FORM 37

Rule 60(1)

FINDING INTO DEATH WITH INQUEST

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

Court reference: 1138/05

Inquest into the Death of FAYE GWYNNETH LANCASHIRE

Delivered On:	
Delivered At:	Coroners Court of Victoria Level 11, 222 Exhibition Street, Melbourne, 3000
Hearing Dates:	19th April, 2010, 20th April, 2010, 21st April, 2010, 22nd April, 2010, 23rd April, 2010, 6th December, 2010 and 7th December, 2010
Findings of:	JOHN OLLE
Representation:	Dr Sharon Keeling for the family Mr Chris Winneke for Mr Draper Mr Neil Murdoch for the Bays Private Hospital Ms Fiona Ellis for the Frankston Hospital
Place of death:	Frankston Hospital, Hastings Road, Frankston 3199
Police Coronial Support Unit (PCSU):	Acting Sergeant Kelly Ramsey

FORM 37

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FINDING INTO DEATH WITH INQUEST

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

Court reference: 1138/05

In the Coroners Court of Victoria at Melbourne
I, JOHN OLLE, Coroner

having investigated the death of:

Details of deceased:

Surname: LANCASHIRE
First name: FAYE
Address: 800 Moorooduc Highway, Mornington, Victoria 3931

AND having held an inquest in relation to this death on 19th April, 2010, 20th April, 2010, 21st April, 2010, 22nd April, 2010, 23rd April, 2010, 6th December, 2010 and 7th December, 2010 at Melbourne
find that the identity of the deceased was FAY GWYNNETH LANCASHIRE
and death occurred on or about 4th April, 2005

at Frankston Hospital, Hastings Road, Frankston 3199

from
1a. PRESUMED SEPTIC SHOCK WITH MULTIPLE ORGAN FAILURE
1b. ACUTE ABDOMEN
1c. ACUTE SUPPURATIVE APPENDICITIS
2. RECENT LAPAROSCOPIC DIVISION OF PERITONEAL ADHESIONS

in the following circumstances:

1. On the 31st March, 2005, Mrs Faye Lancashire was admitted to the Bays Hospital under the care of Mr Geoffrey Draper. Details of Mrs Lancashire's admission are set out in a chronology, attached to this finding. The document is entitled Faye Gwynneth Lancashire Chronology, prepared by Dr Keeling for the family.

About an Inquest

2. The Coroners Court is different from other Courts. It is inquisitorial, rather than adversarial. In other words, an inquest is not a trial, with a prosecutor and a defendant, but an enquiry that seeks to find the truth about a person's death - to establish what happened, rather than who is to blame. This gives Coroners more freedom but less power. More flexible in the evidence they accept, but they can't punish.

3. Coroners consider all the evidence and material that comes before them. Not every issue makes its way to the finding, but everything has been weighed up and analysed.

4. Following inquest, each party provided detailed submissions. The comprehensive submissions identify the major issues arising from the inquest. The major issues for my consideration can be identified as follows:

- Lararotomy
- Antibiotocs
- Transfer to Frankston Hospital
- Need to instruct nursing staff to undertake nursing observations overnight
- Was there delay and/or inadequate management following notification of the deteriorating condition of Mrs Lancashire
- Was the bowel resection and ureteric stenting during laparotomy unnecessary

5. I take this opportunity to thank Counsel for their invaluable assistance.

6. First, I should like to thank Mrs Lancashire's family for their patience during this coronial investigation and for their quiet dignity. Despite their obvious grief, they have maintained their sense of fairness and moderation. They want to find out what happened, how Mrs Lancashire died, and whether her death could have been prevented, but they do not necessarily seek to cast blame.

7. None of those involved in this inquest have come under any pressure to hide the truth. On the contrary, together they have done their very best to seek it out.

Laparotomy

8. Dr Keeling[1] submits:

a. Mr Draper's failure to undertake a laparotomy contributed to Mrs Lancashire's death;
b. according to expert evidence, the most likely clinical diagnosis was appendicitis and the only way to treat the condition was by way of laparotomy.[2]

9. In reply, Mr Winneke[3] submits:

[1] Dr Keeling for the family
[2] Submission family page 15
[3] Mr Winneke for Mr Draper

a. Associate Professor Wall was supportive of Mr Draper's judgement not to undertake a laparotomy any time on 1st April and 2nd April;
b. Associate Professor Wall described Mr Draper's judgement as sound, considering Mrs Lancashire's present condition.[4] Further, that Associate Professor Wall supported Mr Draper's judgement that there was a lack of indication of appendix information.

10. The experts were not critical of Mr Draper's decision not to proceed to laparotomy.

11. Dr Jacobs was clear. Mr Draper's decision not to proceed to lararotomy was reasonable.[5]

12. Dr Keeling submits:

a. it was inappropriate surgical management to await Mrs Lancashire's deterioration before performing a laparotomy.[6]

b. Mr Draper failed to investigate the suitability of the hospital being equipped for resuscitation due to septic shock or for performing a laporotomy.[7]

13. I endorse the submission in reply. Both Associate Professor Wall and Mr Jacobs concurred, given the history of the condition and the exhibited symptoms, surgery was not urgent on the evening of April 2nd.[8]

14. In any event, Mr Winneke submits statements of Associate Professor Wall were retrospective analysis, as opposed to a consideration of assessing reasonable clinical judgement on the available information.[9]

15. Dr Jacobs explained the appropriate course was commence resuscitation at the Bays Hospital at 3.30 rather than transferring Mrs Lancashire.[10]

16. In my view, the decision not to undertake a laparotomy in all circumstances was not unreasonable.

Antibiotics

17. The family submits:

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4 Submission of Mr Draper, paragraph 19
5 T - 298
6 Submission of family, page 16
7 Submissions of the family, pages 17 and 18
8 Dr Draper's submission, paragraph 31 and 37
9 Submission to Mr Draper, paragraph 21
10 T - 300

a. according to Mr Jacobs, in the knowledge that Mrs Lancashire was febrile for almost 12 hours and aware she was hyotensive, tachycardic and in septic shock.[11] Mr Draper ought to have prescribed antibiotics;
b. Mrs Lancashire had an 85-90% chance of survival, had antibiotics been commenced;[12]
c. the rationale provided by Mr Draper for not prescribing antibiotics was not supported by Associate Professor Wall or Mr Jacobs. [13]

18. In response, Mr Winneke submits:

a. only in hindsight would Mr Jacobs have prescribed antibiotics and only be treated post-operative causes of febrile illness;[14]
b. In any event, Mr Jacobs and Associate Professor Wall agreed it was not common practice in 2005 and further, there was no research in 2005 which indicated intravenous antibiotics altered the outcome of acute appendicitis.[15]
c. that it was thus not unreasonable of Mr Draper not to commence antibiotics.

19. Mr Draper frankly acknowledged he did not consider anti-biotics.

20. Dr Jacobs deposed he would have commenced antibiotics. He explained, however, that until the precipitous drop in blood pressure around 3.30am Sunday morning, there was "not much else going on".[16]

21. Importantly, the experts concurred in 2005 there was no evidence to suggest antibiotics would be beneficial.

22. Whether the commencement of antibiotics would have altered the outcome is a matter of speculation. Without the benefit of hindsight, in 2005 it was not unreasonable not to commence antibiotics.

Transfer to Frankston Hospital

23. Dr Keeling submits:

a. Mr Draper should have arranged the transfer;

11 Family submission, page 19
12 Family submission, page 20
13 Family submission, page 21
14 Paragraph 41, Mr Draper's submission
15 Paragraph 11, Mr Draper's submission, paragraph 42 and 45 to 46
16 T - 299

b. Mr Draper's claim he decided that a laparotomy and appendicectomy was appropriate should not be accepted because Mr Draper:

i) Did not inform nursing staff;
ii) Did not book Operating Theatre at any time for 3rd April;
iii) Did not arrange an anaesthetist for that time.[17]

24. In reply, Mr Winneke referred to the evidence of Associate Professor Wall:

a. who acknowledged that given the history of the condition, transfer to Frankston Hospital was not urgent;[18]
b. Associate Professor Wall's evidence is not suggestive that a transfer plan should have been in place; rather, he expressed good reasons not to transfer;[19]
c. Though Associate Professor Wall initially suggested a transfer was appropriate, he ultimately acknowledged that the conduct of Mr Draper not to transfer was reasonable.[20]

25. Mr Draper could not have anticipated the rapid deterioration of Mrs Lancashire's condition. All experts were stunned by the dramatic deterioration in Mrs Lancashire's condition.

26. Following the 9.30 phone call from the ward, Mr Draper considered a lapartomy would probably be required. He would decide the following morning. The experts endorsed his clinical judgement as sound.

27. I accept the evidence of Mr Draper. There was no perception of urgency. He had not settled his decision to perform a lapartomy. It follows there is no reasonable basis to criticise him for not having arranged transfer to Frankston Hospital.

Need to Instruct Nursing Staff to Undertake Nursing Observation Overnight

28. The family submit:

a. Mr Draper should have directed nursing staff to perform hourly observations;
b. according to Associate Professor Wall, doctors are responsible for instructing nurses about the care required, including frequency of observations;[21]
c. both Mr Jacobs and Associate Professor Wall believe Mr Draper should have instructed hourly observations be made.[22]

17 Page 21, 22 of family submission
18 Mr Draper's submission, paragraph 31
19 Paragraph 38 Mr Draper's submission
20 Submission Mr Draper, paragraph 17-21
21 Family submission page 22
22 Family submission page 22

29. In reply Mr Winneke submits:

a. Mr Draper was entitled to expect nurses would conduct frequent observations, adjust care accordingly and notify him of significant changes;[23]
b. Nurse Brown prepared a frequent observation chart and according to her, the hourly observations occurred. She was aware that frequent attention was required in all circumstances.[24]

30. I am satisfied hourly observations were carried out. Nurse Brown was experienced and diligent. She called Nurse Ashcroft at midnight. I accept the evidence of nursing staff that hourly observations were carried out between midnight and 4.00am.

31. Whether Mr Draper should have directed nursing staff is thus academic. It follows Dr Keeling's submission his failure to direct hourly observations did not contribute to the cause of death.

Was there delayed and/or inadequate Management

32. The family submit that following notification of a deterioration of Mrs Lancashire's condition the failure to make a call for MICA was improper practice because:

a. Mrs Lancashire's condition was beyond the capacity of the hospital;[25]
b. Mr Draper had no initial plan to transfer Mrs Lancashire if her condition deteriorated;[26]
c. Associate Professor Wall and Mr Jacobs agree that failing to attend Mrs Lancashire at 4.13am on the 3rd April, 2005, was against required medical practice;[27]
d. Associate Professor Wall was critical of Mr Draper for failing to emphasise the importance of the volume of Gelofusin being administered by the nurses to treat the shock.[28]

33. In reply Mr Winneke submits:

a. Mr Draper was not informed of the extent of the deterioration of Mrs Lancashire in the 4.13am telephone call;
b. Mr Draper was informed only of the lack of urinary output;[29]

23 Mr Draper's submission paragraph 52, 53
24 Family submission paragraph 55-57
25 Family submission page 23
26 Family submission page 24
27 Family submission page 25
28 Family submission page 26
29 Mr Draper submission paragraph 70

c. the contemporaneous note made by Nurse Brown, supports his submission on this point;[30]
d. delay in calling the ambulance was not unreasonable;
e. it is speculative to conclude delay in calling a MICA was a cause of death of Mrs Lancashire;[31]
f. there was consensus between the experts that it was appropriate that Mr Draper conduct the initial treatment, rather than immediately calling MICA;[32]
g. there is no clear evidentiary basis to find that delays had any bearing on the outcome.[33]

34. In addition to being informed of the negative urinary output, I find Mr Draper was informed of the clinical observations in the 4.13 phone call. In addition to ordering an in dwelling catheter, he ordered a fluid challenge. He asked to be advised with the outcome of the Gelofusin. Associate Professor Wall was not critical of the regime ordered by Mr Draper.

35. At some time subsequent to the 4.13 call, but prior to the 5.20 call, Mr Draper decided to attend hospital. He had not anticipated the parlous state of Mrs Lancashire's condition.

36. The experts are in heated agreement relating to the clinical dilemma confronting Mr Draper. I have carefully reviewed his course of conduct and can find no fair or reasonable basis to criticise the exercise of his clinical judgement.

37. He appropriately sought advice and acted upon it. He was confronted by a clinical picture he could not have reasonably anticipated.

38. Mr Draper acknowledged Mrs Lancashire's parlous state exceeded his experience. Thereafter, Mr Draper made appropriate and timely enquiries to enable him to exercise his clinical judgement in the best interests of Mrs Lancashire.

39. The issue for my determination is not whether other courses of management were available to Mr Draper. My task is to assess whether the clinical judgement exercised by Mr Draper was reasonable in all the circumstances. In my view, without the benefit of hindsight and doing the best I can to assess his clinical decisions in 2005, I cannot criticise the judgement exercised by Mr Draper.

40. All experts agree Mrs Lancashire's condition was so grave that the sad outcome may not have altered irrespective of any measure implemented.

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30 Submission Mr Draper, paragraph 71
31 Submission Mr Draper, paragraph 80
32 Submission Mr Draper, paragraph 83
33 Mr Draper submission paragraph 89

Bays Hospital Nursing Staff

41. I do not accept the family submission:

a. nursing staff failed to undertake frequent observations of vital signs between 2130 on 2 April and 0400 on 3 April;
b. Bays Hospital nursing staff failed to measure blood pressure at midnight on 2 April 2005.

42. Bays Hospital nursing staff did not inform Mr Draper of the change in clinical condition between midnight on 2 April and 4.00am on 3 April, 2005, however, I do not consider it was necessary in all the circumstances. The experts did not suggest otherwise.

Undertake unnecessary bowel resection and ureteric stenting during laparotomy

43. The family submits:

a. it was evident that Mrs Lancashire was not a stable patient, which according to Associate Professor Wall, is a prerequisite to conducting a resection and ureteric stenting;[34]
b. Mr Draper should have ceased the operation after removing her appendix, ensuring the operation was as short as possible in duration.[35]

44. In response:

a. Mr Jacobs and Associate Professor Wall agreed with the rationale to conduct a resection as to "leave no stone unturned" considering the rate of deterioration of patient;[36]
b. Mr Prendergast would guide the surgeon on the question of the patient's stability.[37]

45. I find no reasonable basis to criticise Mr Draper in respect to the nature, extent or duration of the laparotomy performed at Frankston Hospital. Further, I accept the submission that the anesthetist was the appropriate specialist in terms of the stability of the patient and I do not consider there to be any criticism levelled at Mr Prendergast or any basis to criticise his clinical judgement.

46. Counsel for Frankston Hospital submits that the examination of intensive flow chart reveals that in the immediate post operative period, Mrs Lancashire's condition was consistent (if not

34 Family submission page 26
35 Family submission page 27, 28
36 Mr Draper;s submission, paragraph 91 and 93
37 Mr Draper's submission, paragraph 92

improved) as compared with the pre-surgery condition.[38] Further, Ms Ellis submits the anaesthesia did not contribute to worsening Mrs Lancashire's metabolic state.

47. Ms Ellis submits that Mr Prendergast should not have directed Mr Draper to shorten the operation. Mrs Lancashire was desperately unwell and that problem had to be fixed if she had any prospect of survival.[39]

48. Finally, Ms Ellis submits that the removal of the appendix only, would not have improved Mrs Lancashire's condition.[40]

49. I accept the submissions of Ms Ellis and repeat there is no reasonable basis to criticise the clinical judgement exercised by Mr Prendergast.

Nursing Staff failed to Undertake Frequent Observations of Vital Signs Between 2130 on 2 April and 0400 on 3 April

50. Counsel for family submit:

a. according to Ms Rogerson (Nurse), Mr Jacobs, Mr Draper and Associate Professor Wall, the nursing staff should have made hourly observations.[41]
b. if Mrs Lancashire's deteriorating condition had been more regularly monitored, Mr Draper would have been notified.[42]

51. In response, Mr Murdoch[43] submits:

a. it is a matter of speculation to suggest that if observations were recorded, they would demonstrate deterioration.[44]
b. Mrs Lancashire's clinical presentation was not clear, evident by Mr Draper's first assessment at 0530 where there was no immediate transfer/call to MICA, nor a plan for laparotomy at the Bays hospital.[45]

52. I do not consider the regularity of observation regime undertaken by nursing staff unreasonable.

38 Submission Frankston Hospital, page 4
39 Submission of Frankston Hospital, page 4
40 Submission of Frankston Hospital, page 4
41 Family submission page 28
42 Family submission paragraph 29
43 Counsel for Bays Hospital
44 Submission of Bays Hospital, page 6
45 Submission of Bays Hospital, page 6

Whether nursing staff failed to measure blood pressure at midnight on 2 April 2005

53. Dr Keeling submits:

a. there were no records of vital signs being taken between midnight on 2 April and 0400 on 3 April.
b. if there had been records kept, her blood pressure readings would have prompted notification to Mr Draper and was likely to have meant Mrs Lancashire could have survived.[46]

54. In response, Mr Murdoch submits:

a. that Mrs Lancashire was alert, amiable, communicative and able to walk, establishing that she had sufficient blood pressure to keep her brain perfused.[47]
b. that no instructions had been left by Mr Draper to specify the circumstances in which nursing staff should contact him.[48]

55. Dr Keeling's submission invites speculation and I reject her submissions.

Bays Hospital - The need to inform Mr Draper of the change in clinical condition between midnight on 2 April and 4.00am on 3 April 2005

56. Dr Keeling submits that according to Mr Jacobs, the change to Mrs Lancashire's heart rate, respiratory rate, oxygen saturations and episode sweating required nursing staff to notify Mr Draper, per clinical nursing practice.[49]

57. In response, Mr Murdoch submits:

a. there was no evidence that informing Mr Draper earlier would have led to life saving prevention.[50]
b. there is no evidence it was a failure of the nurses to exercise reasonable care not to call.[51]

58. I do not consider there is proper basis to criticise nursing staff at the Bays Hospital.

46 Family submission, page 30
47 Submission Bays Hospital, page 4
48 Submission Bays Hospital, page 5 and 7
49 Family submission page 31
50 Submission of Bays Hospital, page 2
51 Submission of Bays Hospital, page 5 and 7

59. Whilst noting the submission in reply by Dr Keeling I endorse the submission of Mr Winneke:[52]

> *"All of the surgeons who gave evidence expressed surprise at the deterioration in Mrs Lancashire's health, but more particularly at the relatively minor septic focus that caused the dramatic decline. Associate Professor Wall felt that there was either some sinister pathogen or underlying immune deficiency that led to Mrs Lancashire succumbing. Mr Jacobs remained mystified as to why Mrs Lancashire died from what appeared to be a relatively minor septic focus. He described the circumstances as being "exceedingly unusual" one."*

60. Dr Michael Burke, Forensic Pathologist, explained:

> *"The operative records and the post mortem examination did not show a generalised peritonitis. The dramatic clinical decline that occurred to Faye Lancashire would have suggested a generalised peritonitis causing overwhelming sepsis. Certainly the microscopic examination of the appendix, adjacent ileum and post mortem examination of small and large bowel showed fibrinous inflammatory material over the serosa of the bowel. There was no frank pus seen at the operation or at the autopsy examination. Furthermore, the blood culture result was negative."* [53]

61. Finally, Mr Winneke submitted that Mr Jacobs was likewise struck that there was no evidence there was bacteria growing in her blood, or even if the culture's taken at the Bays or Frankston Hospital. [54]

62. The death of Faye Lancashire is a tragedy. There is no reasonable basis, however, to criticise the clinical judgement exercised by medical or nursing staff involved in Mrs Lancashire's care at either the Bays Hospital or Frankston Hospital.

Post Mortem Medical Examination

63. On 6 April, 2005, Dr Michael Burke, Forensic Pathologist at Victorian Institute of Forensic Medicine, performed an autopsy on Faye Lancashire. Dr Burke found the cause of death to be 1(a) Presumed Septic Shock with multiple organ failure, 1(b) Acute Abdomen, 1(c) Acute Suppurative Appendicitis and (2) Recent Laparoscopic Division of Peritoneal Adhesions.

64. Mr Jacobs' description is apt. Mrs Lancashire died of multi system organ failure as a result of what was clearly low grade appendicitis:

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52 Paragraph 95, Submission Mr Draper
53 Post Mortem report, Dr Michael Burke, Forensic Pathologist
54 Transcript 316.

".... the circumstances in which this occurs is exceedingly rare. The nearest analogy I can think of would be of someone developing a cavernous sinus thrombus and cerebral abscess following a pimple on the face. Documented, but exceedingly rare." [55]

65. I thank Counsel for their able assistance in this inquest.

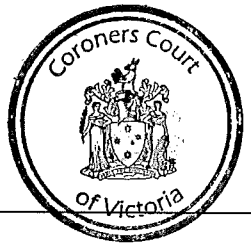
66. The death of Mrs Lancashire is a tragic loss for her family. I repeat throughout the inquest, the family have displayed great dignity.

67. I offer the family my sincere condolences.

Finding

I find the cause of death of Faye Gwynneth Lancashire to be 1(a) Presumed Septic Shock with multiple organ failure, 1(b) Acute Abdomen, 1(c) Acute Suppurative Appendicitis and (2) Recent Laparoscopic Division of Peritoneal Adhesions.

Signature:



John Olle
Coroner
Date: 23rd June 2011

Att: Attachment A: Dr Keeling's Chronology

55 Report Mr Jacobs