Cyril CHURCHILL

Cyril Churchill, aged 68, died on 13 November 2017 from surgical complications following the removal of his inflamed gallbladder and delays in post-operative management. A laparoscopic cholecystectomy was performed and following the procedure, Mr Churchill's blood pressure became dangerously low despite repeated doses of medication, intravenous fluids and blood transfusions. Mr Churchill's treating team considered two possible explanations for his symptoms, but there was disagreement as to if there was internal bleeding or that his symptoms rather related to an infectious process, most probably a septic shower. A MET call was put out as Mr Churchill continued to be hypotensive despite treatment. As other staff arrived, there was a lack of clarity as to who was acting as team leader, and concerns over the risk of another general anaesthetic given Mr Churchill's blood pressure. After significant delay Mr Churchill eventually returned to surgery, where three litres of blood were drained, and a damaged aberrant branch of the cystic artery was repaired. Mr Churchill was transferred to Royal Darwin Hospital the next day with multiorgan failure as the result of prolonged hypotension. Despite treatment in the Intensive Care Unit, he did not recover and was palliated with his family present.

The Coroner found that death occurred by misadventure with the inadvertent cutting of an aberrant branch of the cystic artery leading to massive blood loss and subsequent multiorgan failure. It was noted that this is a recognised complication of cholecystectomy, with 20% of the population having aberrant cystic arteries.
The Coroner made five recommendations related to point of care ultrasound, health records management, clinical communication and clinical escalation roles including leadership of MET calls.
The CRC has reviewed these findings and made enquiries with the relevant stakeholders.

August 2021 Update

The WA Country Health Service (WACHS) provided a preliminary update regarding the implementation of the recommendations. Members agreed that recommendation four regarding improving communications between clinicians involved in patient care was applicable to all Health Service Providers.

February 2022 Update

The WACHS review of the findings and recommendations continued, with each Health Service Provider considering recommendation 4. In response to recommendation 1, WACHS have developed the *Use of Focused Ultrasound for Diagnostic Purposes in Emergency Departments Guideline.* The guideline includes minimum education, training and credentialing requirements for practitioners using ultrasound point of care as well as guidance as to the appropriate clinical circumstances in which it should be used. The guideline is currently seeking executive endorsement/approval.

In consideration of recommendation 2 and 3, the WACHS Health Records Management Policy and WACHS Documentation Clinical Practice Standard have been reviewed. The Policy and Standard are to be read together. The WACHS review of the Policy and Standard found that they provide adequate guidance on what constitutes a medico-legal report and why such documents may not appear on a

patient's health record. In response to recommendation 3, the Standard was amended and includes the following requirement "entries made by clinicians in or for a patient's health record are not to be removed, left unfiled or deleted unless an appropriately authorised person determines it is to be removed in compliance with the requirements of relevant legislation".

No further amendments are planned to the Policy or Standard in response to the Coroners recommendations.

All Health Service Providers have governance mechanisms and programs in place that are available to staff to ensure effective communication and escalation occurs in resolving disagreement between clinicians as to the management of a patient during clinical deterioration. In response to recommendation 4 members observed mechanisms to include policies, escalation pathways, governance framework models, programs and staff training. In all Health Service Providers when the escalation process is not progressing in a timely manner then staff members can contact their 'executive on call' to assist. The WACHS *Recognising and Responding to Acute Deterioration (RRAD) Policy* requires sites to document and display internal and external contacts for escalation and medical emergency response. The escalation document includes advice that at any time the escalation process is not progressing in a timely manner, staff members can contact the relevant executive on call. CRC members observed the South Metropolitan Health Service, Fiona Stanley Fremantle Hospitals Group *Communicating for Safety Framework* as an exemplar, with the framework noted to highlight the relationship between each system, process, policy and documentation in one document. All Health Service Providers offer training to staff, and some Health Service Providers and individual hospitals have specific programs in place to support staff to speak up when clinicians disagree on the management of a patient. CRC members observed that whilst these programs have worked successfully in some Health Service Providers, others have found them to be less effective and that good cultural engagement can impact upon successful implementation.

In response to recommendation 5 the WACHS *Recognising and Responding to Acute Deterioration (RRAD) Policy* was reviewed and republished in November 2021 to include a clear statement that the role of Medical Emergency Response Team Leader is clearly identified at the start of the Medical Emergency Response call and thereafter when that leadership role changes.

The CRC members agreed that the recommendations 1 and 5 have been considered actioned and completed and recommendation 2, 3 and 4 have been considered and deemed closed.

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