IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2013 004813

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 60(2)
Section 67 of the ***Coroners Act 2008***

I, ROSEMARY CARLIN, Coroner having investigated the death of SUSAN RUTH LOVELL without holding an inquest:

find that the identity of the deceased was SUSAN RUTH LOVELL

born on 21 April 1953

and that the death occurred on 24 October 2013

at the Alfred Hospital, 55 Commercial Road, Prahran, Victoria, 3181

from:

1(a) COMPLICATIONS OF METASTATIC MELANOMA IN THE SETTING OF NECK OF FEMUR FRACTURE FOLLOWING A FALL (OPERATED AND PALLIATED)

Pursuant to section 67(1) of the *Coroners Act 2008* there is a public interest to be served in making findings with respect to the following circumstances:

1. Mrs Susan Lovell was born on 21 April 1953. She was 60 years old when she died in palliative care at the Alfred Hospital. She lived in Hawthorn East with her family and is survived by her husband and children. Mrs Lovell was a Senior English Teacher at Melbourne Grammar School and is remembered as a loving wife, mother and valued member of the community.

2. During my investigation Mrs Lovell's husband, Graeme Lovell, provided extensive information about his wife's medical background and the circumstances surrounding her death. I obtained medical records, letters, statements and other material from Mrs Lovell's treating clinicians and an independent report from a dermatologist. I was also advised by the

Coroner's Prevention Unit (CPU)[1] as to the clinical care and management of Mrs Lovell in the Alfred Hospital. I have drawn on all this material as to the factual matters in this finding.

BACKGROUND AND CIRCUMSTANCES

Mrs Lovell's skin lesion

3. According to Mr Lovell, in mid-January 2010 Mrs Lovell noticed that a small mole on the back of her left calf was becoming larger and darker.

4. On 14 January 2010 Mrs Lovell attended her general medical practitioner Dr Mark Spring in relation to the lesion. The attendance is not documented in Dr Spring's medical records, however he prepared a referral in which he asked dermatologist Dr Timothy Rutherford to see Mrs Lovell in relation to 'a pigmented lesion on the calf region which has recently increased in size and has varied pigmentation'[2].

5. On 22 January 2010 Mrs Lovell attended Dr Rutherford. He noted she had a history of a basal cell carcinoma on her left cheek and a family history of non-melanoma skin cancer. Dr Rutherford examined Mrs Lovell's lesion using polarised light and dermoscopy. He diagnosed it as a seborrhoeic keratosis, a common benign skin lesion. He sent a letter dated 25 January 2010 to Dr Spring outlining his opinion and recommending that Mrs Lovell have a full skin check every 12 to 24 months.

6. Mr Lovell reported that his wife stopped worrying about the lesion after her visit to Dr Rutherford and waited for it to run its course and shrivel up. Instead, according to Mr Lovell, the lesion kept growing, reaching 1–1.2cm in diameter and 4–5mm in thickness at its maximum. It was regularly knocked, causing it to bleed.

7. On 11 November 2010 Mrs Lovell re-presented to Dr Spring in relation to the lesion. Dr Spring applied silver nitrate to it. He requested Mrs Lovell return in one week, but she failed to do so. Dr Spring's notes are short but do not record that the lesion had changed in appearance.

[1] The role of the CPU is to assist coroners investigating deaths, particularly deaths that occur in a healthcare setting. The CPU is staffed by healthcare professionals, including practising physicians and nurses, not associated with the health professionals and institutions under consideration. They are therefore able to give independent advice to the Coroner.

[2] Letter from Dr Spring to Dr Rutherford dated 14 January 2010.

8. Mr Lovell stated that over the next few weeks the lesion continued to bleed and started to smell like 'rotting flesh'[3].

9. On 10 December 2010 Mrs Lovell again attended Dr Spring and asked him to remove the lesion. Dr Spring's notes are again short, but do not record any reporting of bleeding or smell. Dr Spring excised a 1cm area of flesh around the growth. He dressed, but did not stitch, the wound. He did not send the excised tissue to pathology as he believed the lesion was a seborrhoeic keratosis based on Dr Rutherford's advice.

10. On 13 December 2010 Dr Spring re-dressed the wound. His notes do not record any concern with the wound.

Diagnosis of malignant melanoma

11. On 27 June 2011 Mrs Lovell presented to Dr Spring with lymph node enlargement in her left groin. At that time the wound to her left calf had healed. Dr Spring ordered an ultrasound of her left groin. The ultrasound report gave a differential diagnosis of reactive lymphadenopathy but indicated a possible primary or secondary malignancy. Dr Spring referred Mrs Lovell to surgeon Mr Robert Millar.

12. On 11 July 2011 Mr Millar performed a fine needle aspiration. The aspiration showed probable amelanotic melanoma[4].

13. On 14 July 2011 Mrs Lovell was admitted to the Epworth Hospital. Later that day, Mr Millar performed a superficial left groin dissection and re-excised the area of the growth on Mrs Lovell's calf. Pathology detected metastatic malignant melanoma in her groin dissection and no melanoma in her calf.[5]

14. On the same day Mr Millar wrote to Dr Spring with the results. He noted that Mrs Lovell had a number of moles on her legs, but none appeared to be a potential primary site. He reported that it appeared there was an unknown primary site for the melanoma 'which we do see not uncommonly in my experience'[6].

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[3] Chronology of Events prepared by Graeme Lovell and provided to the Court.
[4] A type of melanoma lacking in melanin and described in Dorland's Illustrated Medical Dictionary, 31st Edition, as 'an unpigmented malignant melanoma'.
[5] The Melbourne Pathology report by Dr Sandy Darling did not say the melanoma was amelanotic melanoma.
[6] Letter to Dr Spring from Mr Millar dated 14 July 2011.

15. Mr Millar referred Mrs Lovell to oncologist and haematologist Dr Rowan Doig who saw her on 15 July 2011. Mrs Lovell remained at Epworth Hospital in recovery until her discharge on 19 July 2011.

16. On 28 July 2011 Dr Doig wrote to Mr Millar. He did not express an opinion on the likely primary site of Mrs Lovell's cancer except in so far as he offered a prognosis in which he referred to the degree of lymph node involvement and 'a possible ulcerated primary tumour'.

17. Over the next two years Mrs Lovell regularly consulted her various treating clinicians. These included psychiatrist Dr Bruce Batago, who prescribed Sertaline for Mrs Lovell's depression and neurosurgeon Dr Paul D'Urso, after tests revealed the cancer had spread to her brain.

18. Mrs Lovell's cancer was managed by Interferon treatment, surgery, radiation therapy and oral chemotherapy.

Mrs Lovell's final admission to hospital

Declining health and treatment

19. In the lead up to her final admission to hospital, Mrs Lovell's health deteriorated and she was described as weak and unwell. Her motor skills appeared compromised and she struggled with balance.

20. On 8 September 2013 Mr Lovell took his wife to the Emergency Department at the Alfred Hospital where she was admitted. Mr Lovell reported that during this admission she fell on a couple of occasions while getting out of her bed. On 12 September 2013 she had a lumbar puncture and her health appeared to improve.

21. On 16 September 2013 Mrs Lovell was discharged home, but her health declined. On 21 September 2013, she fell while walking up stairs and was transported to the Emergency Department at the Alfred Hospital and re-admitted.

22. A decision was made to insert a ventricular peritoneal (VP) shunt to treat Mrs Lovell's hydrocephalus[7]. The procedure was booked for Monday 30 September 2013. On the preceding Thursday Mrs Lovell was discharged so she could spend the weekend at home.

[7] An abnormal enlargement of brain ventricles caused by a build-up of cerebro spinal fluid.

23. At home, Mrs Lovell's health again deteriorated. She was described as becoming ataxic and was re-admitted to hospital a day early, on Sunday 29 September 2013. On 30 September 2013, Mrs Lovell had the VP shunt inserted and the procedure was uncomplicated.

The fall

24. On 1 October 2013 at around 2.10 a.m. Mrs Lovell attempted to get out of her bed and fell onto her right rip, fracturing her right neck of femur.

25. On 2 October 2013 Mrs Lovell's fracture was treated with the insertion of a dynamic hip screw. Her post-operative course was complicated by ileus, hyponatraemia, urinary tract infection and delirium.

26. On 18 October 2013 Mrs Lovell had a seizure. Her treating clinicians spoke to her family regarding her poor prognosis and a decision was made to palliate her. Thereafter Mrs Lovell received comfort care. A morphine and clonazepam syringe driver was commenced on 20 October 2013 and she died four days later, on 24 October 2013.

POST MORTEM EXAMINATION

27. Dr Heinrich Bouwer, Forensic Pathologist with the Victorian Institute of Forensic Medicine, inspected Mrs Lovell's body. The examination revealed a bruise displaying varying colours on the right chest and there was evidence of recent abdominal and right hip surgery. In the absence of a full autopsy, Dr Bouwer reported the medical cause of death as 1(a) complications of metastatic melanoma in the setting of neck of femur fracture following a fall (operated and palliated).

MEDICAL MANAGEMENT OF MRS LOVELL BY DR SPRING AND DR RUTHERFORD

Concerns raised by Mr Lovell

28. Mr Lovell raised concerns regarding the treatment provided to his wife by Dr Spring and Dr Rutherford.[8] Specifically, Mr Lovell took issue with Dr Spring's management of Mrs Lovell's skin lesion, especially his failure to send it for pathological examination after excision. He also believed that the lesion was very likely the primary site of his wife's melanoma and that Dr Rutherford had misdiagnosed it as a seborrhoeic keratosis.

[8] Mr Lovell advised the Court that he had also notified the Australian Health Practitioner Regulation Agency (AHPRA) of his concerns. AHPRA conducted its own investigations into Dr Spring and Dr Rutherford which were completed in 2014.

29. I investigated Mr Lovell's concerns by reference to his account of events, clinical notes and letters of Dr Spring and Dr Rutherford, an opinion from Mrs Lovell's oncologist Dr Doig and a statement from independent dermatologist Dr Jenny Byth, who examined Dr Rutherford's treatment of Mrs Lovell.[9]

Dr Spring's treatment

30. Dr Spring stated that 'at all times I tried my best to provide good care to Mrs Lovell.'[10] He also stated 'in retrospect, I regret not having pathology of the lesion of Mrs Lovell's leg'. He did not, however, concede that he ought to have done so.

31. Although she was addressing Dr Rutherford's treatment, not Dr Spring's, Dr Byth noted that it is 'usual practice' to submit seborrhoeic keratoses that have been surgically removed for any reason, including cosmetic concern, for histology 'even in the absence of worrying features'[11]. The Royal Australian College of General Practitioners (RACGP) has no guidelines governing this situation.

32. Although there were no clinical guidelines, given Mrs Lovell's ongoing concern in relation to the lesion and the fact Dr Rutherford's advice was 11 months prior, it would have been prudent for Dr Spring to send the excised lesion for histological assessment. Had he done this, it would either have quelled Mrs Lovell's concerns and justified no further treatment (if not malignant) or allowed for earlier intervention and treatment (if it was).

Dr Rutherford's treatment

33. Dr Rutherford saw Mrs Lovell once regarding her skin lesion. The consultation, on 22 January 2010, lasted 4 minutes and 46 seconds. Dr Rutherford took her history and noted previous basal cell carcinoma and a family history of non-melanoma skin cancer. He examined her lesion and diagnosed it as a seborrhoeic keratosis.

34. Dr Byth stated that seborrhoeic keratoses are extremely common and the vast majority are diagnosed clinically, without histological assessment and without treatment. If treatment does

[9] My coronial investigation was completely separate from AHPRA's investigation, however during my investigation I compulsorily obtained material from AHPRA pursuant to Section 42 of the *Coroners Act 2008*. This material included letters from Dr Spring and Dr Rutherford as well as an independent expert report obtained by AHPRA from dermatologist Dr Jenny Byth in relation to Dr Rutherford's treatment. I obtained consent from Drs Spring, Rutherford and Byth to use their letters/report for the purpose of my investigation.

[10] Letter from Dr Mark Spring to AHPRA dated 2 January 2014.

[11] Statement of Dr Jenny Byth dated 15 September 2014, page 3.

occur it is usually by destructive methods such as cryotherapy or cautery without histological confirmation of the diagnosis.

35. Dr Rutherford said he did not take a biopsy of the lesion 'given the typical clinical, polarized light and dermoscopic features'. According to Dr Byth, Dr Rutherford's decision not to subject the lesion to histological assessment, via biopsy or excision, was in keeping with the course followed by the majority of practitioners who diagnose seborrhoeic keratosis based on clinical features. Dr Byth noted that seborrhoeic keratoses frequently change and grow over time and, because they are prominent, may bleed as a result of trauma. She indicated that even change and bleeding, do not necessarily call for biopsy.[12]

36. The evidence does not permit a conclusion that Dr Rutherford's diagnosis of the lesion as a seborrhoeic keratosis was correct; however, based on the opinion of Dr Byth I am satisfied that the manner in which he reached that diagnosis was reasonable and, given that diagnosis, that his treatment was appropriate.

37. Mr Lovell pointed out that Dr Rutherford used the word 'atypical' to describe the lesion in the letter he wrote to Dr Spring after his consultation[13]. However, in context I do not consider this word detracts from Dr Rutherford's assessment or treatment, as seborrhoeic keratosis have many different presentations and in any event he was referring to Mrs Lovell's concern, not his opinion.

Primary site of the melanoma

38. The Melanoma Institute of Australia states that melanoma cells which spread from the primary tumour usually occur in the node group nearest the original skin cancer site and that once cancer has developed to metastatic melanoma it is difficult to identify the primary source of the cancer.[14]

39. In support of his contention that Mrs Lovell's calf lesion was the primary site of her melanoma, Mr Lovell relied upon the fact that her metastatic melanoma was first diagnosed in her groin on the same side and that despite numerous scans, no other primary site was detected. He also believed his wife's lesion had the appearance of an amelanotic melanoma[15], which was the probable diagnosis upon fine needle aspiration of her left groin.

[12] Statement of Dr Jenny Byth dated 15 September 2014, page 3.
[13] It reads: *'Thankyou for referring Susan...who was concerned about an atypical pigmented lesion on her left calf.'*
[14] Accessed at www.melanoma.org.au.
[15] An assertion not without its difficulties.

40. On the other hand, Dr Spring pointed to the fact Mr Millar's re-excision of the area around Mrs Lovell's left calf lesion did not reveal melanoma upon histological assessment. Further, the probable diagnosis of amelanotic, as opposed to melanotic, melanoma was never confirmed.

41. Mr Lovell's belief was understandable, as was his frustration that no-one in the medical profession seemed to acknowledge it. He called it the 'elephant in the room'[16]. However, as I explained to Mr Lovell I am required to act on evidence, not theory or supposition. It was for this reason, I sought the opinion of oncologist, Dr Doig[17]. I provided Dr Doig with a complete chronology of events prior to Mrs Lovell's melanoma diagnosis and referred him to information on the Melanoma Institute of Australia website regarding the spread of melanoma from the primary site.

42. Dr Doig noted that fine needle aspirate is an inferior way of diagnosing any form of cancer due to possible sampling errors and other technical issues. The only reliable diagnosis was from the groin dissection, which confirmed malignant melanoma, but not amelanotic melanoma. In any event Dr Doig noted the treatment and prognosis would be the same for amelanotic and melanotic melanoma.

43. Dr Doig also stated that a good proportion of melanoma that relapse in lymph nodes is of an occult primary site, that is, a site hidden and not able to be readily detected. The reason for this is unclear, but may relate to involution (ingrowth and curling inwards) of the primary melanoma, by the time the metastases are detected. He concluded that he could not determine whether the suspect skin lesion was a seborrhoeic keratosis or a melanoma and he believed there was 'absolutely no specialist' who could do so in the absence of 'having seen or taken a histopathological sample of that lesion when it was first diagnosed'[18].

44. I accept the opinion of Dr Doig. In short, we will never know whether the skin lesion excised by Dr Spring was a melanoma for the simple reason that it was never tested.

Might there have been a different outcome?

45. It is not my role to deal in hypotheticals, however the significance of a possible missed diagnosis warrants consideration.

[16] Mention Hearing on 14 December 2015, Transcript page 8.
[17] Dr Doig was Mrs Lovell's treating oncologist from the time of diagnosis of her malignant melanoma, although he noted that in the last 6 to 12 months of her life she was primarily under the care of the Oncology and Radiation Oncology Team at the Alfred Hospital.
[18] Letter from Dr Rowan Doig dated 20 July 2015.

46. Even if the calf lesion had been a melanoma, Dr Doig theorised there was no way of knowing whether a correct diagnosis would have resulted in an increased chance of a cure. He stated that 'lymph node metastases can occur at an early stage or even in a delayed fashion after a primary diagnosis of melanoma in a limb is made'. Without knowing more about the nature of the tumour it was simply impossible to say.

47. Thus, even if the calf lesion had been a melanoma, it is impossible to say whether a correct clinical diagnosis in January 2010 or a diagnosis after pathology in December 2010, would have made a difference to Mrs Lovell's outcome given the possibility of early metastases. The lack of histological assessment has not only prevented a determination of whether the lesion was a melanoma, but also of the significance of a missed diagnosis if it was.

THE ALFRED HOSPITAL'S FALLS PREVENTION MEASURES

48. Mrs Lovell was re-admitted to the Alfred Hospital on 29 September 2013 for an elective insertion of a VP shunt the following day.

49. On 30 September 2013 Mrs Lovell was assessed as a 'super high' falls risk by staff using the hospital's Falls Risk Assessment Scoring System (FRASS). According to Mr Lovell, his wife was returned to her room in Neurosurgery Ward 2 East Bed 1 ('W2EB1') after her procedure and at this time she was placed in a floor line bed with a bright orange 'Super High Falls Risk' sign above the bed.

50. Mr Lovell recounted that after the procedure his wife was confused and was not able to follow instructions. She did not have a urinary catheter and had to be stopped from getting up to go to the toilet a couple of times. She was given a bed pan but found it difficult to use. According to Mr Lovell the nurse looking after her was so concerned about her falls risk that she arranged for her to be moved to a bed where she could be observed by a 'patient attendee' and also obtained a 'prox mat' to alert the attendee if she tried to get up.[19]

51. Sarah Hudson, Falls Prevention Consultant at Alfred Health reported that all mandatory falls prevention strategies were implemented in Mrs Lovell's Falls Prevention Plan after her FRASS assessment. This included placement in a 'maximum observation area' and the use of a 'floor line bed' at its lowest height.[20]

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[19] Mr Lovell's Chronology of Events, page 40.

[20] Alfred Health Falls Risk Assessment Scoring System (FRASS) & Falls Prevention Plan signed and dated 30 September 2013.

52. Further, according to Ms Hudson, Ms Lovell was transferred from W2EB1 to a high visual room. She was placed in a four bed room opposite the nursing station and was in Bed 10 located next to the door. A Constant Patient Observer (CPO) was stationed outside Mrs Lovell's room 'to provide constant visual observations at a distance of greater than 1 metre'.[21] Ms Hudson said although initially there was a 'Proximate' (a type of sensor alarm) in place, it was removed when Mrs Lovell was transferred to the high visual room.

53. Ms Hudson stated Mrs Lovell also received 'hourly graphic observations' by nursing staff because she had been given anaesthetic for the procedure earlier that day. Because of the VP shunt, nursing staff were also completing 'hourly neurological observations'.

54. The nurse unit manager spoke to the CPO the morning after the fall. He reported that at the time Mrs Lovell fell he was sitting at his station, however he was looking down completing his patient observations rather than into the room. He said he was required to note these observations every 15 minutes. He looked up at the same time that Mrs Lovell fell.

55. Obviously, as there was no Proximate near Mrs Lovell's bed, the CPO was not alerted when Mrs Lovell stood up from her bed.

56. Mr Lovell claims the reason his wife stood up was to go the toilet. He argued she should have had a catheter fitted. However, I am satisfied the neurosurgeon's decision not to insert a catheter was reasonable given the associated risks of urinary tract infection or secondary infection of the VP shunt, particularly given Mrs Lovell's previous history of urinary tract infections.

FINDING

57. I am satisfied having considered all of the evidence before me that further investigation is not required.

58. Mr Lovell was of great assistance during my investigation. His stated objective was to do 'everything possible to protect other people' in his wife's situation. Mr Lovell is to be commended for this ideal and his efforts to achieve it.

59. Mrs Lovell leaves a legacy as a wife, mother and teacher. The support she received from her family and colleagues, including as she continued to teach while her health deteriorated, is

[21] Statement of Sarah Hudson dated 24 December 2015, page 2.

extraordinary and a testament to her character. I express my condolences to Mrs Lovell's family and friends on her tragic death.

60. I find that Mrs Susan Lovell died on 24 October 2013 from complications of metastatic melanoma in the setting of neck of femur fracture following a fall (operated and palliated).

COMMENTS

Pursuant to section 67(3) of the *Coroners Act 2008*, I make the following comments connected with the death:

Mr Lovell's advocacy in law reform

1. Following his wife's death Mr Lovell was active in seeking reform to benefit others. He campaigned for changes to the Australian Health Practitioner Regulation Agency (AHPRA) notification process, in particular to the manner in which feedback is provided to notifiers. In August 2015 Australian Health Ministers accepted a recommendation, following independent review, to improve the AHPRA complaints process. Mr Lovell's experience was cited in the review.[22] Mr Lovell also made a submission and presentation to the Victorian Parliamentary Inquiry into End of Life Choices.

Management of excised skin lesions

2. For reasons already explained the evidence does not allow me to determine the primary site of Mrs Lovell's melanoma, nor whether early detection and treatment would have been effective.

3. In articles published in the Australian Family Physician, the RACGP's peer reviewed journal, authors recommend excision biopsy 'even when a confident clinical diagnosis of melanoma is made'[23] and suggest excision biopsy is the 'gold standard for treatment' of non-melanoma skin cancers.[24]

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[22] Independent Review of the National Registration and Accreditatiion Scheme for health professions, Final Report December 2014.

[23] John F Thompson, Richard A Scolyer and Richard F Kefford, 'Melanoma' (July 2012) 41(7) *Australian Family Physician* 449, 470-473.

[24] Philip Clarke, 'Nonmelanoma skin cancers' (July 2012) 41(7) *Australian Family Physician* 449, 476-480.

4. In a case, such as this, where there has been a confident clinical diagnosis of a benign skin lesion, but nevertheless the lesion is excised for some reason, consideration needs to be given to whether the lesion should be sent to pathology for confirmation.

Adequacy of clinical notes

5. Dr Spring's notes were brief and in the case of Mrs Lovell's attendance on 14 January 2010, missing altogether. More detailed notes by Dr Spring would have assisted determination as to precisely what occurred in his consultations with Mrs Lovell, particularly the presentation of her lesion.

6. The importance of clinical notes has been emphasised in many coronial findings and yet poor note taking by medical practitioners remains a concern in this jurisdiction. Comprehensive contemporaneous notes constitute a formal record allowing for later reference by the same or a different practitioner. This can be vital in the provision of good clinical care.

7. Comprehensive contemporaneous notes also facilitate retrospective scrutiny. Doctors need to understand that detailed notes can help them in the future as memories fail and recollections of events may differ. Conversely, the lack of notes can work against them. Detailed notes permit a more ready acceptance of the proposition that if something is not recorded, it did not occur. Scant notes, on the other hand, tend to detract from that proposition.

Falls risk strategies

8. Mrs Lovell's risk of falling was appreciated by the Alfred Hospital and she was appropriately assessed as a 'super high' falls risk. The Hospital followed its policies to ensure her safety and yet she still fell. A CPO was stationed in the designated position supposedly providing 'constant' observation at the time of her fall. The CPO had the task of observing four patients and was completing paperwork when Mrs Lovell stood up. By the time he looked up she was already falling.

9. I recognise that in dealing with a high falls risk patient there are often competing considerations and it is probably impossible to eradicate the risk altogether however, it remains unclear why a Proximate cannot be used in conjunction with a CPO.

10. Ms Hudson advised that Alfred Hospital has 20 Proximates available for use and 'it is standard practice not to use a proximate when a CPO is in attendance'. In my view it is unrealistic to expect a CPO to be able to monitor a patient every single moment, let alone four patients. If a Proximate had been used in this case, the CPO would have been alerted the instant Mrs Lovell stood up. There is no guarantee he would have been able to prevent her fall, however it is possible. A Proximate or similar sensor alert device serves to provide an additional layer of protection against falls especially for patients in Mrs Lovell's 'super high' risk category.

RECOMMENDATIONS

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

1. That the Royal Australian College of General Practitioners consider circulating educational material to its members regarding best practice as to management of skin lesions, including after excision.

2. That the Royal Australian College of General Practitioners consider the need to establish guidelines as to best practice when a skin lesion has been excised, even after it has been clinically diagnosed as benign.

3. That the Royal Australian College of General Practitioners continue to educate its members as to the importance of comprehensive contemporaneous clinical notes.

4. That Alfred Health amends its policies to require the use of Proximate or similar sensor alert devices in conjunction with visual observations by a Constant Patient Observer or other nursing staff when a patient is assessed as a very high falls risk.

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

The family of Mrs Susan Lovell;
Dr Mark Spring;
Dr Timothy Rutherford;
Dr Rowan Doig;
Dr Jenny Byth;
Australian Health Practitioners Regulation Agency;
Royal Australian College of General Practitioners;

The Australasian College of Dermatologists;

The Investigating Member; and

The Interested parties.

Signature:

ROSEMARY CARLIN
CORONER
2 March 2016