IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2019 006038

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Coroner Leveasque Peterson
Deceased:	Thelma Annie Ogilvy
Date of birth:	16 November 1928
Date of death:	2 November 2019
Cause of death:	1(a) Abdominal sepsis complicating perforated diverticular abscess of the sigmoid colon
Place of death:	Dandenong Hospital, 135 David Street, Dandenong, Victoria, 3175

INTRODUCTION

1. On 2 November 2019, Thelma Annie Ogilvy was 90 years old when she died at Dandenong Hospital.

2. Prior to her death, Thelma lived in rural Victoria. Her family described that she was "young at heart, vibrant, still living independently and had a busy social life."

3. Thelma's medical history included macular degeneration, osteoporosis, osteoarthritis, glaucoma, depression, ischemic heart disease, hypertension, polymyalgia rheumatica, an appendicectomy, a hysterectomy, diverticulitis, arthritis, dysphagia/loss of weight, and a pharyngeal pouch repair in 2019. She was on a variety of medications for her arthritis, hypertension and heart disease.

4. Thelma had undergone a laparotomy in the weeks before her death.

THE CORONIAL INVESTIGATION

5. Thelma's death was reported to the Coroner as it fell within the definition of a reportable death in the *Coroners Act 2008* (the Act). Reportable deaths include deaths that are unexpected, unnatural or violent or result from accident or injury.

6. The role of a coroner is to independently investigate reportable deaths to establish, if possible, identity, medical cause of death, and surrounding circumstances. Surrounding circumstances are limited to events which are sufficiently proximate and causally related to the death. The purpose of a coronial investigation is to establish the facts, not to cast blame or determine criminal or civil liability.

7. Under the Act, coroners also have the important functions of helping to prevent deaths and promoting public health and safety and the administration of justice through the making of comments or recommendations in appropriate cases about any matter connected to the death under investigation.

8. Taking into account the circumstances of death and concerns raised by family members, I referred this case for review by the Health and Medical Investigations Team of the Coroner's Prevention Unit (**CPU**) of the medical management of Thelma. The CPU provided advice which has guided and informed my investigation.

9. This finding draws on the totality of the coronial investigation into the death of Thelma Annie Ogilvy. Whilst I have reviewed all the material, I will only refer to that which is directly relevant to my findings or necessary for narrative clarity. In the coronial jurisdiction, facts must be established on the balance of probabilities.[1]

10. 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 explications. Adverse findings or comments against individuals in their professional capacity, or against institutions, are not to be made with the benefit of hindsight but only on the basis of what was known or should reasonably have been known or done at the time, and only where the evidence supports a finding that they departed materially from the standards of their profession and, in so doing, caused or contributed to the death under investigation.

MATTERS IN RELATION TO WHICH A FINDING MUST, IF POSSIBLE, BE MADE

Circumstances in which the death occurred

11. On 21 October 2019 Thelma presented with abdominal pain to Warragul Hospital, which is operated by West Gippsland Healthcare Group (**WGHG**).

12. She was found to have a closed loop small bowel obstruction and underwent a laparotomy the same day. At operation, Thelma was found to have dense omental and uterine adhesions.[2] Adhesiolysis[3] was undertaken. The bowel was viable and there was no excision of the bowel or anastomosis[4] performed. She appeared to recover from this procedure and was eating and drinking at the time of hospital discharge.

13. On 27 October 2019, Thelma re-presented to Warragul Hospital feeling unwell with abdominal discomfort, some nausea and reporting that she had not opened her bowels for four days.

14. A computerised tomography (**CT**) scan of her abdomen and pelvis was undertaken. According to Emergency Department (**ED**) notes, a verbal report was received via phone

[1] Subject to the principles enunciated in *Briginshaw v Briginshaw* (1938) 60 CLR 336. The effect of this and similar authorities is that coroners should not make adverse findings against, or comments about, individuals unless the evidence provides a comfortable level of satisfaction as to those matters taking into account the consequences of such findings or comments.

[2] Adhesions are a form of scar tissue that forms in the abdomen following infection, inflammation or surgery. Bowel may become caught or twisted in adhesions, resulting in the development of bowel obstruction.

[3] Division of adhesions by cutting or diathermy. This frees up the entangled bowel.

[4] Surgical rejoining of the bowel.

from the radiology department indicating a distal small bowel obstruction. The formal report also indicated the presence of "small bubbles of free intraperitoneal" gas around the liver, indicating bowel perforation.

15. Thelma was admitted under the surgical team for intravenous (**IV**) fluids and nil by mouth.

16. The following morning, on 28 October 2019, Thelma was surgically reviewed. Notes from the consultant ward round indicate that the treating team were aware that the CT scan demonstrated distended distal small bowel and free gas in the peritoneal cavity. It was noted that medical management was discussed with Thelma's family.

17. Thelma was also reviewed by physicians and was found to have sustained a NSTEMI[5] and atrial flutter.[6] Management was discussed with cardiology at Monash Health and appropriate treatment initiated, including the commencement of anticoagulation.

18. After surgical consultant review, non-surgical management of her abdominal condition was undertaken. At this time, Thelma's C-reactive protein (**CRP**)[7] was not elevated at 12 mg/L. There was a plan to undertake a gastrograffin study[8] to follow-up, but this was not successful due to vomiting. Thelma subsequently opened her bowels multiple times.

19. Consultant surgical review noted Thelma's condition to be improved. Her abdomen was soft and non-tender and she was commenced on oral fluids.

20. On 30 October 2019, Thelma was discharged home with notes indicating that she was bright and tolerating food and fluids with no nausea.

21. On 31 October 2019, 11 days after her bowel obstruction operation, Thelma returned to Warragul Hospital ED with a one-day history of lower abdominal pain, vomiting and diarrhoea. A CT scan of the abdomen and pelvis demonstrated a small amount of free fluid in the abdomen and a collection of fluid in the pelvis with thickening of the colon due to either diverticulitis, colitis or as a reaction to the fluid in the abdomen. There was no bowel obstruction and no free gas in the abdomen to suggest bowel perforation.

[5] A form of heart attack, often accompanying significant illness in elderly or otherwise predisposed persons.
[6] A disturbance of heart rhythm similar to atrial fibrillation. If is very common in the elderly and often associated with acute illness. Treatment with anti-coagulant medication is intended to lower the risk of stroke which accompanies this disturbance of heart rhythm. Apixaban was commenced in this case.
[7] CRP is a non-specific marker of infection/inflammation.
[8] Gastrograffin is an orally administered radiological contrast that outlines the bowel on x-ray ot CT

22. Thelma was commenced on appropriate antibiotics, IV fluids and had a urinary catheter inserted to monitor her fluid status. Her CRP and white blood cell count were elevated, in keeping with the presence of infection/inflammation, however her renal function was at her normal baseline and serum lactate[9] was not elevated.

23. The treating team at Warragul Hospital then determined to transfer Thelma to a tertiary centre. The decision to transfer Thelma was made on the basis that Warragul as a regional hospital lacked the facilities that Thelma required for further management. Having had a NSTEMI in her second presentation on 27 October 2019, it was considered that she would require cardiology input along with surgical management, and that if she required further surgery, she would likely require admission to the Intensive Care Unit (**ICU**) or at least Critical Care Unit (**CCU**) post operatively – neither of which were available at Warragul Hospital. The treating team considered that given Thelma's age and recent NSTEMI along with representations, she warranted care in a tertiary centre under a dedicated colorectal team with the support of ICU and cardiology.

24. On 31 October 2019 at 9.40pm, Thelma was referred and accepted by the Monash Medical Centre Surgical Registrar but there were no beds available.

25. The following day, on 1 November 2019 at 1.13pm, Thelma was re-referred to the Colorectal unit based at Dandenong Hospital. The referral was accepted and Thelma was transferred at 10pm that evening following a bed becoming available.

26. Observations taken at Warragul until the time of transfer indicated normal respiratory rate, oxygen saturations, blood pressure and pulse. She was febrile on one occasion.

27. Thelma was transferred to Dandenong Hospital by non-emergency ambulance, provided by Royal Flying Doctor Service (**RFDS**). There were delays in the arrival of this vehicle.

28. On arrival at Dandenong Hospital, Thelma was assessed by the surgical registrar who noted that she was in a stable condition with normal observations and a soft abdomen with tenderness in the lower quadrants bilaterally, but no signs of peritonitis. The clinical impression was of an 'abdominal collection post-laparotomy' and the immediate plan was for continuation of current treatment including antibiotics, fluids and fasting.

[9] Lactate or lactic acid is produced by tissues that have insufficient oxygen or blood supply for normal metabolism. Elevated lactate is a marker of the presence of severe sepsis.

29. On 2 November 2019, at the surgical ward round, Thelma was noted to "not feel too unwell". She had no abdominal pain, although there was tenderness in the lower abdomen. An elevated white blood cell count was noted. There was a plan to repeat the CT scan with a view to undertaking percutaneous drainage[10] of the collection.

30. At 12.20pm the same day, Thelma was the subject of a Medical Emergency Team (**MET**) call due to low blood pressure following a shower. Thelma's low blood pressure had recovered at review on the MET call. There was concern regarding sepsis, as the lactate was mildly elevated at 3.8. Further fluids were administered and there was discussion regarding drainage of the fluid collection in theatre or percutaneously.

31. At 1.45pm, Thelma's blood pressure again dropped and a second MET call was initiated. Thelma was transferred to the Intensive Care Unit (**ICU**) and a plan was made to discuss with family the developments and goals of care.

32. However, at 5.08pm, Thelma experienced a sudden PEA cardiac arrest.[11] Cardiopulmonary resuscitation was commenced but sadly, Thelma was unable to be revived and was declared deceased at 5.33pm.

Identity of the deceased

33. On 2 November 2019, Thelma Annie Ogilvy, born 16 November 1928, was visually identified by her daughter, Wendy Attenborough. Identity is not in dispute and requires no further investigation.

Medical cause of death

34. On 9 November 2019, Forensic Pathologist Dr Henry Bouwer from the Victorian Institute of Forensic Medicine (**VIFM**) conducted an autopsy and reviewed a post mortem CT scan, medical records from Monash Health and Korumburra Medical Centre, and the Police Report of Death (Form 83). Dr Bouwer provided a written report of his findings dated 21 May 2020.

35. The post-mortem examination revealed evidence of recent abdominal surgery. Dr Bouwer found that there was no further bowel obstruction, however there was peritonitis with pus in the abdominal cavity from a perforated diverticular abscess in the sigmoid colon. The heart

[10] Undertaken with a needle passed through the abdominal wall into the fluid collection under radiological guidance. This potentially avoids the need for a repeat laparotomy.

[11] PEA = pulseless electrical activity. This is a form of cardiac arrest where there is normal electrical activity on the cardiac monitor, but no cardiac output. There are several major causes, including massive PE, shock (including septic shock), tension pneumothorax. Treatment is directed at the underlying cause.

was not significantly enlarged but there was triple vessel coronary artery atherosclerosis and no established acute myocardial infarction.

36. Dr Bouwer commented that there was no evidence to suggest recurrent small bowel obstruction or a complication of recent surgery.

37. Post mortem microbiology of the abdominal fluid detected the organism *Enterococcus faecium* which often complicates abdominal sepsis in the setting of perforation. Normal skin flora was detected on a wound swab of the abdomen.

38. Dr Bouwer concluded that on the basis of information available to him at the time, he was of the opinion Thelma's death was due to natural causes and that a reasonable formulation for the medical cause of death was: '1(a) Abdominal sepsis complicating perforated diverticular abscess of the sigmoid colon.'

39. I accept and adopt Dr Bouwer's opinion.

INTERNAL HOSPITAL REVIEWS

WGHG Internal Review

40. In correspondence dated 11 December 2020, WGHG advised that it was unaware of the fact of, or cause of, Thelma's death until the time it received a request for a statement as part of the coronial investigation in November 2020.

41. WGHG stated that it would have been usual for Thelma's case to be presented at the surgical Morbidity and Mortality meeting. As part of this process, WGHG would typically present all transfers and take steps to follow up their outcomes. However, in Thelma's case, this did not occur as the Morbidity and Mortality meetings were halted throughout 2020 and 2021 due to the COVID-19 pandemic.[12]

42. Upon becoming notified of Thelma's death in November 2020, then-Chief Medical Officer Dr Peter Trye conducted a clinical review which consisted of working with the surgical team and Quality and Safety Department to better understand Thelma's presentations and management and to identify any recommendations for improvement.

[12] WGHG confirmed that the surgical Morbidity and Mortality meetings have since recommenced.

43. The review showed that there was a delay in transfer due to a lack of beds at the receiving hospital. However, it was determined that there were no clear flags which should have alerted the treating team that Thelma's condition was deteriorating or that attempts should have been made to escalate the transfer.

Monash Health Internal Review

44. Monash Health advised that Thelma's case was reviewed at the Colorectal Unit Mortality and Morbidity meeting on 6 November 2019.

45. The review did not find any care management concerns and it was determined that Thelma's death was likely not preventable in the setting of post-operative myocardial infarction and atrial flutter. No prevention opportunities or recommendations were identified.

FAMILY CONCERNS AND REVIEW OF MEDICAL MANAGEMENT

46. In submissions to the court, Thelma's family raised a number of specific concerns with regard to the adequacy of care provided to Thelma by WGHG and Monash Health.

47. Taking into account these concerns, I sought a review of Thema's medical management by the Health and Medical Investigations Team of the CPU. The CPU was established in 2008 to strengthen the prevention role of the coroner. The unit assists the Coroner with research in matters related to public health and safety and in relation to the formulation of prevention recommendations. The CPU also reviews medical care and treatment in cases referred by the coroner. The CPU is comprised of health professionals with training in a range of areas including medicine, nursing, public health and mental health.

48. After considering all available evidence, the CPU advised that Thelma's medical management by WGHG and Monash Health was reasonable and appropriate. The CPU found that while there were delays in transfer from Warragul to Dandenong Hospital, the evidence suggests that this did not cause or contribute to the outcome of Thelma's death.

49. In the sections below, I have summarised the CPU's advice and my conclusions in response to each of the key concerns raised by Thelma's family.

50. While the CPU did not identify any prevention opportunities with regard to Thelma's medical care, it did raise concerns with regard to the failure of Monash Health to notify WGHG of Thelma's death. This represented a missed opportunity for WGHG to conduct a prompt review of Thelma's case in order to identify any issues or consider opportunities for system

improvements. At the CPU's suggestion, I have determined to make a recommendation that Monash Health conduct a review of its processes in this regard.

51. In response to the CPU's concerns, the Executive Director of Quality and Safety at Monash Health, Dr Carlos Scheinkestel, agreed that a review of Monash Health notification processes represented "a worthwhile recommendation". However, he considered that this issue should be understood as a statewide problem, rather than being restricted to Monash Health. While there is insufficient evidence in this matter to justify a statewide recommendation, I have determined to include further comments on this issue at the conclusion of my finding.

Communication issues

52. Thelma's family raised a concern in their submissions as follows:

a) Family felt ill-informed at both Warragul and Dandenong Hospitals.

53. After reviewing all available evidence, the CPU noted that while medical records showed that some discussions with family had taken place, it could not comment further on the nature or adequacy of those conversations or draw any conclusions with regard to this aspect of care.

54. Poor communication by medical staff is an issue which is raised frequently by families during the coronial investigation. It is clear that infrequent, inappropriate, or uncertain communications may amplify distress during an already heightened emotional time.

55. However, while I am sympathetic to families' experiences in this regard, I am unable to investigate or comment further with regard to issues of communication. This is because the coronial jurisdiction is limited to issues which are causal, or contributory, to the death. In this case, there is no evidence to suggest that poor communication was a factor which contributed to Thelma's death.

56. I note that it remains open to Thelma's family to raise these issues either directly with the relevant hospitals or alternatively with the Health Complaints Commissioner if desired.

Delays in transfer to Dandenong Hospital

57. Thelma's family also raised concerns with regard to delays in transferring her from Warrangul to Dandenong Hospital, as follows:

a) *Family disgusted at waiting 28 hours for a bed/transport after the surgeon demanded she be sent to Melbourne immediately. Felt utterly let down by the public hospital system/ambulance service.*

b) There was a visible deterioration on the Friday before she went to Dandenong but Warragul seemed not to want to try to get her to Melbourne quickly. Surely she was an emergency case?

c) Family questioned how more serious did it have it get before she was rushed to Melbourne? Did they not rush because of her age? Why, when the surgeon asked for her to be sent to Melbourne immediately, was she not made a priority?

d) We feel that whole last day at Warragul Hospital she was dying and nothing was being done. And by the time she got to Dandenong it was too late.

58. On the CPU's advice, I sought further information from WGHG and Monash Health with regard to apparent delays in Thelma's transfer from Warragul to Dandenong Hospital.

59. In two statements dated 11 December 2020 and 7 February 2023, WGHG explained that there were a number of factors which contributed to the delay, including the inability to secure a bed and then a delay in the ambulance transfer, as detailed below:

a) The decision to transfer Thelma was made on the basis that Warragul as a regional hospital lacked the facilities that Thelma required for further management. The treating team considered that given Thelma's age and recent NSTEMI along with representations, she warranted care in a tertiary centre under a dedicated colorectal team with the support of ICU and cardiology.

b) The initial plan was to transfer Thelma to Monash Medical Centre (**MMC**) on the night of 31 October 2019, but it is documented that there were no beds available at MMC or Dandenong Hospital on that night.

c) Then-Chief Medical Officer Dr Trye stated that he was unable to comment on whether transfer to an alternative health service was considered when it was indicated by Monash Health that no beds were available, although he acknowledged this possibility was not documented in the notes.

d) The following morning the plan was to transfer to Dandenong Hospital. The hospital was contacted and a message was left with the colorectal fellow to call back.

e) Medical notes written at 1.36pm on 1 November 2019 indicate that Thelma had been accepted by the colorectal fellow and that she was for transfer. If no beds were available, WGHG was to call the ED Admitting Officer (**AO**) to arrange for the patient to present through the ED. WGHG called the bed coordinator three times, but the line was busy each time.

f) When contact was made, the bed coordinator advised that there was a possibility of a bed being available later that day and to call back around 4-6pm after their bed meeting.

g) Medical records indicate that the original ambulance booking via the RFDS transport was made at 3pm, with expected arrival time at Warragul Hospital at around 6pm.

h) It is documented that RFDS were experiencing repeated delays. The reason for the delays is not noted.

i) RFDS did not arrive until around 10.30pm on 1 November 2019.

60. The Monash Health case sheet records that Thelma's transfer was treated as 'low acuity'.

61. Upon internal review, WGHG acknowledged that delays had occurred but determined that there were no clear flags which should have alerted the treating team that Thelma's condition was deteriorating or that attempts should have been made to escalate the transfer.

62. After reviewing all available information, the CPU agreed with this conclusion and advised that clinical decision making in treating Thelma's transfer as 'low acuity' was reasonable and appropriate in the circumstances.

63. The CPU explained that transfer urgency is determined on the basis of the clinical condition of the patient as determined by the referring medical practitioners requesting transfer. In this instance, Thelma presented as clinically stable. Observations taken at Warragul Hospital during the period until her transfer at 10.30pm on 1 November 2019 indicated normal respiratory rate, oxygen saturations, blood pressure and pulse. She was febrile on one occasion. Blood tests demonstrated an elevated white blood cell count and CRP in keeping with the suspected infection. Serum lactate was normal, indicating normal tissue perfusion and metabolic state. On the basis of this presentation, an emergency ambulance was not requested and the acuity was recorded as low.

64. While delays should be avoided where possible, the CPU noted that Thelma did not appear to have deteriorated throughout the time that she was awaiting transfer and continued to present as clinically stable throughout her transit. This was evident in the fact that Thelma arrived to Dandenong Hospital in relatively good condition.

65. Moreover, the CPU noted that the treatment commenced by Warragul Hospital was appropriate and was continued upon arrival to Dandenong, without any need for immediate escalation. This supports the conclusion that delays in her transfer did not contribute to the outcome of Thelma's death.

66. I accept and adopt the CPU's advice on this issue.

67. I have included further comments with regard to issues of delay in transfer below.

Appropriateness of nil by mouth

68. Thelma's family raised a further concern regarding the appropriateness of the clinical decision to maintain Thelma as nil by mouth, as follows:

    a) *Family was concerned that throughout this whole episode, from her surgery to her passing, she was nil by mouth most of the time, and had barely eaten.*

69. The CPU advised that Thelma was appropriately kept nil by mouth following her admission to Warragul and transfer to Monash Health because there was concern regarding a bowel/abdominal infection. Gut rest by fasting is a principle of management of this in the first instance.

70. I accept and adopt the CPU's advice on this issue.

Appropriateness of discharge decisions

71. In addition to the issues discussed above, Thelma's family raised concerns that:

    a) *She was admitted three times and released twice. Family believe she wasn't well enough to go home but was released anyway. Why? She was discharged too often and too early for her family's liking.*

72. CPU reviewed all medical records and considered that the discharge decisions was appropriate in the circumstances, given that Thelma appeared to be recovering at the time each discharge decision was made.

73. When Thelma was discharged on 28 October 2019, her CRP level of 12 was close to normal, indicating no significant infection or inflammation was present at this time. At the time of re-presentation on 31 October 2019, the CRP was 120 and rose to 217, indicating the presence of significant, likely bacterial, infection. This was appropriately suspected and treated.

74. I accept and adopt the CPU's advice on this issue.

Uncertainties regarding the medical cause of death

75. Thelma's family noted that some uncertainties remained as to Thelma's medical cause of death, as follows:

    a) *The family are still waiting on autopsy results so are still none the wiser as to the cause of death.*

    b) *We were told after she passed away that Thelma had pleurisy, which was a total shock to her family as this has never been mentioned by anyone before.*

76. As noted above, Forensic Pathologist Dr Bouwer concluded that the medical cause of death was: '1(a) Abdominal sepsis complicating perforated diverticular abscess of the sigmoid colon.' I note that the Senior Next of Kin has received a complete copy of the Medical Examination Report (**MER**) as completed by Dr Bouwer.

77. After reviewing the MER, the CPU noted that there was no evidence of pleurisy at post mortem. There were, however, bilateral pleural effusions. These is a common finding in persons with serious illness, heart disease and sepsis.

78. Thelma's family described her lovingly as "young at heart, vibrant, [and] still living independently" at the time she was admitted to hospital on 21 October 2019. This description captures a life well lived. Nonetheless, the CPU observed that by medical standards, Thelma presented as a frail elderly woman, weighing approximately 40kg, with multiple significant co-morbidities. As such, her operation for a bowel obstruction would have been a significant physiological insult to her, and the development of complications made recovery less likely.

79. In these circumstances, despite the best efforts of her treating teams, the CPU considered that Thelma's death by natural causes was not preventable.

80. Where a family member's decline in health occurs in rapid progression, it can be understandably distressing and difficult for family members to accept. I express my sincere

condolences to Thelma's family for their tragic loss and hope these findings may provide some comfort and closure that the medical care provided to Thelma did not cause, or contribute, to her death.

COMMENTS

81. Pursuant to section 67(3) of the Act, I make the following comments connected with the death.

Transfer of low acuity patients from regional hospitals to tertiary centres

82. While there is no evidence in this case to suggest that delays in Thelma's transfer to Dandenong Hospital either caused, or contributed, to her death, it appears that delays in transfer of low acuity patients may represent a broader, systemic issue.

83. In correspondence dated 7 February 2023, Chief Medical Officer Dr Letitia Clark commented that transfers from Warrigal Hospital to tertiary centres are "challenging." She explained that:

    a) As a regional hospital, Warrigal does not have facilities or speciality staff to provide care for certain patients that arrive in the ED. As such, transfers are a common occurrence, with approximately 3% of ED presentations last quarter requiring transfer to another hospital for ongoing care.

    b) The process for transferring patients who are acutely unwell or requiring resuscitation "works well" as Adult Retrieval Victoria has knowledge of all acute beds/ICU beds across the state and is able to coordinate the transfer process.

    c) However, for less unwell patients such as Thelma, the process of transfer is more difficult.

    d) Dr Clark described that, "It is not uncommon for our doctors to have patients "accepted" by inpatient teams at our referral hospitals, without immediate access to beds. Often this involves multiple call backs and delays – as there was in this case. Calling the AO (admitting officer) in the receiving hospital is a way of escalating a more urgent patient, and this was done. A less urgent patient is most often discussed with the bed manager only. There is usually an attempt to call around most of the hospitals in Melbourne to find a bed, but in my experience, this rarely changes the place that a patient is transferred to, and uses up a lot of time and resources both at our end, and receiving hospitals."

84. In response to this issue, Dr Clark suggested a system whereby hospitals could be "zoned" such that regional hospitals had one service or group to call, who then had to accept the patient. Further, she stated that a "higher responsibility should be applied to the receiving hospital so if there is clearly a clinical need for a patient to be at the tertiary centre that the patient is accepted and sent without waiting to access an inpatient bed."

85. Dr Clark considered that these remedial measures would result in a "far better and safer [outcome] for our regional and rural patients who frequently get stuck waiting to be transferred to the most appropriate place for definitive treatment."

86. I thank Dr Clark for her helpful comments in illuminating what appears to be a systemic issue with regard to the transfer of low acuity patients from regional hospitals to tertiary centres. I have determined to provide a copy of this finding to both Safer Care Victoria and the Secretary to the Department of Health for further consideration of this issue.

Notification of referring hospitals and doctors with regard to patient outcomes

87. As mentioned above, the Executive Director of Quality and Safety at Monash Health, Dr Carlos Scheinkestel accepted that there was a need for Monash Health to review its processes with regard to the notification of referring hospitals and doctors of patient outcomes.

88. However, Dr Scheinkestel qualified that this represented a system-wide problem which occurred across the state, rather than being limited to Monash Health.

89. In this regard, Dr Scheinkestel stated that Monash Health was "rarely" notified of patient outcomes or complications where it referred patients to other organisations, usually for services unavailable at Monash. Dr Scheinkestel provided two examples where this had occurred following recent referrals to The Royal Children's Hospital and the Alfred.

90. Dr Scheinkestel emphasised that feedback to a referring hospital is "important in system improvement, improving patient care and trying to prevent recurrence of adverse events".

91. As such, he suggested there was a need for statewide review of hospital processes in this regard.

92. While the evidence in this case does not justify a statewide recommendation, I have determined to provide a copy of this finding to both Safer Care Victoria and the Secretary to the Department of Health for further consideration of this issue.

FINDINGS AND CONCLUSION

93. Pursuant to section 67(1) of the *Coroners Act 2008* I make the following findings:

    a) the identity of the deceased was Thelma Annie Ogilvy, born 16 November 1928;

    b) the death occurred on 2 November 2019 at Dandenong Hospital, 135 David Street, Dandenong, Victoria, 3175, from abdominal sepsis complicating perforated diverticular abscess of the sigmoid colon; and

    c) the death occurred in the circumstances described above.

94. Having considered all of the evidence, I am satisfied that Thelma's medical care was reasonable and appropriate in the circumstances and that delays in her transfer to Dandenong Hospital did not cause, or contribute, to her death.

95. Tragically, despite the best efforts of her treating teams at Warragul and Dandenong Hospitals, Thelma's death was unable to be prevented.

RECOMMENDATIONS

Pursuant to section 72(2) of the Act, I make the following recommendation:

(i) that Monash Health review its processes to ensure timely notification of referring hospitals and doctors with regard to patient outcomes.

I convey my sincere condolences to Thelma's family for their loss.

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

Wendy Attenborough, Senior Next of Kin

Dr Evie Yeap, Monash Health

Associate Professor Anjali Dhulia, Chief Medical Officer, Monash Health

Dr Letitia Clark, Chief Medical Officer, West Gippsland Healthcare Group

Safer Care Victoria

Professor Euan Wallace, Secretary to the Department of Health

Signature:

Coroner Leveasque Peterson

Date : 30 May 2023

NOTE: Under section 83 of the ***Coroners Act 2008*** ('the Act'), a person with sufficient interest in an investigation may appeal to the Trial Division of the Supreme Court against the findings of a coroner in respect of a death after an investigation. An appeal must be made within 6 months after the day on which the determination is made, unless the Supreme Court grants leave to appeal out of time under section 86 of the Act.