IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: 03813 / 2009

FINDING INTO DEATH WITH INQUEST

Form 37 Rule 60(1)
Section 67 of the ***Coroners Act 2008***

Inquest into the Death of: MARGARET WEBBER

Delivered On:	28 May 2014
Delivered At:	Coroners Court of Victoria Level 11, 222 Exhibition Street, Melbourne
Hearing Dates:	11 and 12 March 2014
Findings of:	PHILLIP BYRNE
Representation:	Ms Deborah Foy of Counsel for Eastern Health
Police Coronial Support Unit	Leading Senior Constable Tracey Ramsey

I, PHILLIP BYRNE, Coroner, having investigated the death of MARGARET WEBBER

AND having held an inquest in relation to this death on 11 and 12 March 2014
at MELBOURNE
find that the identity of the deceased was MARGARET WEBBER
born on 13 October 1960
and the death occurred on 3 July 2009
at Maroondah Hospital, Davey Drive, Ringwood East
from:

1 (a) ASPIRATION OF STOMACH CONTENTS

1 (b) PNEUMONIA

in the following circumstances:

1. Ms Margaret Webber, 48 years at the time of her death, resided at SCOPE, a registered care facility in Wantirna.

2. Ms Webber had a complex medical history that included cerebral palsy, type one diabetes mellitus, peptic ulcer disease, chronic ear infections, severe hearing impairment, asthma, recurrent urinary tract infection, impaired kidney function, arthritis and persistently abnormal liver function. As a result of her cerebral palsy Ms Webber had communications difficulties; she was non-verbal.

3. The Royal District Nursing Service (RDNS) was engaged to visit Ms Webber twice a day to check her blood sugar levels, administer insulin, eardrops and an asthma preventer.

4. Although a resident at SCOPE, Ms Webber spent periods of time living with her mother, Dr Lorna Webber, who was very involved in her daughter's care. Ms Webber would normally stay with Dr Webber when her blood sugar levels were high, or she appeared medically unstable. The arrangement on foot was if blood sugar levels were high, the RDNS nurse would bring that to the attention of Dr Webber and/or the staff at SCOPE; Dr Webber would then attend the facility and take Ms Webber back to her address at 18/22-24 Hamilton Road, Bayswater. I interpolate that Dr Webber is not a doctor of medicine, but as I understand it, a geneticist.

5. In the event, on the morning of 2 July 2009 the RDNS nurse attended upon Ms Webber and noted her blood sugar levels were high, she had ketonuria and had a persistent cough. Insulin was administered. Later in the day it was noted that Ms Webber's blood sugar

levels remained high; insulin was again administered and in accordance with Ms Webber's management plan Dr Webber was notified. Dr Webber attended the facility and, as was her practice when her daughter's blood sugar did not return to normal, took her home.

6. Dr Webber, in her letter to the Court dated 5 August 2009, relates how overnight on 2 - 3 July 2009 Ms Webber was "agitated" and "restless". Consequently, at 4am she again took her daughter's blood sugar levels and noted they remained high whereas they would generally settle down overnight. Dr Webber concluded "something else was wrong". Dr Webber stated she gave Ms Webber her morning dosage of insulin, noted she was "extra thirsty" and stayed with her.

7. At approximately 6am, shortly after drinking a lot of fluid, Ms Webber vomited up what her mother described as "about a litre of black blood". An ambulance was summoned and Ms Webber was conveyed to Maroondah Hospital where she was admitted to the Emergency Department. Dr Webber has claimed that the first doctor who attended Ms Webber disagreed with the ambulance paramedic's suggestion that the patient had vomited blood; I have presumed that the ambulance paramedic's suggestion that it was blood vomited is based on what was relayed to them by Dr Webber. I have concluded that this apparent contradiction is explained by the doctor having been advised it was "black blood"; as it was described as dark, coffee ground vomit (not bright, red, fresh blood) the doctor has come to the view that while the vomit may have contained some old blood, it was not what I will call a pure blood vomit.

BACKGROUND TO CORONIAL INVESTIGATION

8. I took over carriage of this matter in mid April 2013. My immediate concern was its antiquity, a 2009 matter. Not having had management of the file from the outset brings its own difficulties.

9. On examining the file there is a notation made by the coroner who initially had carriage of the matter indicating she intended to refer to the case to the Clinical Liaison Service (CLS), an internal unit staffed by doctors and nurses, who provide expert advice to assist the coroner as to the appropriate course of investigation.[1] My enquiries indicate no such referral ever occurred.

[1] The Clinical Liaison Service (CLS), now known as the Health and Medical Investigation Team (HMIT) is a unique initiative of the Coroners Court of Victoria and the Victorian Institute of Forensic Medicine (VIFM) to improve patient safety. HMIT is staffed by practising Physicians and Nurses who are independent of the health professionals or

10. If that was not enough, although clearly a "reportable death" in my view, the matter only came to light when the circumstances surrounding the death were brought to the attention of the Court some months after the death by Dr Webber. A death certificate had been issued by one of the treating doctors.

11. However, I note an entry in the medical records apparently made by an ICU Registrar that after Ms Webber's death "the coroners' office was notified about the case and says that it is not a coroners' case". The query would have been made to the Initial Investigations Office of the Coroners Court;[2] regrettably the advice provided by that office was incorrect. The report should have been taken and the matter referred to the duty coroner for a determination. I cannot definitively say what that determination would have been, the death was "reportable" as the vomit and aspiration occurred in the setting of a medical procedure, the attempted insertion of an arterial line.

12. As a consequence of the non-acceptance of the report, no coronial autopsy, to distinguish it from a hospital autopsy, was performed. There is some controversy about whether the hospital autopsy was requested or offered, but I take that matter no further because an autopsy was performed and an autopsy report has been provided to the Court.

13. In her initial letter, dated 3 August 2009, bringing her daughter's death to the attention of the coroner, and in her subsequent letter dated 9 September 2009, Dr Webber made strident criticisms of many aspects of the medical management of her daughter. One of the first things I did, having considered that the matter would ultimately go to formal inquest, was to request the Police Coronial Support Unit (PCSU) to prepare a Brief of Evidence. The Brief was subsequently provided to me and I directed copies of it be provided to the interested parties. I decided to progress the matter by listing for a Mention/Directions Hearing to determine the future course of the matter.

14. On 27 November 2013, I held a Mention/Directions Hearing. Dr Webber (legally unrepresented) attended as did legal representatives for Eastern Health (Maroondah Hospital), SCOPE and the RDNS. Early on, I established Dr Webber, like myself, had no issues with SCOPE or RDNS so I excused them from further attendance. Importantly, I

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institutions involved. They assist the Coroner's investigation of deaths occurring in a healthcare setting by evaluating the clinical management and care provided and identifying areas of improvement similar deaths may be avoided in the future.

[2] The Initial Investigations Office ceased operation as of August 2013, and was replaced by Coronial Admissions & Enquiries, a department within the Victorian Institute of Forensic Medicine.

indicated that I proposed to take the matter to a formal inquest, the scope and parameters for that hearing were set and a tentative list of witnesses was settled. I add that prior to the Mention/Directions Hearing I had invited Dr Webber to outline her concerns so that they could be addressed at the subsequent hearing. By way of a handwritten letter dated 17 September 2013, Dr Webber outlined her complaints. There was a peripheral matter in relation to the wording of the Death Certificate that I said was outside my power to remedy, but assured Dr Webber that the cause of death that will ultimately be on a Death Certificate will be in accord with the formal finding at the conclusion of the Inquest.

15. The matter proceeded to inquest on 11 and 12 March 2014. Dr Webber remained unrepresented, Ms D Foy of counsel appeared for Eastern Health. I heard evidence from the following:

- Dr Lorna Webber;
- Dr Namal Munasinghe, Emergency Department Registrar;
- Dr Miriam Bartlett, Consultant Endocrinologist (at the relevant time Endocrinology Registrar);
- Dr Mayur Garg, Consultant Gastroenterologist (at the relevant time Gastroenterology Registrar).

16. The fact that two of the witnesses who gave evidence, Drs Bartlett and Garg, who at the time of treating Ms Webber were Registrars, have progressed on to be Consultants in their respective fields, amply demonstrates the inordinate delay in this matter getting to formal inquest. One of the upshots, or more correctly downsides, of this delay is the effect the effluction of time has on the memories and recollections of witnesses.

LEGAL REPRESENTATION

17. As stated, at the formal inquest Dr Webber was not legally represented. At the earlier Mention/Directions Hearing I canvassed the issue of legal representation. I stressed that ultimately it was a matter for her, but advised that matters such as this, a quite complex medical matter, it is almost invariably disadvantageous to seek to represent ones own interest. An inquest, by its very nature, is often a stressful emotional hearing so that even an intelligent stoic person like Dr Webber may struggle. It is one thing to present ones own evidence in chief, but to competently and comprehensively cross examine witnesses in relation to areas where they have some special expertise can be problematic.

18. At the hearing, Leading Senior Constable Tracey Ramsey of the Police Coronial Support Unit appeared to assist. As Dr Webber was not legally represented, I indicated to her that, within the constraints of her role of assisting the Court, LSC Ramsey would assist where she was able. During the hearing, LSC Ramsey did actively assist Dr Webber, who also played an active part in the process.

19. This disadvantage of non-representation was especially manifest when it came to formal submissions. Dr Webber merely reiterated her fundamental position that her daughter's death was due to a gastrointestinal bleed that went untreated, and that the death could have been prevented had a blood transfusion been undertaken earlier in the day; she did not refer to specific evidence to support her claim, save that she maintained that one of the doctors who was involved in the treatment of Ms Webber early in the day had indicated to her that a blood transfusion would occur; that person remained unidentified. I do not want to be seen as in anyway critical of Dr Webber.

20. On the other hand, Ms Foy – competent, experienced counsel – sustained each element of her submission by reference to the precise evidence which supported her contention. Ms Foy's oral submission was precise and targeted – with attention to the specific evidence that went to the core issues.

21. In deference to Dr Webber's firmly held belief concerning transfusion I propose to address that issue in some detail. Haemoglobin levels are central to the issue, hence the results of blood tests at various times during the day are critical.

22. It may appear trite, but findings are made on cogent evidence; a contention will not prevail merely because is it made, to be successful it has to be supported by hard evidence.

23. In broad terms I examined Ms Webber's movement through the various units at Maroondah Hospital from her attendance by ambulance to the Emergency Department (Drs Munasinghe and Primrose) at 7.08am, through the Endocrinology Unit (Drs Fayed and Bartlett), to assessment by Dr Garg (the Gastroenterology Unit) and finally to ICU where Ms Webber died at 7.05pm.

24. On arrival in the ED, Ms Webber was seen by Dr Munasinghe. He was advised by Dr Lorna Webber (and ambulance paramedics) that Ms Webber had, at approximately 6am, had large coffee ground vomit believed by Dr Webber to have contained a large quantity of blood; a haematemesis. Dr Primrose took over management of Ms Webber when Dr Munasinghe went off duty.

25. After various radiological and pathological investigations, Ms Webber was diagnosed with, and treated for, diabetic ketoacidosis (DKA), a potentially serious condition. She was administered intravenous fluids and insulin infusions. It is clear that whilst the initial diagnosis and the focus of those treating Ms Webber was DKA. A chest x-ray performed in the ED confirmed a developing left lung pneumonia. It should be noted that a gastrointestinal bleed was a differential diagnosis. As to that prospect, a blood test at 7.55am showed a haemoglobin level of 114g/L, essentially normal for Ms Webber. It is maintained that there were no overt signs of a significant gastrointestinal bleed.

26. At 10.15am blood gas result demonstrated a slight fall in haemoglobin to 104g/L. This was not considered significant or indicative of a gastrointestinal bleed, but was in line with what was expected following the introduction during the morning of intravenous fluids to address the DKA issue.

27. After various treatments in the ED, Ms Webber was referred to the Endocrinology Unit where Dr Fayed (in the absence at that time of Dr Miriam Bartlett) took a comprehensive history, and after discussion with Dr Murray Gertman, Consultant Endocrinologist who had previously treated Ms Webber as a private patient, and who advised Ms Webber be admitted to the Endocrinology Unit and advised the following treatment:

- Commence insulin infusion,
- Ensure adequate hydration,
- Treat the chest infection shown by chest x-ray,
- Continue to measure blood sugar levels.

28. The DKA treatment involved intravenous insulin infusion, intravenous fluids together with intravenous antibiotics. Dr Bartlett, the Endocrinology Registrar, returned from a clinic at Box Hill Hospital and took over the treatment of Ms Webber. Dr Bartlett stated she believed she first saw Ms Webber between 12.30 and 1pm. At 1.05pm Ceftriaxone was given intravenously, and Dr Bartlett ordered further full blood tests. As a consequence, blood was taken at 1.50pm.

29. Dr Bartlett, in evidence, related how having read the notes and taken a history from Dr Webber, turned her mind to the prospect of a gastrointestinal bleed. That is why she ordered "retest blood now". She considered it important to continue to rehydrate Ms Webber. Dr Bartlett says she spoke with the Gastroenterology Registrar, Dr Mayur Garg,

some time after 2pm with a view to having Ms Webber transferred to the Gastroenterology Unit. Dr Garg, who was in theatre at the time, advised he would examine Ms Webber after theatre, but indicated he may consider a gastroscopy to seek to establish if there was a gastrointestinal bleed. The 1.50pm blood tests became available to Dr Bartlett at 3pm. She became concerned as Ms Webber's haemoglobin levels had fallen to 84g/L. Dr Bartlett concluded that could be suggestive of a recent acute blood loss and considered a blood transfusion would be necessary. Dr Bartlett maintains that the decision to transfuse was not taken prior to this because clinical signs did not suggest the need to transfuse. Dr Bartlett related how over a period of time around 3.30pm she endeavoured to "start the process" as she was concerned that the haemoglobin could have fallen to 70g/L or thereabouts during the intervening period. She endeavoured to get a third line in place to facilitate a transfusion when the time came to do so. She conceded she had great difficulty in doing so, claiming it was "very, very tricky". Dr Bartlett's entries in the medical records are timed at 12.58pm and 4.45pm; the first entry was made after her initial assessment of Ms Webber and the second late in the afternoon; not literally contemporaneously as she performed each action. She stated "a lot happened" between 3.30pm and 4.45pm and she wrote her notes thereafter.

30. In light of her difficulty in obtaining a third intravenous line, Dr Bartlett attended the ICU to ascertain whether they would accept her patient to facilitate a central line. Having been advised ICU would accept Ms Webber, Dr Bartlett relates how, after only having been gone for approximately 20 minutes, she returned to the ward only to observe Ms Webber's condition had significantly deteriorated and she had become alarmingly hypotensive.

31. Shortly prior to 5pm, Ms Webber was transferred to ICU; by now, having regard to the rapid deterioration in Ms Webber's condition, for the dual purposes of gaining a central line and stabilising the patient with a view to an upper gastrointestinal endoscopy to determine whether the deterioration was due to a sudden acute bleed.

32. Dr Bartlett had discussed the case with Dr Garg, the Gastroenterology Registrar. Dr Garg's notes in the medical records are made at 5.05pm, after he had seen and assessed Ms Webber in ICU. Dr Garg considered an endoscopy would in all likelihood be performed that evening, although he maintained that the reason for the sudden deterioration remained "unclear". He said it could have been an acute bleed (although there was no clear evidence of such) or it could be due to sepsis. Dr Garg "favoured" sepsis as the likely cause. I include at this point an excerpt from Dr Garg's statement to the Court as to the bases for

his belief and the management plan settled with his colleagues Dr Anna Foley and Dr Sally James:

> *"My impression of the clinical picture at the time was that the relative contribution of sepsis or gastrointestinal blood loss to the tachycardia and hypotension was unclear. I discussed this case with Dr Sally James (the consultant gastroenterologist on-call for the Eastern Health Haematemesis and Melaena Service) and Dr Anna Foley (the Gastroenterology Registrar on call after hours for Eastern Health [from 1700 hours] to whom I handed-over the care of this patient). Given the presence of fever and respiratory distress, and the absence of the passage of melaena or recurrent haematemesis (combined with a history of 'coffee-ground' haematemesis signifying only altered blood in the stomach) in the 11 hours until my review, sepsis was favoured to be the likely cause. Nonetheless, we advised a plan for aggressive resuscitation with fluid and blood transfusions, acid suppression with a pantoprazole infusion, and urgent repeat blood tests including an FBE, LFTs and coags with consultation with Dr Anna Foley and H&M Consultant Dr Sally James with notification of blood test results and any evidence of gastrointestinal bleeding as evidenced by haematemesis or melaena as well as clinical status. This plan was conveyed to the ICU team. The decision for urgent endoscopy that evening was to be made by Dr Anna Foley and Dr Sally James depending on this update. Another factor in our decision was the very high risk of potential cardio-respiratory deterioration due to the administration of anaesthetic in a patient with shock and incomplete resuscitation. This assessment and plan was discussed with both Dr Anna Foley and Dr Sally James, who were in agreement with the same."* (my emphasis)

It should be understood that if a gastroscopy were to be undertaken, it would be conducted under a general anaesthetic.

33. At approximately 6.30pm, Dr Lorna Webber left the ICU for a short time. In her absence, a cascade of events occurred rendering the treatment plan redundant.

34. While treating doctors were endeavouring to insert an arterial line, Ms Webber had a large dark liquid vomit (it was noted without fresh blood), aspirated part of that vomit and almost immediately went into cardiac arrest from which, in spite of full resuscitation measures, she was unable to be revived. Aspiration pneumonia is a recognised cause of

acute cardiorespiratory failure. It is noteworthy that arterial blood gas performed only minutes prior to the fatal vomit and aspiration showed a haemoglobin level of 67g/L.

35. The almost inescapable conclusion is that throughout the 24 hours prior to death, Ms Webber was suffering a slow bleed. The hospital autopsy showed black fluid resembling arterial blood and food within the stomach with bronchopneumonia due to aspiration in the lungs. The pathologist who performed the autopsy advised the source of a gastrointestinal bleed was not identified.

36. Dr Garg opined, and I accept his opinion, that patients with longstanding diabetes mellitus and DKA may have gastroparesis and it is possible that this blood remained in Ms Webber's stomach throughout the previous night and that day. Dr Garg also gave evidence that a significant percentage of gastric bleeds cease spontaneously. At no stage of presentation and treatment were there signs of fresh blood.

37. I have no doubt that Dr Webber's belief that she was advised mid-morning that her daughter was to receive a blood transfusion is genuine and firmly held, and will not alter irrespective of any finding I may make. She has maintained that position from the outset, but in evidence was unable to say who conveyed that information to her, or indeed whether it was a doctor or a nurse who conveyed that message. What is clear, is that there is no mention in the medical records of the prospect of a blood transfusion until quite late in the afternoon, when, after discussions with Dr Garg, Dr Bartlett considered a transfusion would need to occur and "started the process" to facilitate it. Even then, with a drop in haemoglobin to 84g/L (with a suspicion it would be lower by that time) that decision to transfuse could, in light of the International Guidelines of Blood Transfusion, be considered conservative. Those guidelines indicate that transfusions "should be administered to a patient with a hemoglobin [sic] level of 70g/L or less", and that transfusions would "rarely" be indicated where a patient's haemoglobin level is above 100g/L but almost always indicated where the haemoglobin level is below 60g/L.[3]

38. As the evidence unfolded over two days, it became clear that this case was not ONLY about the prospect of a gastrointestinal bleed and the treatment, or lack thereof, which was the primary focus of Dr Webber's stated position. Ms Webber's condition was due to a constellation of serious illnesses hence the difficulties encountered in diagnosing and treating her symptoms.

[3] Statement A4, Clinical Guidelines: International Consensus on Nonvariceal Upper Gastrointestinal Bleeding

SUMMARY

39. The reality is Ms Webber was a complex patient who had a number of significant active medical issues that needed to be managed. For most of Ms Webber's hospital stay, pneumonia and sepsis were believed to be the cause of her tachycardia, hypotension, fever and respiratory distress, in the absence of malaena or recurrent suspected haematemesis since her vomit at 6am. Gastrointestinal blood loss was reasonably considered as a differential diagnosis and monitored both clinically and via repeated full blood examinations. As stated, no significant haemoglobin level drop was evidenced until 4.45pm.

40. Ms Webber was subsequently commenced on an intravenous pantoprazole infusion, and a blood transfusion was ordered. Shortly thereafter, Ms Webber deteriorated and was transferred to ICU to more safely manage her haemodynamic instability. Additional intravenous access was required as her existing peripheral lines were being used for vital treatments (intravenous insulin and fluids); ceasing either of these treatments for a blood transfusion would have been premature, as the management of her diabetic ketoacidosis was the most pressing concern at that stage. Obtaining adequate IV access for ongoing treatment proved difficult. Ms Webber's joint contractures may have hindered achieving vascular access because her affected joints may not have been fully extendable to reveal her veins. Additionally, dehydrated or unwell patients can have poor peripheral perfusion, which may also make obtaining IV access more difficult.

41. The National Blood Authority (Australia) guidelines state that in patients with acute upper gastrointestinal blood loss and a haemoglobin level between 70 and 100g/L, red cell transfusion is generally considered appropriate, and where haemoglobin is greater than 100g/L transfusion is clearly inappropriate. As such, it was reasonable to not transfuse Ms Webber at the time of admission or while she remained stable on the ward without clinical evidence of ongoing blood loss.

42. In the setting of her clinical deterioration at 4.57pm, blood transfusion became a management priority and six units of blood were requested when Ms Webber was admitted to ICU, even before it was identified that her haemoglobin levels had subsequently dropped to 67g/L at 6.25pm.

ROLE OF THE CORONER

43. I stress it is not the role of the coroner to lay or appropriation blame or fault *per se*.[4] However, I am required to consider whether an act or omission departed from an established standard or norm or was in breach of a recognised duty, to the extent that it was a causal factor in the death under investigation; that is the only sense in which a person or other entity can be held to be responsible. I purposely avoid the term culpable because it carries with it a connotation of blameworthiness.

44. The New Zealand Court of Appeal in *The Coroner's Court v Susan Newton and Fairfax NZ Ltd*,[5] has described this complex dichotomy as "the implicit attribution of blame".

45. No matter how firmly held Dr Webber's belief is, I have to make my findings on the evidence, which I have thoroughly and carefully considered. Dr Webber's fundamental contention is not supported by the weight of evidence.

46. This leads me to the crux of this difficult matter. I have to focus on the cause of death to consider whether an act or omission (or both) were causal factors in the death. The evidence on this critical issue is the evidence contained in the Autopsy Report together with evidence of doctors in ICU who were present when the vomit, aspiration and arrest occurred.

CONCLUSION

47. I formally find that Ms Webber's untimely death was due to a cardiac arrest which occurred when she vomited and aspirated stomach contents into already compromised lungs due to sepsis/pneumonia.

48. I accept Ms Foy's submission that the aspiration that led to cardiac arrest and death was not expected nor predictable.

49. I do not accept that the cause of death was due to a failure to transfuse blood, either in the morning, afternoon or evening of 3 July 2009.

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[4] *Keown v Khan* (1999) 1 VR 69, per Calloway JA

[5] [2006] NZAR 312 (CA)

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

Dr Lorna Webber

Eastern Health

SCOPE

Royal District Nursing Service

Signature:

PHILLIP BYRNE
CORONER
Date: **28 May 2014**