FORM 38

Rule 60(2)

FINDING INTO DEATH WITHOUT INQUEST

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

Court reference: 5746/08

In the Coroners Court of Victoria at Melbourne

I IAIN TRELOAR WEST, Deputy State Coroner

having investigated the death of:

Details of deceased:

Surname: STEPHENS
First name: JULIE
Address: 375 Bluff Road, Hampton 3188

without holding an inquest:

find that the identity of the deceased was JULIE ANNETTE STEPHENS and death occurred on 19th December, 2008

at Frankston Hospital, Hastings Road, Frankston 3199

from
1a. SEPSIS

Pursuant to Section 67(2) of the **Coroners Act 2008**, an inquest into the death was not held and the deceased was not immediately before the person died, a person placed in custody or care; but there is a public interest to be served in making findings regarding the following circumstances:

1. Ms Julie Stephens, aged 54 years, was ambulance transferred to Frankston Hospital on the 5th December 2008, with lethargy, poor intake and stating that she was unable to cope at home. Ms Stephens had a past medical history of congestive cardiac failure, sleep apnoea, respiratory failure on home oxygen, hypothyroidism and morbid obesity. In addition, she suffered infective exacerbation of chronic obstructive pulmonary disease and osteoarthritis and had previously been discharged from the hospital on the 2nd December with a chest infection and the oral antibiotic, Amoxicillin Duo Forte. Following admission Ms Stephen was initially admitted to the ward where she was diagnosed as having pneumonia, for which she was given antibiotic cover. It was documented that she had an allergy to morphine.

2. On the 10th December Ms Stephens was transferred to the Intensive Care Unit with septic shock secondary to pneumonia and as she was intubated, she was administered morphine at 3mg per hour as part of the sedation infusion following her intubation and ventilation. This was subsequently stopped late the next day, when it was realized she had a documented allergy to morphine. On the 12th she was in septic shock with adult respiratory disease syndrome, pneumonia and acute renal failure, for which she was commenced on dialysis. Ms Stephen's condition continued to deteriorate and on the 15th December she had increasing abnormal liver function test results, however, she was considered too unwell to undergo an investigative cholangiogram. On the 17th December, Ms Stephens was diagnosed with possible abdominal sepsis, acute renal failure, hypochloremia and pneumonia, and following family consultation on the 19th December, the decision was made to cease active management. Following a not for resuscitation order being given, Ms Stephens was extubated and died at 6.30pm on the 19th December, 2008.

3. On the 30th December 2008, an autopsy examination was performed by Forensic Pathologist, Dr Sarah Parsons, who concluded that the cause of death was due to sepsis, however, its exact cause was uncertain. At the time the examination was conducted, the pathologist was aware of family concerns that morphine was given, even though Ms Stephens was allergic to it. The pathologist comments in her report, that tests undertaken on anti mortem blood revealed no indication of anaphylaxis, hence there is no evidence of an allergic reaction.

4. The family wrote to the Coroners Court, questioning how Ms Stephens became infected; how morphine was administered when she was allergic to the drug and whether investigations and treatment undertaken, was timely. The case was referred to the Clinical Liaison Service[1] at the Coronial Services Centre for review. The Service discussed the circumstances of the death at a multidisciplinary Case Review Meeting chaired by a coroner on the 26th June 2009, wherein they had regard to the medical records of the Frankston Hospital, family letters of concern, the pathology report and the police circumstances of death. Discussions indicated that it was difficult to isolate what caused her infection, she having been admitted to hospital with a community acquired chest infection on a background of chronic obstructive pulmonary disease and congestive cardiac failure. These and her other co-morbidities contributed to her reduced cardiac and respiratory reserve. Whilst the issue regarding the giving of morphine was a very valid concern, there was no evidence that Ms Stephens reacted adversely to the medication. As to the timing of her presentation to the hospital, there were no indications to admit her directly to the Intensive Care Unit from the Emergency Department.

[1] The Clinical Liaison Service, comprising doctors and nurses, assists the Coroners Court in ensuring that the true nature and extent of deaths occurring during specialized clinical provision are fully elucidated and that any remedial factors are identified to prevent any future occurrences.

5. I formally find that Julie Stephens died from sepsis in a setting of reduced cardiac and respiratory reserve and that her hospital management was within normal parameters of reasonable health care management.

COMMENTS:

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

1. Further issues raised by the family include allegations that doctors lied to family members and that Ms Stephens had a number of medical conditions that had not been treated for up to two years, despite multiple hospital admissions. These are not matters for coronial investigation and if they are to be pursued, it should be done through the Office of the Health Services Commissioner.

2. The criticism raised by the family of morphine have been inappropriately administered, is justified. There are multiple references in the medical records to Julie Stephens' opiate allergy, yet it appears they were only noticed on the 11th December. It further appears that an "Allergies and Adverse Reactions" sticker was placed, for the first time, on the medication chart within the records, on the 11th December.

RECOMMENDATIONS:

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

1. That Frankston Hospital considers placing an allergy warning sticker on the front cover of medical records for all patients with known drug and food allergies.

Signature:

Iain West
Deputy State Coroner

Date: 4th March 2010

Coroners Court of Victoria