IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: 2010 4389

FINDING INTO DEATH WITH INQUEST

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

Inquest into the Death of: Robert Charles AVERY

Delivered On:	1 July 2015
Delivered At:	Coroners Court of Victoria, 65 Kavanagh Street Southbank, Melbourne 3006
Hearing Dates:	28 & 29 April 2014
Findings of:	IAIN WEST, DEPUTY STATE CORONER
Representation:	Mr P Halley on behalf of The Valley Private Hospital Mr S Cash on behalf of Dr McHenry Mr J Goetz on behalf of Dr Phillips
Counsel Assisting the Coroner	Mr G McFarlane

I, IAIN TRELOAR WEST, Deputy State Coroner having investigated the death of Robert Charles AVERY

AND having held an inquest in relation to this death on 28 and 29 April 2014

at the Melbourne Coroners Court

find that the identity of the deceased was Robert Charles AVERY

born on 5 August 1923

and his death occurred on 20 July 2010

at Dandenong Hospital, 135 David Street Dandenong 3175, Victoria

from

1. (a) SEPTIC SHOCK

1. (b) UROSEPSIS

2. HEART DISEASE

in the following circumstances:

1. Robert Avery was an 86-year-old man who resided in Lysterfield South with his son, Mr Verne Avery and his daughter in law.
2. Mr Avery had a medical and surgical history, which included emphysema, dyslipidaemia, hypertension, type 2 diabetes, congestive cardiac failure, ischemic heart disease, stroke, chronic renal impairment, abdominal aortic aneurysm and diverticular disease (bowel resection and colostomy).
3. Mr Avery was admitted to The Valley Private Hospital on 15 July 2010 on referral from Dr Richard Gilhome for a colonoscopy to investigate his constipation, which had lasted for 5-6 weeks. The colonoscopy was to be performed by Dr Ray McHenry, a General and Bariatric Surgeon who had performed over 1500 colonoscopies. Bowel preparation was given by nursing staff and medications were withheld as a requirement of fasting in readiness for the procedure. Intravenous fluids were commenced at 11.00 pm with one litre to be given over 12 hours.
4. On the morning of 16 July 2010, Mr Avery was transferred to the day ward prior to the colonoscopy procedure. He was examined by anaesthetist Dr Mark Rudelic who deemed the administration of an anaesthetic for a colonoscopy too great a risk for Mr Avery, as he was short of breath at rest. Mr Avery was then examined by Dr McHenry who agreed with Dr Rudelic's assessment. The colonoscopy was subsequently cancelled and a CT colonography was arranged instead, with no sedation or anaesthetic required.

Post Procedure Management 16 July 2010:

5. Mr Avery was returned to the ward at 1.00 pm and remained drowsy and on oxygen therapy. He was taken for a CT colonography at 2.15pm. (The subsequent reporting of the scan demonstrated two non-obstructed hernias, in the right inguinal area and anterior abdominal wall and a stable large infra-renal aortic aneurysm.) Mr Avery was returned to the ward and by mid afternoon had passed 1150 mls of urine. Dr McHenry formed the opinion that Mr Avery could be discharged home that day.

6. Dr Indra Jayasuriya, Endocrinologist and Consultant Physician who had been managing Mr Avery's type II diabetes for a number of years subsequently reviewed Mr Avery and noted that his blood sugar levels were low, particularly at night and in the morning. He therefore advised that there be a change to his Mixtard 30.70, to 15 units in the morning and 0 units at night. Dr Jayasuriya did not make any observations which suggested that Mr Avery was otherwise unwell, or dehydrated. Following consultation between Dr Jayasuriya and Dr McHenry, it was decided that Mr Avery was to stay in hospital an extra night in order to have his insulin dosage changed.

7. At 9.00 pm, orange juice and sugar together with a sandwich were taken. At approximately 9.30 pm, hospital staff contacted Dr McHenry and reported that Mr Avery's blood pressure was relatively low, as were his blood sugars, and that he had a small amount of bright red bleeding from his rectum. (The rectal bleeding I am satisfied was related to the insertion of the small catheter required to pump air into the colon during Mr Avery's procedure and that it abraded, in all probability, a haemorrhoid or polyp.) Dr McHenry advised nursing staff to request the emergency department doctor to review Mr Avery.

Post Procedure Management 17 July 2010:

8. The review of Mr Avery was undertaken by Dr John Phillips, an Emergency Medicine Physician, at approximately 12.15 am on 17 July 2010, after completing his Emergency Department shift. On being contacted, he was told that Mr Avery had undergone a procedure and his blood pressure and blood sugars were low due to minimal oral intake. On review, Dr Phillips noted that Mr Avery's blood pressure and sugar levels had improved after some food and fluids. The blood pressure was 100mmHg systolic and the blood sugar level was 16.3. He noted that since 9.00 pm, his systolic blood pressure had increased from 90mmHg to 104mmhg and then 109mmHg at 10.30 pm. His blood sugar level had increased from 3.7 to 15. Dr Phillips ordered an ECG and full bloods (FBE, urea and electrolytes, CRP) for the morning (bloods collected at 9.05 am) and requested ongoing observation and that Mr Avery be reviewed the next day by his treating doctors. Following his review, Dr Phillips wrote contemporaneous notes in the medical records. Dr Phillips did not contact Dr McHenry as he believed Mr Avery had stabilised and considered his notes to be a sufficient handover.

9. At approximately 8 to 8.30 am, Dr McHenry reviewed Mr Avery with a view to discharging him that day. Dr McHenry stated he looked at Mr Avery's observation chart but did not refer to the progress notes made by Dr Phillips and hence, did not see that blood tests had been ordered. He noted that the rectal bleeding, whilst not of significant volume, had stopped and that Mr Avery did not complain of discomfort or of other symptoms. Mr McHenry made no examination entries in the progress notes. He was aware that overnight there had been two readings of blood pressure in the 90s, with all other systolic pressures being 100, or more. He considered that Mr Avery's oxygen saturations had been normal, as had his temperature and pulse. Dr McHenry saw no reason why Mr Avery should not be discharged subject to review by Dr Jayasuriya. This review subsequently took place, with Mr Avery's blood sugars being found to be stable.

10. At 12.00 pm, Mr Avery had a *'medium PR bleed'* according to nursing notes. This was not documented on the fluid or bowel chart. There was no further bleeding and haemodynamically, Mr Avery was unchanged. His systolic pressure at this time was 119mmHg. At 1.30 pm, Mr Avery was due for discharge home, however, informed nursing staff that he was having difficulty voiding and had not voided that morning. A bladder scan showed Mr Avery had approximately 900ml of urine in his bladder. Dr McHenry was notified and requested that an indwelling catheter be inserted which was to stay in for 2

hours, and then Mr Avery could be discharged home. The urinary catheter was subsequently inserted by Dr Phillips.

11. Later in the afternoon, despite objection voiced by family as to *"his very obvious serious state of health,"* Mr Avery was discharged home and into the care of his son and daughter-in-law.

Home Care:

12. Following his return home, Mr Avery had a small amount of soup before going to bed, with his son and daughter-in-law being so concerned about his physical condition, that they took it in turns to monitor him throughout the night.

13. The next morning, 18 July 2010, a district nurse arrived to administer insulin. Mr Avery was unwell and the nurse insisted that the family organize an ambulance transfer to Dandenong Hospital. She voiced her shock and dismay at Mr Avery's serious condition.

Admission to Dandenong Hospital:

14. Later in the day, Mr Avery was admitted to Dandenong Hospital suffering dehydration and low blood pressure. On arrival, he was afebrile with a respiratory rate of 30, oxygen saturation of 95% and a systolic blood pressure of 70. He was lethargic with a Glasgow Coma Score (GCS) of 13 out of 15. Mr Avery was assessed as being intravascularly dehydrated with a distended abdomen and palpable bladder. Bloods showed worse renal function and confirmed neutrophilia, thrombocytopenia and an albium of 20. He was given intravenous fluids and antibiotics and had an indwelling catheter inserted. A urine test showed a urinary tract infection and an intravenous broad spectrum antibiotic was started. Mr Avery passed 800mls of urine by 9.00 pm, but urine output declined overnight.

15. Mr Avery's condition failed to improve on the 19th and upon review at 9.20 am on 20 July, his condition had further deteriorated. He was made not for resuscitation in the event of a cardiac arrest and on further review at 1.20 pm, he had a GCS of 8. Mr Avery was hypotensive, pale, bradycardic and acidotic on blood gas leading to a diagnosis of septic shock. Intravenous fluids were given with improved GCS. The intensive care registrar reported that the urine cultures had grown a gram negative resistant organism (enterobacter aerogenes) and it was felt Mr Avery was likely to do poorly due to his comorbidities. Conservative management with IV fluids and ongoing antibiotics was implemented.

16. Mr Avery later died at 6.00 pm on 20 July 2010. His death was subsequently reported to the coroner by his son.

Post Mortem Examination:

17. Pathologist Dr Nadia Dickenson from Southern Cross Pathology Australia completed an autopsy on Mr Avery and provided a written report of her findings. She identified cardiac enlargement with right ventricular hypertrophy, aortic and mitral valve calcification, evidence of central and peripheral atherosclerosis, abdominal aortic aneurysm and diverticular disease of the colon with no evidence of perforation. She also identified recent cerebral infarction, right parietal lobe and petechial pontine haemorrhages and hypoxic cerebellar changes.

18. Dr Dickenson documented the cause of death as:

    1. (a) Heart Failure

    2. (a) Septic Shock

    2. (b) Urosepsis

2. (c) Urinary Tract Infection

19. I do not accept this is as an accurate way to formulate the cause of death. It is more appropriate to record it as:

    1. (a) Septic Shock

    1. (b) Urosepsis

    2. Heart Disease

Appropriateness of Discharge from The Valley Private Hospital:

20. The primary concern of family and the purpose of the inquest, was to determine whether Mr Avery was appropriately discharged from hospital on 17 July 2010.

21. Mr Avery was an elderly man with multiple comorbidities, but at the time of admission to The Valley Private Hospital there was no indication that any of them were particularly active. Nevertheless, there was a deterioration in his condition whilst he was an inpatient. Mr Verne Avery told the hearing that in his opinion, his father should not have been discharged as he was extremely unwell on the 17,th in that he was difficult to understand, grey in appearance, with cracked lips and ketones on his breath

22. At the request of the Court, Dr Sally Bell, Gastroenterologist at St Vincent's Hospital, provided an expert opinion in relation to Mr Avery's discharge and his management whilst a patient. She stated; '*I believe it was inappropriate for the patient to have been discharged from The Valley Private with a number of unresolved medical symptoms, in particular poor oral intake, which in combination with recent bowel preparation was likely to result in dehydration, poor urine output, urinary obstruction and hypotension, all of which were likely to contribute to renal failure. In addition there was evidence of sepsis on investigation (raised CRP and neutrophilia) which were not acted on.*'

23. Further, Dr Bell stated that The Valley Private admission was characterised by '*poor quality or absent medical notes. There are no notes from the admitting surgeon (Mr McHenry) or the attending physician Dr Indra Jayasuria and there is no evidence that a history was taken, the patient examined or diagnosed or a management plan formulated after the procedure was cancelled because of the patient's respiratory status.*' There was also a failure to examine and document Mr Avery's status after reports of clinical deterioration from nursing staff and despite 2 reports on rectal bleeding documented in the nursing notes (although not on the bowel chart), no rectal examination was done. Dr Bell stated that the blood tests, which were ordered by the emergency doctor, were not followed up by the treating doctors and should have raised the diagnosis of infection. In addition, she stated that the nursing staff failed to document the bowel prep given to Mr Avery. There was no recorded oral or IV intake from 1.00 pm on 16 July 2010 and no urine output recorded from 10.00 am on 16 July 2010. The fluid balance chart from 17 July 2010 was blank.

24. Dr Bell opined that there was '*inadequate nursing care and medical management during Mr Avery's hospital stay. The combination of hypotension and poor urine output should have raised the possibility of acute renal injury secondary to dehydration, obstruction or sepsis. The patient should have remained in hospital to assess whether he were able to pass urine successfully after the catheter was removed. In addition, if there was evidence of hypotension and dehydration, further intravenous fluids may have been used. Early treatment of sepsis may have prevented subsequent development of septic shock and death, even in the setting of a resistant organism, as this would have been identified much earlier*

and appropriate antibiotic adjustment made prior to the development of septic shock. In addition to the urinary issues, there is no documentation of hypoglycaemia in the setting of poor oral intake. No adjustment of insulin was made and the patient was at risk of further hypoglycaemia if the poor intake persisted. Lastly the nursing notes report PR bleeding yet no rectal examination was performed nor was any haemoglobin ordered to exclude significant GI haemorrhage."

Evidence of the Treating Doctors and Issues Raised by Dr Bell: (In the order in which the doctors were called)

Dr Jayasuriya:

25. Dr Jayasuriya told the hearing that he was requested to review Mr Avery's diabetes by Dr McHenry and that he saw him during the afternoon of Saturday the 16.th Mr Avery had been a patient of Dr Jayasuriya for four or five years. The inquest was told that no examination was undertaken as he was there purely to manage Mr Avery's blood sugars. As Mr Avery had low sugar, his night time insulin dose was stopped. Dr Jayasuriya recorded the medication change in the progress notes and also prepared a note advising the Royal District Nursing Service of the change, for the nurses to fax to the Service in order to alert them for future home visits.

26. On the morning of the 17,th Dr Jayasuriya again reviewed Mr Avery. He described Mr Avery as *'looking reasonable'* and *'a bit tired'* but, nevertheless, he was able to ambulate as he remembered he had to wait for him to return from the toilet. He could communicate with Mr Avery and told the inquest that had he appeared unwell, he would have notified either Dr McHenry or the nurses. Mr Avery's blood sugars were found to be stable and he was advised that he was to continue on the current medication plan.

27. There is no criticism of Dr Jayasuriya as I am satisfied his management of Mr Avery was reasonable.

Dr Phillips:

28. Dr Phillips received no direct communication from Dr McHenry either to request that he review Mr Avery or to provide him with any information regarding Mr Avery's medical history. He reviewed Mr Avery shortly after midnight on the 17th , waking him in order to do so.

29. He stated that whilst he could not recall making a detailed assessment of Mr Avery's condition, *'nothing stood out as being significantly wrong'*. He told the hearing that he did not believe that Mr Avery was hypotensive and in fact felt there had been improvement in his condition. He stated he was happy with the later blood pressure readings and that they were not necessarily indicative of him being hypotensive and that his reading of 100mmHg raised no particular concerns.

30. Dr Phillips stated that as the nursing staff had not expressed concern about the extent of rectal blood loss, or that it was ongoing, he did not perform a rectal examination or inspect the pad. The evidence of Dr Bell was that a rectal examination should have been done. However, there was no record made by nursing staff in an attempt to quantify the amount of blood loss (how many pads had been required), nor whether the blood was fresh or old. Dr Phillips stated he did not believe Mr Avery was having a large amount of rectal bleeding, and if he thought he was, he would have performed an examination. His decision was based not only on an absence of concern from the nurses, but there was no sign of significant bleeding in the colostomy bag.

31. Dr Phillips' clinical opinion (based on the medical record and observation charts), was that there had been an overall improvement in Mr Avery and hence his notation in the progress notes that he '*was stable on the ward and could be safely observed overnight.*' He requested repeat pathology to be taken. Dr Phillips did not order blood tests to be undertaken straight away and asked that they be done in readiness for the doctors to review them later in the morning. On this point he explained that things are done differently on the ward, unlike in the emergency department where the tests would be done straight away. He disagreed with Dr Bell's opinion, that if it was worth doing the blood tests, it was worth doing them straight away.

32. Dr Phillips made notes following his examination as a handover to the treating doctors and with the expectation, that a doctor would look at them. In addition, he believed *'that the blood tests would be reviewed by the doctors in the morning.'* Dr Phillips went on to state that he assumed, if there was an awareness of blood tests to be undertaken, discharge of a patient would not occur until the results were sent back to the hospital and checked.

33. Dr Phillips again attended Mr Avery when he inserted the urinary catheter later in the day. He told the hearing that he noted nothing unusual about Mr Avery's appearance and/or condition and had no serious concerns for his wellbeing. He stated that he was not notified of any other concerns regarding Mr Avery and did not review his blood test results as he was not his treating doctor. Dr Phillips made progress notes of his observations. He was not made aware of any plans to discharge Mr Avery after his bladder was emptied.

34. There is contradictory evidence between Dr Bell and Dr Phillips as to whether Mr Avery was dehydrated, with Dr Phillips being of the opinion that he was not. He stated that none of the classic dehydration signs of headaches, dizziness, thirst and tachycardia were evident and whilst Mr Avery's blood pressure was '*lowish*'(109 mmHg at 10.30 pm), he was of the opinion that he was not hypotensive. Being an emergency department doctor, I am satisfied that Dr Phillips would routinely be assessing hydration in patients and hence, he was qualified to accurately assess whether Mr Avery was appropriately hydrated. Nevertheless, I accept Dr Bell's criticism that having been called to see Mr Avery for low blood pressure, he should have documented his volume status, which was not done.

35. Dr Phillips should not be criticised for failing to ascertain the results of the blood tests, as it was reasonable for him to assume the nurse and/or Dr McHenry would inform themselves of the results and act upon them accordingly.

36. The evidence supports a finding that Dr Phillips' management was reasonable.

Dr McHenry:

37. Dr McHenry stated that Mr Avery could be discharged home as he found '*no clinical difference in his state at admission and in his condition on the day of discharge. Examination of the tests arranged by the emergency doctor showed that his urea and creatinine were precisely the same as they had been when measured on 30 October 2008 and 19 June 2009. Haemoglobin was 115, which would be perfectly normal for someone with chronic renal failure such as Mr Avery. Unequivocally, Mr Avery was not dehydrated at the time of his discharge from the Valley Private.*' He further stated, '*There was no indication that I should be looking for what turned out to have been a highly resistant bug in his urine which he had come in with.*'

38. Dr McHenry further stated that his assessment for discharge was based on the fact that '*in the end Mr Avery had had no procedure involving any sort of sedation...his blood-vital signs, his oxygen off air were normal, his blood pressure was at much the same level as it was for most of it except for that night and there is really no evidence-no reason I could see,*

given that he had not had an anaesthetic, that he couldn't go home.' No examination notes were recorded at any time by Dr McHenry.

39. Dr Bell stated that Dr McHenry should have followed up the blood test results. Dr McHenry conceded that had he looked at Dr Phillips' progress notes, he would have been aware that the tests had been ordered.

40. Dr Bell was critical of the decision to discharge Mr Avery on the 17th as in her opinion the following unresolved issues remained:

    a. Poor urine output secondary to inadequate fluid intake

    b. Onset of urinary retention

    c. Persistent hypotension

    d. Elevated C-reactive protein (CRP of 154) and neutrophil count suggestive of sepsis

    e. Uninvestigated rectal bleeding

    a. Dr McHenry does not accept Mr Avery had poor urine output due to inadequate fluid intake. Mr Avery was on a 1.5 litre fluid restriction. He explained that of the amount of fluid taken into the body, some of it passes as urine, some as sweat and some passes via the bowel. On the 15,th the fluid balance chart recorded 100 mls intake with no output recorded. (It can't be determined whether there was in fact no output, or there was a failure to record the output.) Dr McHenry stated however, that Mr Avery would have had a significant amount of bowel preparation (up to 3 litres) which, whilst not recorded, could be judged by the type and degree of bowel response (diarrhoea). The chart for the 16th records 1.15 litres output of urine from midnight to 10.00 am, which Dr Bell considered reasonable. Thereafter the fluid balance chart was empty, as it was for the 17,th indicating that there was no documented output from 10.00 am on the 16th to the time the catheter was inserted on the 17.th However, Dr McHenry relied on 963 mls being expelled upon catheterization (not recorded on the chart), to indicate that this did not equate to poor urinary output. He stated that the volume of urine passed was entirely within normal and expected limits and was indicative that renal function had not deteriorated and that it excluded Mr Avery being dehydrated. I am satisfied that the fluid balance chart cannot be relied on to reflect intake and output, with it being conceded by the hospital that there was inadequate record keeping. In the absence of accurate records of hydration status, it cannot be concluded that there was poor urine output secondary to inadequate fluid intake.

    b. In Dr McHenry's opinion, the urine retention was caused "*by the circumstances of some pain in the rectum, unfamiliar surroundings and an elderly man with some stress.*" He further stated that there was '*absolutely no evidence of a urinary tract infection*' as Mr Avery was not suffering from temperature, rigors, shaking, raised pulse rate and a general appearance of being well, which are common signs of a urinary tract infection. Dr McHenry accepted that it is not the normal course to discharge a patient post catheterisation, without an appropriate trial of voiding. It was Dr McHenry's judgement, however, that Mr Avery was more likely to pass urine at home in his own surroundings, without any stress. In addition, he was aware that Mr Avery would be seen by the district nurse at his home in the morning, hence if retention continued to be a problem, the nurse could address it or have him

referred back to the hospital. He further stated *'there was no obstruction to the kidney, only to the bladder outlet on 17 July 2010.'*

c. I am not satisfied that the evidence supports a finding of persistent hypotension. Mr Avery's blood pressure on arrival was 110/50, 90/50 on the 16th and on discharge, 129/60. Whilst Dr Bell considered the discharge level low for a person of Mr Avery's age, and on a beta blocker, this was disputed by Dr Phillips and Dr McHenry. Dr Phillips stated that the readings did not meet the medical definition of hypotension. During the course of his evidence, Dr McHenry stated that it was not unusual for a man of his age and who was not on anti-hypotensive medication. There was agreement that it is important not to look at the readings in isolation and that other parameters needed to be considered, including his usual blood pressure. In addition, Dr McHenry had the advantage of seeing Mr Avery on the day of his discharge.

d. The issue of unresolved sepsis arose because Dr McHenry was unaware of the CPR and neutrophil count readings. He did not know bloods had been ordered, because he did not look at the progress notes. Even had he done so, neither provisional nor final haematology reports were available on the morning of the 17th as they had not been faxed to the hospital by then, nor had the CPR report. It appears, however, that when Dr McHenry was contacted at 1.30 pm about Mr Avery's urinary retention, the test results had been received by the hospital and were not brought to his attention by nursing staff. This omission, of failing to notify the doctors of the abnormal results, was conceded by The Valley Private Hospital. In relation to Dr Bell's assessment that early treatment of the sepsis may have prevented subsequent developments of septic shock and death, Dr McHenry stated that clinically, there was no evidence of sepsis at the time of his assessment of Mr Avery. (This was acknowledged by Dr Bell.) He also believed that even if standard broad based antibiotics had been administered on the 17,th they would not have controlled the infection, nor had any effect on it.

e. Dr McHenry was of the view that the rectal bleeding was caused by the alternative procedure, with this view being shared by Dr Bell. He stated that Mr Avery's rectal bleeding had stopped when reviewed on the morning of the 17th and that there was no complaint of discomfort or any other symptoms to him at the time. He further stated that he would not have conducted an internal rectal examination as this would have exacerbated the bleed and would have been most uncomfortable.

Findings:

41. Mr Avery should not have been discharged home on the 17th July 2010.

42. Dr McHenry told the hearing that it was common practice to make a discharge assessment by only looking at the patient and the observations chart and that there were no clinical suspicions that warranted him looking at the progress notes. Mr Avery's death exemplifies the potential danger of this approach.

43. The evidence indicates that discharge occurred with Dr McHenry knowing nothing of Dr Phillips' review, a review he had instigated out of concern for Mr Avery's overnight welfare. He stated that had he known of the blood tests he would have checked the results and it follows, Mr Avery would not have been discharged.

44. Dr McHenry agreed that in the normal course of events you are alerted to whether bloods have been ordered either by a direct conversation with the doctor who ordered them, or by looking at the notes. He stated that it was *'a very unusual thing that I had not been*

contacted directly' by Dr Phillips. In this setting, the failure to hear from Dr Phillips placed an onus on Dr McHenry to either contact him, or to look for entries in the progress notes, before considering whether discharge was appropriate. To have discharged his patient in the absence of undertaking an enquiry, was sub optimal management that fell outside the parameters of reasonable health care practice.

45. I further find that there was a failure to maintain appropriate records during Mr Avery's admission and that nursing staff failed to alert his treating doctors to the abnormal blood results. These omissions were conceded by The Valley Private Hospital and I am satisfied a number of changes have been made to address the issues. The criticism of failure to maintain appropriate records also applies to Mr Avery's treating doctors although the criticism, in so far as it concerns Dr Phillips, is limited to his failure to document the hydration status.

46. The weight of evidence does not permit a finding that Mr Avery was discharged in a dehydrated state. On the day of discharge, Mr Avery was seen by Dr McHenry, Dr Jayasuriya and Dr Phillips. Each doctor stated there was no indication that Mr Avery was dehydrated or clinically unwell.

47. The evidence does not permit a finding of a causative link between the management of Mr Avery by the hospital or by his treating doctors and his ultimate death. It is speculative, and hence inappropriate, to draw conclusions as to whether changes in clinical decision-making during the course of Mr Avery's admission, including had he not been discharged and his infection treated, would have prevented the tragic outcome.

COMMENTS

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

I. A thorough investigation into the circumstances surrounding Mr Avery's death was significantly impeded by poor quality or absent medical notes. Although not causative of the death in this case, the failure to keep appropriate medical records, and to have them referred to, highlights the potential to adversely impact on patient health. Hospital administrations need to be vigilant in ensuring that appropriate standards are maintained.

II. The inquest also identified shortcomings in alerting treating practitioners to test results. I am advised that The Valley Private Hospital has implemented a new online pathology reporting system, that allows doctors to access diagnostic pathology and radiology results remotely. (Dr McHenry acknowledged the benefits this online facility) The system also:

    a. Displays trends if multiple results are taken over extended periods;

    b. Allows doctors to flag results as abnormal; and

    c. Enables doctors to action results urgently.

III. I am further advised that additional system changes have been implemented and include:

    a. Ward staff competency assessments regarding the Hospital's IV cannulation protocols and general care of the patient with a colostomy.

b. The Bowel Preparation policy, following review by the Stomal Therapist, now includes a section on the management of patients with a stoma receiving bowel preparation, with this having been communicated to all nursing staff.

c. Staff reiteration regarding the importance of fluid balance documentation.

d. Discharge information communication has been reinforced with all staff to ensure that patients and their carers/family are advised to contact the Hospital Coordinator or return to the Emergency Department in the event of a complication or concern post discharge.

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

Mr Nunzio Tartaglia, Nowicki Carbone Lawyers on behalf of Mr Arthur Avery.

Mr Paul Halley, Owen Dixon Chambers on behalf of The Valley Private Hospital

Ms Jacqui Morris, Minter Ellison Lawyers on behalf of The Valley Private Hospital

Ms Judith Knight, Director of Clinical Services, The Valley Private Hospital

Dr Indra Jayasuriya

Mr Sean Cash, Greens List on behalf of Mr Ray McHenry

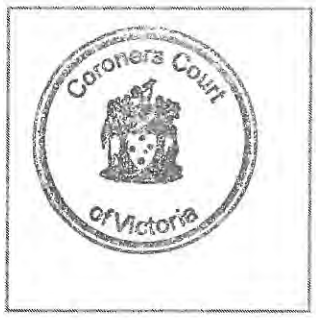
Ms Philippa Duxbury, John W Ball & Sons on behalf of Mr Ray McHenry

Mr John Goetz on behalf of Dr John Phillips

Mr Chris Spain, TressCox Lawyers on behalf of Dr John Phillips

Mr Jamie Halliday, AHPRA

Signature:



IAIN WEST
DEPUTY STATE CORONER
Date: **1 July 2015**