health Services.
Police Coronial Support Unit	Leading Senior Constable Amanda MAYBURY, assisting the Coroner

I, PARESA ANTONIADIS SPANOS, Coroner,
having investigated the death of JOAN COUTTS

and having held an inquest in relation to this death at Melbourne on 19 November 2013:

find that the identity of the deceased was JOAN COUTTS

born on 12 November 1936, aged 72

and that the death occurred on 22 April 2009

at Ballarat Base Hospital, Drummond Street North, Ballarat, Victoria 3350

from:

I (a) PNEUMONIA

I (b) FRACTURED RIBS

II CHRONIC OBSTRUCTIVE PULMONARY DISEASE

in the following circumstances:

BACKGROUND AND PERSONAL CIRCUMSTANCES[1]

1. Joan Coutts was a 72-year-old woman who lived alone in Haddon, 12km west of Ballarat. She had moved to Victoria from Western Australia a number of years before and, although she maintained regular telephone contact with her daughter-in-law in Western Australia, Ms Coutts had no close family or friends living nearby.

2. Ms Coutts had a medical history of chronic obstructive pulmonary disease [COPD],[2] high blood pressure, depression and insulin-dependent diabetic mellitus. Ms Coutts' diabetes was poorly managed and so she had a history of hypoglycaemic blackouts.[3] Ms Coutts held a drivers licence, and had been advised not to drive if her blood sugar was low.

3. On 31 March 2009, Ms Coutts commenced as a client of the Mount Eliza Personal Assistance Call Service [MEPACS]. MEPACS is an emergency response service that provides 24 hour monitoring every day of the year. Each client receives a wearable pendant with an emergency

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[1] This section is a summary of facts that were uncontentious, and provide a context for those circumstances that were contentious and will be discussed in some detail below.

[2] Chronic Obstructive Pulmonary Disease [COPD] is the name given to a group of disorders characterized by narrowing of the breathing tubes that limits (obstructs) the movement of air in and out of the lungs. Specific diseases in this group include chronic bronchitis and emphysema. In the older literature and in certain parts of the world, COPD has been called chronic obstructive lung disease [COLD] or chronic obstructive airway disease [COAD], but the term COPD is now preferred. COPD is an illness characterised worsening respiratory function and the development of additional cardio-pulmonary conditions.

[3] Ms Coutts' most recent hypoglycaemic episode – in relation to which she was transported by ambulance to BBHED – occurred on 1 April 2009.

call button and an alarm base unit that is connected to her/his home telephone line. The pendant can be used (within 50 metres of the base unit) to initiate a call to MEPACS, which in turn telephones the client to establish the reason for the call. Depending on the client's needs, MEPACS will provide assistance by telephone, contact the client's nominated emergency contact to facilitate a welfare check, or alert the emergency services. In addition, a client is required to press the button on the alarm base unit each morning (between 6am and 11am) to indicate that s/he is well and not in need of assistance.

4. Ms Coutts nominated the Ballarat District Nursing and Health Care [BDNHC] as her first point of contact for the MEPACS program given that no family member or other eligible person was available to attend her within 30 minutes of receiving a call from MEPACS. Ms Coutts' missed her daily welfare check, that is she failed to depress the button on the base unit, on about 40% of days between 31 March 2009 and 14 April 2009.[4]

MEDICAL HISTORY PROXIMATE TO DEATH

5. On or about 8 April 2009, Ms Coutts suffered a fall at home. Two days later, on the Good Friday public holiday, Ms Coutts attended the Eureka Medical and Dental Centre, which was not her usual general medical practice. When seen by Dr Eggleston, Ms Coutts complained of right sided chest pain on inspiration and on movement. Dr Eggleston referred Ms Coutts to the Emergency Department at Ballarat Base Hospital [BBHED] for a chest x-ray to confirm suspected fractured ribs. Dr Eggleston wrote a detailed letter of referral to the BBHED, noting in particular that Ms Coutts was experiencing "a lot of distress" and "severe" pain and that she was at risk of complications due to her co-morbid conditions, COPD and diabetes.[5]

6. Ms Coutts then drove herself to the BBHED (operated by Ballarat Health Services) armed with a referral letter from Dr Eggleston.

7. At 1.24pm on 10 April 2009, Ms Coutts was assessed by Triage Nurse Matthew Phillips who documented the presenting complaint as rib pain from a fall two days earlier, that was worse on inspiration/movement, with no shortness of breath.[6] Ms Coutts' history of COPD and diabetes was noted, as was the time at which she last took pain relief. Nurse Phillips also

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[4] Coronial Brief of Evidence (Statement of Dean A. Richardson).

[5] Coronial Brief of Evidence (Dr Frederick Eggleston).

[6] Whilst Nurse Phillips recorded 'Nil SOB' (Shortness Of Breath) on the computer records, the triage label affixed to Ms Coutts' admission document was incomplete (due to text space constraints) and read 'Ni'.

recorded his observations of Ms Coutts' oxygen saturation and heart rate on the triage form. On the basis of the above information, Ms Coutts was assigned to Triage Category 5, which is the least urgent category requiring assessment and treatment within 120 minutes of arrival.[7]

8. Notwithstanding the triage categorisation, BBHED Dr Edias Shumba examined Ms Coutts at 1.37pm, within about 13 minutes of triage. By 2pm, Dr Shumba had ordered a chest x-ray and provided Ms Coutts with analgesia.

9. Dr Shumba reviewed the x-ray film at approximately 3pm and diagnosed multiple right rib fractures. Having noted Ms Coutts' pain description as "9 of out 10", he prescribed diclofenac suppositories (anti-inflammatory analgesic), panadeine forte and endone for pain relief. Ms Coutts was discharged home with a plan for her to be reviewed by her usual doctor, Dr Carol Head at Ballarat Community Health Centre.[8] Dr Shumba faxed a brief letter to Ms Coutts' general practitioner about her presentation at BHHED.

10. On 14 April 2009, Ms Coutts failed to push her call button between 6am and 11am as required. In accordance with their procedure, MEPACS operators telephoned Ms Coutts' home at 11.32am, and again at 11.58am, to ascertain whether she required assistance. Ms Coutts did not respond to either call and so a MEPACS operator asked BDNHC to conduct a visual welfare check. BDNHC reported that it was unsure when a representative could attend Ms Coutts' home that day because "she lives a long way away".[9]

11. However, MEPACS call records indicate that at 12.14pm, BDNHC advised Ms Coutts had been contacted by telephone and that she was well.

12. At 4.06pm on 14 April 2009, Ms Coutts' daughter, Ms Chenery, contacted MEPACS because she had been unable to reach her mother by telephone. MEPACS informed Ms Chenery that BDNHC had spoken with Ms Coutts earlier that day.

13. MEPACS records indicated that approximately 8.20pm MEPACS was advised by Ms Chenery that Ms Coutts had fallen and that paramedics were in attendance to transport her to hospital. Ms Coutts was not wearing her pendant at the time she fell and she had been on the floor for a few hours before crawling to the phone to call her sister, who in turn called paramedics.

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[7] Australian College for Emergency Medicine, *Guidelines on the implementation of the Australasian Triage Scale in emergency department* (November 2013) 7.

[8] Coronial Brief of Evidence, Ms Coutts' BBHED Medical Records created 10 April 2009.

[9] Coronial Brief of Evidence (Statement of Dean A. Richardson).

14. At approximately 9pm on 14 April 2009, Ms Coutts was admitted to Ballarat Base Hospital via the Emergency Department. She was diagnosed with delirium, pneumonia and exacerbated COPD. Ms Coutts' was treated in the Intensive Care Unit, and in consultation with her family, was noted to be 'Not For Resuscitation'. Her condition deteriorated and, in light of her poor prognosis, Ms Coutts' family decided that active treatments should be withdrawn. Ms Coutts died, with family in attendance, on 22 April 2009. A Medical Practitioner's Certificate as to Cause of Death, commonly referred to as a "death certificate" was provided by Dr Paul Leong of Ballarat Base Hospital.

THE DEATH CERTIFICATE

15. Ms Coutts' death was subsequently reported to the Coroner by the Registrar of Births, Deaths and Marriages (BDM), through an established process between BDM and the Coroners Court whereby a designated officer/s within BDM, report deaths that come to their attention where they apprehended a likelihood that the death should have been reported to the Coroner. In the case of Ms Coutts' death certificate, the clue was in the reference to trauma in the form of fractured ribs, associated with her death.

16. The *Coroners Act* 2008 contains an exhaustive definition of "reportable death" and includes, specifically, a death that appears to have been unexpected, unnatural or violent or to have resulted, directly or indirectly, from an accident of injury".[10]

17. Ms Coutts' death should have been reported to the coroner at the time.[11] As the death was not reported in the first instance, there was no opportunity for Mrs Coutts' body to be examined by a forensic pathologist, with or without autopsy, including CT scanning and toxicological analysis, so as to provide advice as to the medical cause of death, as is normally the case when a death is reported shortly after the death has occurred and before cremation or burial.

18. Instead, Ms Coutts' medical records were obtained and reviewed by the coroner, a pathologist and a medical clinician from the Health and Medical Investigation Team of the Coroners Prevention Unit. Forensic Pathologist Dr John Du Plessis, from the Victorian Institute of Forensic Medicine (VIFM) advised that it would be reasonable, in the absence of external

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[10] The *Coroners Act 2008,* like its predecessor the *Coroners Act 1985*, 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 in section 4 includes deaths that appear *to have been unexpected, unnatural or violent or to have resulted, directly or indirectly, from accident or injury* and the *death of a person who immediately before death was a patient within the meaning of the Mental Health Act 1986".* See section 4(2)(a).

[11] This was pursuant to the general obligation to report a death to the coroner (or the police) in section 12 of the *Coroners Act 2008 (Vic).*

examination or autopsy, to attribute Ms Coutts' death to pneumonia in the setting of multiple rib fractures and chronic obstructive pulmonary disease.

INVESTIGATION – SOURCES OF EVIDENCE

19. This finding is based on the totality of the material the product of the coronial investigation of Ms Coutts' death. That is the brief of evidence compiled by Leading Senior Constable Amanda Maybury of the Police Coronial Support Unit, the statements, reports and testimony of those witnesses who testified at inquest and any documents tendered through them, and the final submissions of Counsel. All of this material, together with the inquest transcript, will remain on the coronial file.[12] In writing this finding, I do not purport to summarise all the material and evidence, but will refer to it only in such detail as is warranted by its forensic significance and in the interests of narrative clarity.

PURPOSE OF A CORONIAL INVESTIGATION

20. The purpose of a coronial investigation of a *reportable death* is to ascertain, if possible, the identity of the deceased person, the cause of death and the circumstances in which death occurred.[13] The *cause* of death refers to the *medical* cause of death, incorporating where possible the *mode* or *mechanism* of death. For coronial purposes, the *circumstances* in which death occurred refers to the context or background and surrounding circumstances, but is confined to those circumstances sufficiently proximate and causally relevant to the death, and not merely all circumstances which might form part of a narrative culminating in death.[14]

21. The broader purpose of any coronial investigations is to contribute to the reduction of the number of preventable deaths through the findings of the investigation and the making of recommendations by coroners, generally referred to as the *prevention* role.[15] Coroners are also empowered to report to the Attorney-General in relation to a death; to comment on any matter connected with the death they have investigated, including matters of public health or safety and the administration of justice; and to make recommendations to any Minister or public

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[12] From the commencement of the *Coroners Act 2008* (the Act), that is 1 November 2009, access to documents held by the Coroners Court of Victoria is governed by section 115 of the Act.

[13] Section 67(1) of the *Coroners Act 2008*. All references which follow are to the provisions of this Act, unless otherwise stipulated.

[14] This is the effect of the authorities – see for example *Harmsworth v The State Coroner* [1989] VR 989; *Clancy* v *West* (Unreported 17/08/1994, Supreme Court of Victoria, Harper J.)

[15] The 'prevention' role is now explicitly articulated in the Preamble and purposes of the Act, cf: the *Coroners Act 1985* where this role was generally accepted as 'implicit'.

statutory authority on any matter connected with the death, including public health or safety or the administration of justice.[16] These are effectively the vehicles by which the prevention role may be advanced.[17]

22. It is important to stress that coroners are not empowered to determine the civil or criminal liability arising from the investigation of a reportable death, and are specifically prohibited from including in a finding or comment any statement that a person is, or maybe, guilty of an offence.[18]

FINDINGS AS TO UNCONTENTIOUS MATTERS

23. In relation to Ms Coutts' death, most of the matters I am required to ascertain, if possible, were uncontentious from the outset. Her identity and the date and place of death were not at issue. I find, as a matter of formality, that Joan Coutts born on 12 November 1936, aged 72, late of 22 Stephen Street, Haddon, Victoria 3351, died at Ballarat Base Hospital, Drummond Street North, Ballarat, Victoria 3350, on 22 April 2009.

24. In light of Dr du Plessis' advice, I find that Ms Coutts died of pneumonia in the setting of multiple rib fractures and chronic obstructive pulmonary disease.

FOCUS OF THE CORONIAL INVESTIGATION AND INQUEST

25. In common with many other coronial investigations, the primary focus of the coronial investigation and inquest into Ms Coutts' death was on the circumstances in which she died. Specifically, the adequacy of the clinical management and care provided by Ballarat Base Hospital on 10 April 2009. Encompassed within this broader issue are considerations of the appropriateness of the triage category attributed to Ms Coutts on arrival at BBHED and the

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[16] See sections 72(1), 67(3) and 72(2) regarding reports, comments and recommendations respectively.

[17] See also sections 73(1) and 72(5) which requires publication of coronial findings, comments and recommendations and responses respectively; section 72(3) and (4) which oblige the recipient of a coronial recommendation to respond within three months, specifying a statement of action which has or will be taken in relation to the recommendation.

[18] Section 69(1). However, a coroner may include a statement relating to a notification to the Director of Public Prosecutions *if the coroner believes an indictable offence may have been committed in connection with the death.*[18] See sections 69(2) and 49(1).

decision to discharge her home a short time later. A subsidiary issue was the adequacy of record-keeping at BBHED.

26. In the emergent health care setting, the triage process determines how quickly a patient is examined by a doctor. The triage categorisation is assigned based on the gravity of the patient's presenting complaint, relevant medical history, and assessment findings. Australasian College for Emergency Medicine Guidelines for the Implementation of the Australasian Triage Scale in Emergency Departments [ATS Guidelines][19] establish minimum standards for triage, and documentation of this process. The ATS Guidelines informed triage assessments by nurses at BBHED at the time of Ms Coutts' 10 April 2009 presentation.[20]

TRIAGE ASSESSMENT

27. Dr Mitra, Emergency Physician from the Victorian Institute of Forensic Medicine, provided an expert opinion in writing and at inquest about Ms Coutts' clinical management at BBHED.[21] Dr Mitra expressed the opinion that BBHED's triage assessment notes[22] were incomplete because they did not contain an assessment of the pain experienced by Ms Coutts.[23] Nor could the rationale for the her triage categorisation be understood by reference to the notes.[24] As such, it was Dr Mitra's opinion was that BBHED had failed to comply with the minimum standards of documentation stipulated in the ATS Guidelines[25], a view disputed by Dr Jaycen Cruickshank, Director of Emergency Medicine and an Emergency Physician at Ballarat Health Services.[26]

28. Dr Mitra noted that the ACEM Guidelines recommend that Triage Category 5 be reserved for patients with "chronic [conditions] ... with minimal pain [and] no high risk features" and that the next lowest triage category refers to patients "dead on arrival".[27] In his opinion, assigning

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[19] Above n 8.

[20] Exhibit D and Transcript page 43.

[21] Exhibit A and Transcript pages 4-28.

[22] Coronial Brief of Evidence, page 51.

[23] Transcript page 5.

[24] Transcript page 6.

[25] Exhibit A.

[26] Exhibit E.

[27] Transcript 8.

Ms Coutts to Triage Category 5 was inappropriate given her presentation with severe, "nine-out-of-ten" pain.[28] Dr Mitra would have categorised Ms Coutts to, at least, Triage Category 3.[29] I note that at inquest Dr Shumba "agreed a hundred per cent" that had Ms Coutts' 9-out-of-10 pain been identified at triage, Triage Category 5 would have been inappropriate.[30]

29. Dr Mitra noted that although Ms Coutts' triage categorisation did not appear to have affected the speed with which she was seen by a doctor, the Triage Category 5 designation may have flagged Ms Coutts as a "less sick type patient rather than a more critical [patient]"[31] and so this may have influenced the way in which she was treated.[32]

30. Dr Mitra's observations in this regard appear to be borne out by Dr Shumba's comment about BBHED culture, namely, that Triage Category 5 "may make everybody be a little bit lax or maybe not be very concerned".[33] And by the evidence of Phil Catterson, Nurse Unit Manager at BBHED, who stated that Triage Category 5 indicated that Ms Coutts' treatment required minimal intervention and that she could be seen from the waiting room.[34]

31. Although it is not clear where Ms Coutts was actually examined on 10 April 2009, Mr Catterson's evidence and the complete absence of nursing observations while Ms Coutts was at the BBHED, support a finding that it is likely she remained in a 'fast-track' area of the hospital.[35]

CLINICAL MANAGEMENT AND THE DECISION TO DISCHARGE

32. Dr Mitra did not express any concerns about Dr Shumba's assessment and diagnosis of Ms Coutts' rib fractures or his treatment plan involving analgesics. However, Dr Mitra characterised Ms Coutts' presentation on 10 April 2009 as "high risk". In his assessment, Ms Coutts was at high risk of developing complications such as pneumonia because of the number of rib fractures she sustained, her age, her co-morbid illnesses, her history of falls and

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[28] Exhibit A.

[29] Transcript page 8.

[30] Transcript page 43.

[31] Transcript page 8.

[32] Transcript page 9.

[33] Transcript page 45.

[34] Coronial Brief of Evidence (Statement of Phil Catterson).

[35] Coronial Brief of Evidence (Statement of Phil Catterson), Coronial Brief of Evidence, Ms Coutts' BBHED Medical Records created 10 April 2009 and Exhibit A.

her lack of social supports.[36] These were, in Dr Mitra's opinion, "red flags"[37] that should have been addressed by Dr Shumba either by admitting her to hospital – "in an ideal world"[38] – or through appropriate discharge planning, with multidisciplinary input and/or referral and timely follow-up in the community.[39]

33. Dr Mitra found no evidence in Ms Coutts' medical records that these 'red flags' had been identified, discussed and addressed before she was discharged home. Dr Mitra noted that the Discharge Risk Screening Tool [Discharge Tool], in Ms Coutts' medical record, part of the BBHED *proforma* paperwork, was not completed and, given her history, this was problematic.[40] Such discharge tools are designed to be a patient "safety net" by highlighting issues that suggest the patient may be at risk of complications or readmission to the discharging clinician. Dr Mitra noted that while discharge tools are "standard practice" across Australia, the frequency with which they are completed varies from hospital to hospital and they may not be completed if left solely to the medical staff.[41]

34. Dr Mitra conceded that the treating clinician is usually in the best position to assess a patient and exercise clinical judgement in relation to admission and discharge decisions.[42] However, he did not agree with the decision to discharge Ms Coutts back into the care of her general practitioner. In Dr Mitra's opinion, a general practitioner in an outpatient setting was not capable of managing the complications that were likely in Ms Coutts' case.[43] As it was inevitable that Ms Coutts would continue to experience rib pain, especially after the significant pain relief provided at BBHED had worn off, once "at home, living alone, in bed, unable to move with rib pain, it may be even hard for her to get to [the] analgesia" prescribed by Dr Shumba, let alone drive to her general practitioner.[44]

35. Dr Mitra observed that it is the job of emergency departments to not only identify injuries or disease and treat the acutely ill, but to anticipate complications and minimise the risk of these

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[36] Exhibit A and Transcript page 11.

[37] Transcript page 12.

[38] Transcript page 11.

[39] Exhibit A and Transcript pages 10-11 and 13-14.

[40] Transcript 15.

[41] Transcript pages 15-16.

[42] Transcript 20.

[43] Ibid 26 – 27.

[44] Transcript page 13.

developing. He identified a number of discharge strategies that BBHED might have employed to guard against the development of complications, some of which would have been effective even on a public holiday weekend. The included engaging in multi-disciplinary discharge planning, contacting a family member or other responsible adult to advise of Ms Coutts' condition or discharging her into the care of a responsible person, contacting her general practitioner by telephone on 10 April 2009, conducting a welfare check on Ms Coutts' by telephone the following day, arranging a home visit, respite placement or a referral to allied health services for follow up care.

36. Dr Shumba testified that when he attended on Ms Coutts he would have been provided with the triage nurse's notes[45] and the referral letter from Dr Eggleston.[46] He testified that there was nothing "puzzling" in Ms Coutts' clinical presentation, and her request was clear – she required pain relief.[47] Dr Shumba considered that Ms Coutts was "medically ... fine for discharge"[48] and able to be managed at home with analgesics and followed up by her own doctor.[49]

37. Dr Shumba acknowledged that it was his responsibility, as the treating clinician, to determine whether a patient should be admitted or discharged.[50] In reaching that decision, a range of considerations are evaluated including the risk of potential complications, their subsequent management, the patient's ability to access follow up support, the risk of infection from hospital admission (especially among elderly patients), the patient's social circumstances and, to some degree, their wishes. Dr Shumba stated that there were "no hard and fast rules about whether to admit patients".[51] He acknowledged the benefit of erring on the side of caution[52] but observed that patients are often discharged, once it is established that they have social supports and appropriate mechanisms for follow up.

38. Dr Shumba testified that invariably the patient's needs and circumstances are assessed, however he had no recollection of having discussed Ms Coutts' circumstances, and he

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[45] Inquest Brief 51.

[46] Inquest Brief 8.

[47] Transcript 32.

[48] Transcript 38.

[49] Transcript 30.

[50] Ibid 49.

[51] Ibid 39.

[52] Ibid 49 line 13-27.

acknowledged that there was nothing in her medical records to suggest such a discussion had occurred.[53] He conceded that no-one had completed the Discharge Tool and observed that the BBHED functioned as a team environment, and so sometimes such documentation was completed by medical staff, but more often it fell to the nursing staff.

39. Dr Shumba stated that he is aware of the possible complications posed by multiple fractured ribs in the older patient. However, there were no alarming life-threatening features in Mrs Coutts' presentation to the BBHED.[54] He felt reassured by Ms Coutts' ability to seek help from a general practitioner and to make her own way to the BBHED afterwards. He also pointed to her glucose level and lack of any apparent exacerbation of COPD documented on the triage notes. [55] Dr Shumba maintained that it would have been inappropriate to admit Ms Coutts "on the basis of her co-morbidities" alone[56] and maintained that despite the tragic outcome, he had made the right decision on the day.[57]

40. Dr Cruickshank testified that Dr Shumba's decision to discharge Ms Coutts with appropriate supports, that is referral to her usual doctor and analgesia for 2.5 days, was the appropriate action on the day. This is because Ms Coutts had demonstrated her ability 'on a public holiday, the worst possible day to of the year to access care, by making her own way to her general practitioner and the emergency department, without family support'. As the analgesics prescribed by Dr Shumba were only sufficient for, at most, two and a half days, Ms Coutts would need to seek further review from her general practitioner and, to his knowledge, the opening hours and services available at the practice are comprehensive.[58]

41. However, Dr Cruickshank conceded that there was a risk that Ms Coutts' condition would deteriorate such that she could not make her own way to her general practitioner.[59] He also acknowledged the benefits of admission would have been to ensure that Ms Coutts took her

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[53] Transcript 40.

[54] Transcript 48.

[55] Transcript 34.

[56] Transcript 30.

[57] Transcript page 54.

[58] Transcript 59 - 61.

[59] Ibid 61.

medication, and was encouraged to do deep breathing exercises earlier to guard against the development of pneumonia.[60]

42. In relation to the option to admit Ms Coutts, Dr Cruickshank explained the practical realities of the Easter public holidays meant that there would have been reduced services around town and within the hospital. Indeed, although at the time of Ms Coutts' death, the BBHED had a "Care Coordinator" who coordinated the discharge process for patients with complex needs, their role was not funded to operate on the Easter public holidays and that service was simply unavailable on the day that Ms Coutts presented.[61]

43. Dr Cruickshank acknowledged that it would have been "ideal" if community-based services had been immediately available to Ms Coutts, but noted that the absence of such services (on a public holiday) would not, alone, indicate a need for admission, particularly where a patient is linked to a general practitioner familiar with her/his history.[62] He conceded there was nothing in Ms Coutts' medical records to indicate that anyone at the BBHED explored or thought about Ms Coutts' social supports and that it would have been pertinent to do so.[63]

44. As the Clinical Director, Dr Cruickshank testified that he takes ultimate responsibility for discharge processes and conceded that historically the Discharge Tool was not being used by staff.[64] Following Ms Coutts' death, though not necessarily as a consequence of her death, changes were made to the medical and nursing areas of the proforma Discharge Tool and an audit of compliance indicated that there had been significant improvements.

45. Dr Cruickshank observed that the care coordination services at Ballarat Health Services had matured in the years since Ms Coutts' admission. At the time of inquest in 2013, the Care Coordination service operated seven days per week (but not on public holidays)[65] and included an after hours referral process. A "strong culture of referral to the Care Coordinator" had developed among BBHED staff, particularly in relation to their complex patients.

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[60] Transcript 64.

[61] Transcript 56.

[62] Transcript 57.

[63] Transcript pages 67 and 69.

[64] Transcript 72.

[65] Although, at the time of Inquest, they remained unavailable on Christmas and Easter public holidays.

CONCLUSIONS

46. The standard of proof for coronial findings of fact is the civil standard of proof, on the balance of probabilities, with the *Briginshaw* gloss or explication.[66] The effect of the authorities is that Coroners should not make adverse findings against or comments about individuals, unless the evidence provides a comfortable level of satisfaction that they caused or contributed to the death.

47. I find that the triage assessment of Ms Coutts at the BBHED on 10 April 2009, and the documentation of this process, was inadequate. The triage assessment did not take into account the extent of Ms Coutts' pain and resulted in an inappropriate triage categorization, Triage Category 5.

48. Ms Coutts' triage categorization was not, of course, a circumstance causally related to her death, and, I accept that the triage category to which she was assigned did not detrimentally affect the speed with which she was seen. However, there is evidence that Ms Coutts' assignment to Triage Category 5 may have influenced the level of care and attention she received from the BBHED medical and nursing staff that day.

49. The clinical management and care provided to Ms Coutts' on her presentation to the BBHED on 10 April 2009, can be conceptualised as little more than confirmation of multiple rib fractures by x-ray and the provision of pain relief. While I find no fault with Dr Shumba's diagnosis and prescription of analgesia, optimal management did not end there.

50. I accept the evidence of Dr Mitra, as an independent expert, that emergency department clinicians are not merely tasked to diagnose and treat acutely ill and emergent patients, they must also anticipate the complications that may develop and, through appropriate inquiry, guard against such risks to the extent possible, through the exercise of their clinical judgement.

51. Here, the paucity of documentation concerning Ms Coutts' BBHED presentation makes it difficult to assess Dr Shumba's rationale for discharging her home, with follow up by her

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[66] *Briginshaw v Briginshaw (1938) 60 C.L.R. 336 esp at 362-363.* "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 issues had 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..."

general practitioner. It is not surprising that at inquest four years after he treated Ms Coutts, Dr Shumba had no independent recollection of events.

52. In light of these limitations, I can only be satisfied that Dr Shumba was aware of those circumstances – clinical, medical or otherwise – that were documented or that he had opportunity to observe for himself, and that these factors are likely to have informed his admit/discharge decision. On the available evidence, I cannot determine whether Dr Shumba discussed any discharge related issues with Ms Coutts or anything else, besides her "nine-out-of-ten" pain.

53. In short, I find that the available evidence is insufficient to establish that Dr Shumba engaged in adequate discharge planning. It appears likely that Dr Shumba placed undue reliance on Ms Coutts' ability to access care, and failed to appreciate the significance of the severe pain she was experiencing, and the impact it would have on her ability to move and therefore, access support.

54. I make no adverse finding in relation to Dr Shumba's decision not to admit Ms Coutts to hospital because the available evidence suggests that by not admitting her, Dr Shumba did not depart from the prevailing standards of his profession.

55. However, the available evidence does support a finding that Dr Shumba's discharge planning was sub-optimal, and documentation of the discharge planning process was virtually non-existent.

56. Whilst I note the evidence of Drs Shumba and Cruickshank, that completion of the Discharge Tool was a shared responsibility within the BBHED in April 2009, I find that the failure to allocate primary responsibility for this task contributed to the inadequate planning of Ms Coutts' discharge.

57. Thorough documentation, a more careful triage assessment and conscientious discharge planning by the BBHED may have improved the ultimate outcome for Ms Coutts, but I am unable to conclude that these shortcomings caused or contributed to her death.

COMMENTS

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

1. During the course of the inquest, I was advised that since 2009, Ballarat Health Services has improved its medical file proformas with a view to encouraging more uniform completion of triage and discharge documentation.

2. I was also advised that multi-disciplinary discharge planning is now available seven days per week (excluding the Christmas and Easter public holidays), and that a referral system is in place to ensure that patients discharged after hours receive follow up care.

RECOMMENDATIONS

Pursuant to section 72(2) of the **Coroners Act 2008,** I make the following recommendation/s connected with the death:

1. That Ballarat Health Services consider providing further education to staff about the triage of Emergency Department patients.

2. That Ballarat Health Services consider allocating specific responsibility for the completion of the Discharge Tool within the Emergency Department, to ensure that adequate discharge planning occurs, and that the rationale for discharge decisions is apparent..

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

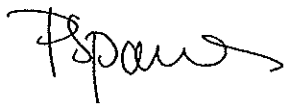
The Ms Coutts' family

Dr Linda Danvers, Ballarat Health Services

Registrar of Births, Deaths and Marriages

Detective Senior Constable Amanda Maybury, Police Coronial Support Unit

Signature:



PARESA ANTONIADIS SPANOS
Coroner
Date: 4 February 2015

Cc: Manager, Coroners Prevention Unit