Coroners Act 1996
[Section 26(1)]

Western *Australia*

RECORD OF INVESTIGATION INTO DEATH

Ref: 29/15

I, Barry Paul King, Coroner, having investigated the death of ***David Yehuda Weiser*** *with an inquest held at the* ***Perth Coroner's Court, Court 51, CLC Building, 501 Hay Street, Perth,*** *on* ***25 August 2015****, find that the identity of the deceased person was* ***David Weiser*** *and that death occurred on* ***13 November 2012*** *at* ***2 Waxberry Close, Halls Head,*** *from* ***gastrointestinal haemorrhage in a man with gastric ulcers*** *in the following circumstances:*

Counsel Appearing:

Ms I O'Brien assisting the Coroner
Mr M L Williams (DLA Piper) appearing on behalf of Health Solutions (WA) Pty Ltd and Dr G Westcott
Mr J R Potter (Friedman Lurie Singh & D'Angelo) appearing on behalf of Mrs S Weiser
Mr D J Bourke (Clayton Utz) appearing on behalf of Dr N Hendrickson

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INTRODUCTION

1. On 11 November 2012, David Yehuda Weiser (the deceased) presented at the Peel Health Campus emergency department (PHC-ED) after feeling unwell and passing a melaena stool. He was examined by an advanced trainee in emergency medicine, Dr Nigel Hendrickson, who diagnosed likely infectious gastroenteritis and discharged him home.

2. The deceased's condition worsened at home. In the early hours of 13 November 2012 he collapsed when attempting to stand. Ambulance officers attended but could not revive him.

3. Forensic pathologist, Dr D M Moss conducted a post mortem examination and formed the opinion that the cause of death was gastrointestinal haemorrhage in a man with gastric ulcers.

4. On 25 August 2015 I held an inquest into the deceased's death. The focus of the evidence was on the quality of the medical care provided to the deceased at the PHC-ED.

5. The documentary evidence adduced at the inquest was a brief of evidence which included statements and reports by relevant doctors as well as medical records pertaining to the deceased.[1]

6. Oral testimony was provided (in order of appearance) by:

   (a) Sachar Weiser, the deceased's son;[2]

   (b) Dr Thomas Hitchcock, consultant in emergency medicine;[3]

   (c) Dr Grant Westcott, consultant emergency physician at the PHC-ED;[4] and

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[1] Exhibit 1
[2] ts 8-11
[3] ts 13-72
[4] ts 73-84

(d) Dr Hendrickson.[5]

7. Counsel provided oral submissions following the oral evidence.

8. After the inquest had been held, Dr Hitchcock brought to my attention (through Ms O'Brien) the *Quality Standards for Emergency Departments and other Hospital-based Emergency Care Services* (the Quality Standards) recently published by the Australasian College for Emergency Medicine (ACEM).[6] This publication was not available at the time of the deceased's death.

THE DECEASED

9. The deceased and his wife Sylvia Weiser, to whom I shall respectfully refer as Sylvia, lived in Halls Head.[7]

10. The deceased was born in Israel on 14 December 1941, making him 70 years old at the time of his death.[8] He served in the Israeli army and participated in three wars.[9] In 1979 he moved to South Africa.[10]

11. In about 1994 he married Sylvia and in November 2000 they moved to Perth.[11] His son Sachar, an accountant who runs a not-for-profit organisation for disengaged children, was from a previous relationship.[12]

12. In Perth the deceased and Sylvia had a restaurant for some time. After that the deceased became a taxi driver, a job which he continued.[13]

[5] ts 84-110
[6] Available at http://www.acem.org.au/Resources/ED-Resources/Quality-Standards.aspx
[7] Exhibit 1, Tab 12
[8] Exhibit 1, Tab 1
[9] *West Australian* 26 August 2015
[10] Exhibit 1, Tab 12
[11] Exhibit 1, Tab 12
[12] Exhibit 1, Tab 16; ts 5 per Weiser, S
[13] Exhibit 1, Tab 12

13. The deceased was known to be strong and stoic.[14] He had a stroke in 1992 and had type 2 diabetes mellitus, as well as gout, asthma and obstructive sleep apnoea. His doctor noted that the deceased had a complicated medical history which was quite reasonably managed, and that the deceased was a compliant patient.[15]

11 NOVEMBER 2012

14. On the morning of Sunday 11 November 2012 the deceased was still in bed when Sylvia left the house at about 8.30 am to go to a cake sale. They had been out for dinner with friends the night before and the deceased had been his usual jovial self.[16]

15. In the afternoon Sylvia turned on her mobile phone to discover a missed call message from the deceased. She called him and he answered with a very weak voice. He said that he was unwell, that he had diarrhoea and that it was black. Sylvia knew that the black colour meant that the stool had blood in it.[17]

16. Sylvia went home and called a doctor friend who advised her to take the deceased to the hospital immediately, so Sylvia drove the deceased to the PHC-ED.[18] They arrived at about 5.30 pm.[19]

17. Sylvia called Sachar, who drove from Perth to the PHC-ED.[20]

18. The deceased was seen by a triage nurse who recorded that the presenting problem was '?melena … Noticed this Am. Nil Hx of same. States episode of dizziness thia am as well. MHX NIDDM P92 reg' which I understand to mean: Query melaena which was noticed this morning. No history of melaena. The patient states that he had an

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[14] Exhibit 1, Tab 12, Tab 16
[15] Exhibit 1, Tab 9
[16] Exhibit 1, Tab 12
[17] Exhibit 1, Tab 12
[18] Exhibit 1, Tab 12
[19] Exhibit 1, Tab 11
[20] Exhibit 1, Tab 12, Tab 16

episode of dizziness this morning as well. He has a medical history of non-insulin dependent diabetes mellitus. His pulse is 92 beats per minute and is regular.[21]

19. The triage nurse allocated the deceased a triage code of '4 Semi Urgent' which indicates an expectation that the deceased would be seen by a doctor within one hour.[22] In fact the deceased was not seen until just after 7.00 pm.[23]

20. The emergency doctor who saw the deceased was Dr Hendrickson.[24]

21. The deceased told Dr Hendrickson that he had an episode of a loose dark stool which he described as melaena, and an episode of dizziness. He denied passing fresh blood from his rectum and denied chest pain, palpitations, nausea, vomiting, fevers and urinary symptoms. He described to Dr Hendrickson a medical history which included type 2 diabetes, chronic renal failure, peripheral neuropathy, hypertension, gout, sleep apnoea and left hemidiaphram phrenic nerve palsy. He also described his current medications, which included 150 mg of aspirin daily.[25]

22. Dr Hendrickson examined the deceased and found that his cardiovascular observations were within normal limits and that his temperature was normal. Dr Hendrickson performed a rectal examination and found dark stool and no fresh blood. Urinalysis indicated a trace of blood, protein and specific gravity of 1.015. [26]

23. Dr Hendrickson arranged for blood testing. The results indicated that haemoglobin was 92 g/L when the normal range was considered to be 122 to 170. Creatinine was

[21] Exhibit 1, Tab 11
[22] Exhibit 1, Tab 13
[23] Exhibit 1, Tab 11
[24] Exhibit 1, Tab 7
[25] Exhibit 1, Tab 7, Tab 11
[26] Exhibit 1, Tab 7

raised at 208 (normal: 40 – 120) as was urea at 32.0 (normal: 3.0 – 8.0).[27]

24. Dr Hendrickson formed the impression that the deceased may have had infective gastroenteritis and dehydration. He advised him to take an anti-diarrhoeal medication as required. Dr Hendrickson went to see the consultant in charge of the PHC-ED, Dr Westcott, and confirmed that a CT scan of the deceased's abdomen and chest was not required.[28]

25. At about 9.00 pm on 11 November 2012 Dr Hendrickson discharged the deceased with follow-up by his general practitioner and a referral to an endoscopy if the dark stool persisted. He told the deceased to return to the PHC-ED if he was feeling unwell.[29] He did not provide the deceased with a discharge summary.[30]

26. The following account relating to Sachar's involvement is based on evidence contained in Sachar's typed and unsigned statement.[31] It is not clear when the statement was prepared, but it appears from my perusal of the Court's correspondence file in relation to the deceased to have been provided to the Court in 2015.

27. When Sachar arrived at the PHC-ED he learned that Dr Hendrickson felt that the deceased was suffering from gastroenteritis. Sachar spoke to the deceased who told him that he had never felt so sick and could hardly keep his eyes open. Sachar was concerned because the deceased rarely complained.

28. Sachar was not happy with the suggestion that gastroenteritis could cause the deceased to be so sick. He queried with hospital staff whether the deceased's symptoms could have been caused by internal bleeding in accordance with his understanding that blood went black from being in the intestines for some time.

[27] Exhibit 1, Tab 11
[28] Exhibit 1, Tab 7; ts 95-96 per Hendrickson, N
[29] Exhibit 1, Tab 7
[30] ts 98 per Hendrickson, N
[31] Exhibit 1, Tab 16

29. Sachar was told that he needed to let the doctor do his job.

30. Sachar noted that the deceased was in good spirits despite feeling so ill. For example, as Dr Hendrickson was putting on a glove for a digital rectal examination, the deceased said, 'I hope you respect me in the morning.'

31. When it appeared that the deceased was to be discharged, Sachar told staff that the deceased needed to be admitted, but he was assured that the deceased just needed to rest. He told them that, if the deceased said he did not feel well, something was really wrong. The deceased told him that the doctors knew what they were doing and that he did feel exhausted and perhaps just needed to rest as claimed.

32. When the deceased and his family left the hospital, Sachar suggested to the deceased that he would take him to Royal Perth Hospital, but the deceased told him that the emergency doctors knew what they were doing.

DID DR HENDRICKSON IGNORE THE CONCERNS OF THE DECEASED'S FAMILY?

33. If the contents of Sachar's statement are factually correct, they describe an unfortunate situation where the reasonable, and ultimately justified, concerns of the deceased's family were discounted by either Dr Hendrickson or nursing staff at the PHC-ED, or both.

34. When asked in particular who had told him to let the doctor do his job, Sachar clearly identified Dr Hendrickson.[32]

35. However, Sachar qualified his evidence to admit that he was unable now to say who had said the other things he had alleged in his statement,[33] and I note that Sylvia

[32] ts 12 per Weiser, S
[33] ts 12 per Weiser, S

makes no mention of these issues in her statement of 4 July 2014.[34]

36. Dr Hendrickson was unable to recall any of the details of his interactions with the deceased's family. However, he denied having said to Sachar or anyone else that he was the doctor and that Sachar had to let him do his job.[35] He also said that he considered information and concerns expressed by patients' family members to be important and that he advises junior doctors whom he supervises to pay attention to what a patient's family says.[36]

37. In these circumstances, I am unable to find whether or not Dr Hendrickson had ignored the deceased's family's concerns as described by Sachar, but it is clear that Sachar left the PHC-ED on 11 November 2012 with the impression that he had.

EVENTS LEADING UP TO DEATH

38. After leaving the PHC-ED with Sylvia, the deceased went home where he ate a little takeaway chicken and went to sleep. During the night he again passed dark stools.[37]

39. The deceased stayed in bed until about 11.00 am on Monday 12 November 2012. He got up and had some oatmeal and then sat out the back while Sylvia did some cake decorating.[38]

40. At about 2.00 pm he was still feeling unwell, so Sylvia suggested that she take him to the doctor, but the deceased did not want to go, expecting that he would feel better by the next day. He went to bed that evening at about 7.00 pm.[39]

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[34] Exhibit 1, Tab 7
[35] ts 108 per Hendrickson, N
[36] ts 108 per Hendrickson, N
[37] Exhibit 1, Tab 12
[38] Exhibit 1, Tab 12
[39] Exhibit 1, Tab 12

41. Sylvia went into the bedroom at about midnight and saw that the deceased was sitting on the edge of the bed. He was sweating and said that that he felt unwell. Sylvia said that they should go to the hospital, but he refused. She sponged him down and made him some tea.[40]

42. At about 3.00 am the deceased was trying to get up from the bed when he collapsed onto the floor in an awkward position.[41]

43. Sylvia called '000' and paramedics attended promptly but were unable to revive the deceased. During cardiopulmonary resuscitation, blood had come out of the deceased's mouth.[42]

44. At 3.30 am one of the paramedics certified that the deceased had died.[43]

THE CAUSE OF DEATH

45. Forensic pathologist Dr D M Moss conducted a post mortem examination and found copious brown liquid emanating from the mouth and extensive gastrointestinal haemorrhage with blood and altered blood extending from the stomach to the rectum. There were two small ulcers in the stomach, one of which showed erosion of a large artery at the ulcer base. The internal organs appeared pale.[44]

46. Toxicological analysis showed a therapeutic level of the anti-diabetic medication gliclazide and a low therapeutic level of paracetamol. A blood test showed satisfactory diabetic control.[45]

[40] Exhibit 1, Tab 12
[41] Exhibit 1, Tab 12
[42] Exhibit 1, Tab 12
[43] Exhibit 1, Tab 2
[44] Exhibit 1, Tab 4
[45] Exhibit 1, Tab 4, Tab 5

47. Vitreous biochemistry showed a markedly raised urea level consistent with the history of gastrointestinal haemorrhage.[46]

48. Dr Moss formed the opinion, which I adopt as my finding, that the cause of death was gastrointestinal haemorrhage in a man with gastric ulcers.[47]

EVIDENCE OF THE STANDARD OF MEDICAL CARE OF THE DECEASED

49. Dr Hitchcock is a consultant in emergency medicine, an emeritus consultant for patient safety at the Health Department of Western Australia, an instructor in advanced paediatric life support and a clinical senior lecturer in emergency medicine at the University of Western Australia. He has been a fellow of the Australian College for Emergency Medicine since 1994.[48]

50. Dr Hitchcock was an impressive witness who provided clear and careful evidence. He reviewed the deceased's case and provided a report dated 27 March 2015 on the standard of medical management provided to the deceased at the PHC-ED.[49]

51. Dr Hitchcock's report included the following points:[50]

    (a) Gastroenteritis is a diarrheal disease of rapid onset that may be accompanied by nausea (93% of cases in one study), vomiting (89%), fever or abdominal pain (76%). Both vomiting and diarrhoea (89%) are usually present although either can occur alone;

    (b) The deceased had a low blood pressure and an elevated pulse, consistent with low circulating blood volume and with dehydration;

[46] Exhibit 1, Tab 4, Tab 5
[47] Exhibit 1, Tab 4
[48] Exhibit 1, Tab 14
[49] Exhibit 1, Tab 14
[50] Exhibit 1, Tab 14

(c) An elevated pulse in the presence of one of the deceased's medications, metoprolol, is very unusual;

(d) The absence of melaena does not exclude gastrointestinal haemorrhage;

(e) The level of urea in the blood was out of proportion to the level of creatinine, consistent with a significant gastrointestinal bleed but not with chronic renal failure;

(f) The information available to Dr Hendrickson of passing altered blood and dizziness, abnormal observations indicating a low circulating blood volume, low haemoglobin and urea elevated out of proportion to the creatinine level was adequate to make a clinical diagnosis of probable gastrointestinal haemorrhage;

(g) The absence of nausea, vomiting, recurrent diarrhoea, colicky abdominal pain and fever made infectious gastroenteritis unlikely.

52. Dr Hitchcock concluded that the deceased was not managed to an appropriate standard at the PHC-ED because an incorrect diagnosis was made and, as a consequence, his undiagnosed condition progressed untreated and he died.[51]

53. However, Dr Hitchcock considered that it was not correct that the standard of care was provided solely by the individual clinicians involved.[52]

54. Dr Hitchcock stated that experience had led him to be cautious when considering standard of care decisions made by individual doctors making diagnostic errors in emergency departments because misdiagnosis is known to occur in emergency medicine.[53]

[51] Exhibit 1, Tab 14
[52] Exhibit 1, Tab 14
[53] Exhibit 1, Tab 14

55. He thought that Dr Hendrickson was capable of making the correct diagnosis but that the error he made was about flawed decision-making rather than incompetence.[54]

56. Dr Hitchcock provided the rather startling evidence that studies have shown a 30% rate of errors in emergency departments, of which diagnostic errors are foremost.[55] He said that, in order to reduce that rate and risks of error, emergency departments should have clinical governance systems.[56]

57. He stated that one such system is to have specialists in emergency medicine available in a formalised team structure to provide oversight and consultation.[57] I note that the Quality Standards emphasises the use of ED teams.

58. Another issue that Dr Hitchcock addressed was the need for emergency departments to have ready access to past medical histories, prescribed medication lists and past laboratory results. He suggested that, if Dr Hendrickson had the deceased's past renal function tests and haematology results, he would have been more likely to have made a correct diagnosis.[58]

59. However, Dr Hitchcock said that Dr Hendrickson was an advanced trainee so was considered a senior doctor and was expected to have a higher degree of responsibility and to work more independently than junior doctors.[59]

60. Dr Hitchcock said that he would have expected Dr Hendrickson to manage cases independently, to identify areas in which he wanted help or a second opinion or to discuss diagnostic and management decisions and even procedures.[60]

[54] ts 34, 68 per Hitchcock, T
[55] ts 69 per Hitchcock, T
[56] Exhibit 1, Tab 14; ts 36, 38 per Hitchcock, T
[57] Exhibit 1, Tab 14; ts 38 per Hitchcock, T
[58] Exhibit 1, Tab 14
[59] Exhibit 1, Tab 14
[60] ts 36 per Hitchcock, T

61. Dr Westcott also said that he would expect any advanced trainee to be able to function reasonably independently and to have a sense of their own limitations and know when to seek out help and advice.[61]

62. As to Dr Westcott, Dr Hitchcock said that his role in relation to Dr Hendrickson was one of consultation and oversight rather than direct supervision.[62]

63. In letters to the Court dated 10 June 2014 and 23 March 2015 Dr Westcott noted that his employment at the PHC-ED at the time of the deceased's death was on a casual or locum basis, assisting the department when permanent staff were unavailable. As he was working in sporadic shifts, it was difficult to gain an appreciation of the knowledge and skill base of all the doctors in the department. That difficulty compounded the factors of staffing across all levels, patient numbers, patient acuity and departmental workload.[63]

64. Dr Westcott had only worked on a few occasions with Dr Hendrickson. He was aware that Dr Hendrickson had more than 10 years' experience as a doctor and that he was an advanced trainee in the specialist training program for emergency medicine. In those circumstances the expected level of supervision was less than for an intern or junior resident.[64]

65. Both Dr Hitchcock and Dr Westcott said that a doctor at Dr Hendrickson's level of training would be expected to make the correct diagnosis of the deceased's condition given the information available.[65]

66. Dr Westcott did not understand how Dr Hendrickson arrived at the diagnosis of gastroenteritis. He said that, had he been aware of the triage report for the deceased showing dark stools with associated dizziness, those

[61] ts 76 per Westcott, G
[62] Exhibit 1, Tab 14
[63] Exhibit 1, Tab 8
[64] Exhibit 1, Tab 8
[65] ts 34 per Hitchcock, T; ts 79 per Westcott, G

details alone would have made him suspicious that the deceased had a potentially life-threatening condition.[66]

67. Dr Westcott said that, had he been aware of the blood test results which increased the suspicion of gastrointestinal bleeding, he would have advised Dr Hendrickson to transfer the deceased to a tertiary hospital for urgent endoscopic investigation of the source of the bleeding.[67]

68. It is apparent from the foregoing that Dr Hendrickson misdiagnosed the deceased's gastrointestinal haemorrhage as gastroenteritis and that, as a result, the standard of medical care provided to the deceased at the PHC-ED on 11 November 2012 was inappropriate.

WOULD THE DECEASED HAVE SURVIVED IF PROPERLY DIAGNOSED?

69. Dr Hitchcock considered that the likely course of treatment had Dr Hendrickson diagnosed the deceased with gastrointestinal haemorrhage would have been an admission to PHC and a transfer to Fremantle Hospital for an endoscopy for diagnostic and repair procedures.[68]

70. While he stressed that he was not experienced in endoscopies, Dr Hitchcock understood that a bleeding point can be injected with vasoconstrictors to stop ongoing haemorrhage and, if that is unsuccessful, surgery can be performed to remove the portion of the stomach that is bleeding.[69]

71. Dr Hitchcock noted that the deceased was in a high-risk category of gastrointestinal haemorrhage, but he stated that if properly diagnosed the deceased would at least not have died when he did and, on balance, if everything had gone well, that he probably would have been treated.[70]

[66] Exhibit 1, Tab 13
[67] Exhibit 1, Tab 13
[68] ts 49-50 per Hitchcock, T
[69] ts 32 and 50 per Hitchcock, T
[70] ts 35 per Hitchcock, T

He explained that the deceased had some anaesthetic risks due to high co-morbidities but that none of them was an absolute contrary indication.[71]

72. It is apparent from Dr Hitchcock's evidence that, at worst, the deceased would not have died at home on 13 November 2012 and that he missed out on a real chance of surviving the gastrointestinal haemorrhage altogether. It is not possible for me to quantify that chance.

DR HENDRICKSON

73. Dr Hendrickson graduated from medical school at Flinders University in South Australia in 1998 and worked as an intern and registrar before moving to Western Australia in January 2000. He worked in the Australian military for five years as a medical officer in varying capacities.[72]

74. He began working intermittently at the PHC in 2005 and also worked at Armadale Hospital.[73]

75. Dr Hendrickson worked as a provisional trainee in emergency medicine for four years and commenced advanced training in that speciality in 2009.[74]

76. Since the death of the deceased, Dr Hendrickson has continued with his training as an emergency medicine specialist and began preparing in June 2013 for the final examination. He sat the written part of that examination on the Friday before the inquest.[75]

77. Dr Hendrickson appeared to me to be truthful and candid. He said that when he learned of the deceased's death he researched the subject of gastrointestinal haemorrhaging extensively and at some stage had a

[71] ts 50 per Hitchcock, T
[72] ts 84-85 per Hendrickson, N; ts 62 per Bourke, D J
[73] ts 85 per Hendrickson, N
[74] ts 62 per Bourke, D J
[75] ts 84 per Hendrickson, N

'goodness gracious, what were you thinking at the time' moment.[76]

78. He said that at the time he was treating the deceased he was not aware of his own limitations, but since then he has become acutely aware by the further reading and studying that he has done.[77]

79. Dr Hendrickson generally agreed with the opinions of Dr Hitchcock and Dr Westcott. He agreed that he had sufficient information at the relevant time to make the diagnosis of gastrointestinal haemorrhage.[78]

80. In oral evidence Dr Hendrickson said that his recollection of the details of the deceased's presentation at the PHC ED remains sketchy at best.[79]

81. Dr Hendrickson considered that it was possible that he did not make that diagnosis because at the time he had a gap in his knowledge about melaena, believing that, unless a stool was very black and had an extremely offensive odour, it was not properly described as melaena. As his rectal examination did not disclose a stool with that odour, he excluded gastrointestinal haemorrhage as a diagnosis.[80]

82. Dr Hendrickson said that he was not aware at the time that he had that gap in his knowledge.[81]

83. He said that, at the time, he was also unaware of the relevance of a urea level raised disproportionately to the creatinine level. It seems that it was another gap in his knowledge of which he was unaware.[82]

84. Dr Hendrickson was unable to explain how he arrived at the diagnosis of gastroenteritis in the absence of symptoms of nausea, vomiting, recurrent watery

[76] ts 101 per Hendrickson, N
[77] ts 109 per Hendrickson, N
[78] ts 94 per Hendrickson, N
[79] ts 85 per Hendrickson, N
[80] ts 91 per Hendrickson, N
[81] ts 91 per Hendrickson, N
[82] ts 92 per Hendrickson, N

diarrhoea, abdominal pain or fever.[83] He said that there were very few things on his notes that point to gastroenteritis and that he was having difficulty reconstructing his thinking at the time.[84]

85. It is apparent from Dr Hendrickson's note which indicated that the deceased should seek a referral to an endoscopy if the melaena persisted, that Dr Hendrickson had not excluded the possibility that the deceased had gastrointestinal haemorrhage. Yet, he discharged the deceased's home.

86. Rather than consulting with Dr Westcott about the deceased' s conditions or his own conclusions, it seems that Dr Hendrickson either confirmed that a CT scan of the deceased was not needed or sought guidance on that issue alone. He candidly admitted that his recollection was that when doing so he passed on an impression to Dr Westcott that he was confident with his diagnosis.[85]

87. Dr Hendrickson has continued to work as an emergency medicine clinician and has recently sat a final examination in that speciality, so it is likely that he has demonstrated his competence in the time since the deceased's death.

88. I appreciate Dr Hitchcock's evidence about the need for emergency departments to have appropriate governance structures in place to support clinicians in order to reduce the incidence of diagnostic errors.

89. However, the nature and the consequences of Dr Hendrickson's misdiagnosis of the deceased's condition leads me to the view that it is appropriate that, under s 50 of the *Coroners Act 1996*, I refer the evidence of his conduct with respect to the treatment of the deceased to the Medical Board of Australia through the Australian Health Practitioner Regulation Agency, as that

[83] ts 94 per Hendrickson, N
[84] ts 109 per Hendrickson, N
[85] ts 96 per Hendrickson, N

evidence might lead that board to inquire into his conduct. Of course, whether the Medical Board of Australia does so inquire is entirely a matter for it to determine.

HOW DEATH OCCURRED

90. Given Dr Hitchcock's evidence, which I accept, that the deceased's condition was incorrectly diagnosed and as a consequence of his undiagnosed condition progressing untreated he died, it is clear that the deceased would not have died when he did had he received appropriate care.

91. I find that death occurred by way of misadventure.

CHANGES SINCE THE DECEASED'S DEATH

92. On 6 December 2012 the Premier of Western Australia directed the Public Sector Commissioner to hold a special inquiry under the *Public Sector Management Act 1994* into the delivery of public health services at the Peel Health Campus by Health Solutions Pty Ltd. Professor Bryant Stokes was appointed the role of special inquirer.[86]

93. Relevant to the deceased's death, the inquiry noted that for some years there had been very serious difficulty in attracting staff, particularly doctors and particularly trained emergency medicine specialists with appropriate qualifications such as Fellow of the Australasian College of Emergency Medicine (FACEM).[87]

94. The inquiry also noted that three reviews had pointed to the need to improve significantly the hospital's IT systems. The inquiry noted that the upgrading was being addressed.[88]

[86] Exhibit 1, Tab 15
[87] Exhibit 1, Tab 15
[88] Exhibit 1, Tab 15

95. On 1 June 2013 the identity of the operator of Peel Health Campus changed from Health Solutions (WA) Pty Ltd to Ramsay Health Care Pty Ltd.[89]

96. The Court received correspondence dated 18 August 2015 and 19 August 2015 from Dr Margaret Sturdy, the chief executive officer of Peel Health Campus, addressing issues of the current nature and level of staffing at the PHC-ED, the patient information system, the provision of discharge summaries and the system for reviewing abnormal test results in discharged patients.[90]

97. Dr Sturdy stated that the PHC-ED is now staffed at all times with a skill mix which includes FACEMs, senior medical officers with many years of emergency medicine experience, registrars who are either undergoing training in medical specialities or who are experienced doctors considering entering formal speciality training, residents and interns.[91]

98. During each day shift there are generally two FACEMs on duty and another FACEM engaged in non-clinical duties. There is a full-time medical director of the emergency department.[92]

99. Dr Sturdy stated that one FACEM is allocated as team leader and has the role to supervise the more junior medical staff, to be the point of reference for clinical concerns, and to oversee the department to ensure that the department 'flows' and that patient risk is mitigated.

100. Dr Sturdy stated that the PHC's patient information system is paper-based and is limited to patients who have had a previous attendance at the PHC. There is a capability to obtain on-line pathology results, radiology images and reports from a variety of providers including those contracted to provide services on site.[93]

[89] Exhibit 1, Tab 17
[90] Exhibit 1, Tab 17
[91] Exhibit 1, Tab 17
[92] Exhibit 1, Tab 17
[93] Exhibit 1, Tab 17

101. However, Drs Hitchcock, Westcott and Hendrickson said that, unlike the public hospitals in which they worked, the PHC-ED did not have direct access to patient records and investigation results unless it related to treatment previously received at the PHC.[94] They impliedly agreed that such information would be very useful at the PHC-ED and could see no reason why it was not available.[95]

102. Dr Hendrickson believed that ready access to past pathology results at the time he saw the deceased would have prompted him to go to Dr Westcott to seek advice.[96]

103. Dr Sturdy stated that discharge summaries are expected to be provided to patients by the PHC-ED. Such summaries are to outline the reason for presenting, the clinical findings, investigations, proposed treatment, and whether follow up or further referral is required.[97]

104. Dr Westcott's evidence in relation to discharge summaries was that they are a good idea in principle but are not practical in reality.[98] However, Dr Hendrickson said that he now made a habit of providing discharge summaries to his patients.[99]

105. I note that Standard 1.8 of the Quality Standards requires that 'Patients who are discharged to the community ... receive discharge information and instruction to ensure adequate care and follow up is provided' and that Standard 1.8.7 appears to require that a written discharge summary is given to the patient.

106. Dr Sturdy stated that the PHC-ED also has a system for reviewing abnormal results of tests following the discharge of patients. If there is further patient review required, the patient is contacted and recalled to the department or advised to see the patient's doctor for assessment.[100]

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[94] ts 56-57 per Hitchcock, T; ts 82-83 per Westcott, G; ts 96-97 per Hendrickson, N
[95] ts 67 per Hitchcock, T; ts 83 per Westcott, G; ts 97 per Hendrickson, N
[96] ts 94 per Hendrickson, N
[97] Exhibit 1, Tab 17
[98] ts 81 per Westcott, G
[99] ts 98 per Hendrickson, N
[100] Exhibit 1, Tab 17

107. Dr Hitchcock said that systems of reviewing abnormal test results may be done electronically or manually. The manual systems can take a considerable time, and in the deceased's case it is unlikely that a review would have been completed in time to have made a difference to the outcome.[101]

ACCESS TO MEDICAL INFORMATION

108. On my view of the evidence, the changes effected to the PHC-ED following the death of the deceased are welcome steps; however, in the face of the high proportion of misdiagnoses in emergency departments in Western Australia, it seems to me that all steps that would be reasonably likely to reduce that proportion should be taken.

109. As noted above, Dr Hitchcock noted the need for emergency departments to have ready access to patient's past medical histories, prescribed medication lists and past laboratory results. He said, perhaps as somewhat of a truism, that the more information that is available at the bedside to clinicians, the better position they are in to make appropriate decisions and diagnoses.[102]

110. Dr Hendrickson did not have the deceased's previous pathology results because they were prepared by a laboratory that was not contracted to the PHC. It may have been possible for him to have contacted the laboratory in order to obtain those results, but at a minimum he would have had to have known which laboratory it was. Searching for the correct laboratory can, as Dr Hitchcock said, take ages.[103] While a patient can sometimes recall which laboratory was used, if the patient is unconscious that possibility does not arise. Dr Hitchcock said that it is one of the uncertainties of working in the emergency department.[104]

[101] ts 40 per Hitchcock, T
[102] ts 18 per Hitchcock, T
[103] ts 56-57 per Hitchcock, T
[104] ts 67 per Hitchcock, T

111. The inability of clinicians to obtain a patient's medical information still exists. While clinicians in public hospitals are able to access a great deal of relevant information from a central database, private hospitals cannot. Dr Westcott said that, from working at private hospitals, he had built up ways of knowing how to go about getting pathology results from the public system. It was, he said, a matter of knowing who to call.[105]

112. Dr Hendrickson agreed, and said that when working in the public system he could not reach out to private systems without knowing who to contact. On a Sunday evening, the opportunities can be limited.[106]

113. In closing submissions, Mr Williams submitted that the *Privacy Act 1988 (Cth)* prohibited the sharing of health information between legally disparate entities in the absence of patient consent, so that no recommendation I might make in relation to the sharing of such information between private and public hospital system could be of benefit.[107]

114. Mr Williams submitted that the use by patients of a means of carrying their own information in a device such as a smart card or on a smart phone may provide a way around the current impediments to communication. He said that the Commonwealth Department of Health had introduced a system known as 'personally controlled eHealth records' or PCEHR, which was an example.[108]

115. When asked about PCEHR by Mr Williams, Dr Hitchcock said that he was unaware of such records being accessed and said they are not a contemporary clinical tool.[109]

116. It is clear to me from the foregoing that a problem with the availability of patient information currently exists in emergency departments. It is at least possible that Dr Hendrickson's inability to have ready access to the

[105] ts 82-83 per Westcott, G
[106] ts 106 per Hendrickson, N
[107] ts 120-121 per Williams, M L
[108] ts 121 per Williams, M L
[109] ts 67 per Hitchcock, T

deceased's medical information contributed indirectly to the deceased's death.

117. It seems to me that there may be several potential means, whether technical, administrative or legislative, of allowing emergency departments to gain access to that sort of information.

118. I make the following recommendation in qualified and general terms since the Western Australian Department of Health was not represented and was not asked to provide evidence at the inquest.

RECOMMENDATION

> If it is not already doing so, the Western Australian Department of Health, take steps to attempt to identify and have in place a means of giving clinicians in emergency departments timely access to patients' health information from all sources.

CONCLUSION

119. The deceased was 70 years old and in reasonably stable health when he began to experience symptoms of gastrointestinal haemorrhage from gastric ulcers.

120. He attended the PHC-ED and described those symptoms to a triage nurse and to the treating emergency doctor, Dr Hendrickson.

121. Dr Hendrickson examined the deceased and arranged for blood tests, the results of which supported a diagnosis of gastrointestinal haemorrhage.

122. Rather than making that diagnosis, somewhat bafflingly Dr Hendrickson arrived at a diagnosis of gastroenteritis despite there being no symptoms or results to support it. He discharged the deceased home.

123. The deceased trusted in the care he received at PHC-ED, so when his condition worsened, he declined his wife's suggestion to take him back to hospital.

124. As a result, the deceased died an untimely death from his undiagnosed condition.

125. The evidence in this inquest shed light on the potential for misdiagnosis by emergency doctors. One means of reducing that potential would be for patients' health information to be readily available to emergency departments.

126. Should the death of the deceased assist to motivate those in a position to effect the necessary changes to bring about that situation, his family might be comforted by the fact that at least one positive result could flow from his death.

Barry King
Coroner
18 September 2015