DLA Piper Australia
140 William Street
Melbourne VIC 3000
PO Box 4301
Melbourne VIC 3000
Australia
DX 147 Melbourne
T +61 3 9274 5000
F +61 3 9274 5111
W www.dlapiper.com

Coroner Jane Hendtlass
Coroners Court of Victoria
Level 11, 222 Exhibition Street
MELBOURNE VIC 3000

Your reference
2006/4228

Our reference
EKT/MIR/3007058/518611
AUM/1204176072.1

19 August 2013

By Post Only

Dear Coroner

FINDING REGARDING THE DEATH OF RUSSELL MCLARTY (2006/4228)

We refer to your finding dated 26 June 2013 and the recommendations contained therein, a number of which were directed at Dr Peter O'Brien as the Director of Medical Services at Warrnambool and District Base Hospital.

Please find **enclosed**, pursuant to section 72 of the *Coroners Act 2008* (Vic), Dr O'Brien's response to your recommendations. In his response Dr O'Brien outlines the actions that he and others at Warrnambool and District Base Hospital have taken in response to the recommendations that you have made.

Yours sincerely

EMMA TOPP
Solicitor
DLA PIPER AUSTRALIA

Direct +61392745107

Emma.Topp@dlapiper.com

MICHAEL REGOS
Partner
DLA PIPER AUSTRALIA

Direct +61392745437

Michael.Regos@dlapiper.com

Enc

South West Healthcare

12 August 2013

Coroner Jane Hendtlass
Coroners Court of Victoria
Level 11, 222 Exhibition Street
MELBOURNE VIC 3000

Dear Coroner,

FINDING REGARDING THE DEATH OF RUSSELL MCLARTY (2006/4248)

I refer to your finding dated 26 June 2013 regarding the death of Russell McLarty.

At the conclusion of your finding you make seven recommendations. Three of those (recommendations two, three and four) are directed at me as the Director of Medical Services at Warrnambool & District Base Hospital (**the hospital**). Following are my responses to your recommendations.

Recommendation two: That the Medical Director of South West Healthcare direct the Director of the Emergency Department at Warrnambool & District Base Hospital to contact Warrnambool Police Station when a patient presents with life-threatening head injuries that are consistent with an assault.

I have considered this recommendation and discussed it with the hospital's Director of Emergency Services.

We are each concerned about the practicality of its implementation in light of issues such as patient privacy and the difficulty in determining when injuries are 'life-threatening' and whether they are consistent with an assault.

I believe that the most appropriate way to address the reporting of potential assaults to police in this context is for the Victorian Department of Health to issue a directive to all public hospitals dealing with the issue following the taking of legal advice on the implications of such a directive in relation to patients' rights of privacy. It is important that such a directive recognise the difficulties in diagnosing an injury as 'life-threatening' and in determining whether that an injury is consistent with assault.

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☑ Warrnambool
Ryot Street
Warrnambool, VIC 3280
Phone: 03 5563 1666
Fax: 03 5564 4220

☐ Camperdown
Robinson Street, PO Box 147
Camperdown, VIC 3260
Phone: 03 5593 7300
Fax: 03 5593 2659

☐ Lismore
102 High Street
Lismore, VIC 3324
Phone: 03 5558 3000
Fax: 03 5596 2265

☐ Macarthur
12 Ardonachie Street
Macarthur, VIC 3286
Phone: 03 5552 2000
Fax: 03 5576 1098

www.southwesthealthcare.com.au
A.B.N. 41 189 754 233

Recommendation three: That the Medical Director of South West Healthcare review the system for the ordering, taking and labelling of pathology specimens at Warrnambool & District Base Hospital to ensure accurate times are recorded at each step in the procedure.

With respect to Your Honour, I am uncertain of the basis for this recommendation. It appears to have stemmed from the following findings:

> At 6 pm Dr Sukabula ordered blood for analysis. Nursing notes indicate the blood was taken at 6.20 pm (paragraph 279 on page 51).
>
> At about 8.50 pm and 9.10 pm vercuronium and phenytoin were administered (paragraph 298 on page 53).
>
> Post mortem analysis of hospital samples labelled 6 pm indicated...morphine, phenytoin, midazolam and propofol used in the emergency response (paragraph 281 on page 51)
>
> Accordingly I have formed the view that Dr Sukabula seems to have labelled the blood tubes with a time of 6 pm and the pathology report of the results indicated the blood was taken at 6 pm. However, the nursing notes indicate the blood was taken at 6.20 pm and the results include phenytoin which was first administered at 8.50 pm (paragraph 282 on pages 51 to 52).
>
> Therefore...I have become sceptical about the relationship between these reported times and the times at which procedures were performed at Warrnambool & District Base Hospital (paragraph 283 on page 52).
>
> At 6.05 pm Dr Sukabula ordered blood tests. It is unclear when the blood was taken for these tests but it seems to have been delayed until after 8.50 pm because it contained medication administered at that time (paragraph 80 on page 76).
>
> This incorrect labelling of the times of taking of pathology specimens has implications for patient management, record keeping at Warrnambool & District Base Hospital and on-going understanding of the events preceding an inter-hospital transfer (paragraph 81 on page 76).

The hospital's system for ordering, taking and labelling pathology specimens was not raised an as issue at the inquest and explanation was not sought from the hospital or its witnesses. This is unfortunate as had the hospital been provided the opportunity to provide comment on the issue, it could have clarified the following for Your Honour.

The Victorian Institute of Forensic Medicine toxicology report states that two blood samples were tested: Blood (AM1) and Blood B (LEG). The sample referred to as Blood B (LEG) was a post mortem specimen. In the toxicology report it was the only specimen to reveal drugs that had been used in the treatment of Mr McLarty at 8.50 pm on 5 November 2006. Blood (AM1) was the sample recorded to have been taken at 6 pm on 5 November 2006. Testing of that sample did not reveal drugs that had been used in the treatment of Mr McLarty at 8.50 pm meaning that the sample must have been taken prior to 8.50 pm.

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The blood test report produced by Healthscope Pathology indicates that its laboratory received the first specimen at 6.20 pm on 5 November 2006. At 6.39 pm its laboratory received a further blood specimen. The blood test report thus confirms that the blood samples ordered by Dr Sukabula were performed soon after they were ordered and had been delivered to Healthscope Pathology by 6.20 pm and 6.39 pm, not after 8.50 pm.

The finding does not refer to other information suggesting that the blood samples documented as being collected at 6.20 pm were not collected at that time.

Having said this, the hospital has undertaken an audit of the medical records of patients presenting to its emergency department with head trauma and requiring transfer to a higher level facility during the 2012/2013 financial year (that is, cases similar to Mr McLarty's).

The medical records pertaining to those cases were independently reviewed by myself and by the Nurse Quality Project Worker. The records were specifically audited for evidence of delay between the ordering, collection and labelling of blood specimens and delay in the administration of medication. The audit did not identify any issues.

The South West Healthcare clinical guideline "Collecting a Specimen of Blood for Pathology (Venepuncture)" directs that "the person who collects the blood labels the sample tube clearly and accurately at the patient's bedside at the time the sample is being collected". As far as could be ascertained during the audit, there was no evidence of non-compliance with this policy.

Recommendation four: That the Medical Director of South West Healthcare investigate the frequency with which there is delay in administration of medications ordered by medical practitioners in the Emergency Department at Warrnambool & District Base Hospital.

This matter was also subject to the aforementioned audit. No evidence of delayed administration of medication was identified in the audit.

Since 2005 trauma response systems throughout Victoria and at the hospital have significantly evolved and advanced. A number of these developments indirectly minimise the risk of delay in the administration of medication to trauma patients.

Among the new systems that have been introduced at the hospital is a documented trauma response code. When this code is called an automatic notification is sent to a number of clinicians including the Emergency Physician, the on-call Surgeon, the on-call Anaesthetist, the Surgical Registrar, the Radiographer and the Clinical Coordinator. There is a consequent rapid availability of sufficient clinical staff with appropriate expertise to manage patients presenting with major trauma. Those clinical staff are tasked to various roles in the management of the trauma meaning that the risk of delay in providing treatment, including medication, is minimised.

Yours sincerely,

DR PETER O'BRIEN
Director of Medical Services
SOUTH WEST HEALTHCARE