FORM 37

Rule 60(1)

FINDING INTO DEATH WITH INQUEST

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

Court reference: 2418/07

Inquest into the Death of WENDY ALICE RYDER

Delivered On:	8th April 2010
Delivered At:	Melbourne
Hearing Dates:	29 January 2010
Findings of:	JOHN OLLE
Representation:	Dr Keeling, for St Vincent's and Mercy Private Hospital and Kelli Wain

Place of death: St Vincents Private Hospital, 41 Victoria Parade, Fitzroy 3065

SCAU: Leading Senior Constable King Taylor

FORM 37

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

Court reference: 2418/07

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

having investigated the death of:

Details of deceased:

Surname: RYDER
First name: WENDY
Address: 46 Willow Grove, Kew 3101

AND having held an inquest in relation to this death on 29 January, 2010
at Melbourne
find that the identity of the deceased was WENDY ALICE RYDER
and death occurred on 27th June, 2007

at St Vincents Private Hospital, 41 Victoria Parade, Fitzroy 3065

from
1a. PULMONARY THROMBOEMBOLISM
1b. DEEP VENOUS THROMBOSIS RIGHT CALF
2. MULTIPLE SCLEROSIS, RECENT ABDOMINAL SURGERY (TAH BSO)

in the following circumstances:

1. Ms Wendy Ryder lived at 46 Willow Grove, Kew. She was aged 62 years at the time of her death.

Medical History

2. Ms Ryder suffered severe Multiple Sclerosis (MS), with cognitive change and spastic tetraparesis.

Ms Ryder's June 2007 admission

3. Professor Mark Cook, Neurologist & Epileptologist, has provided a comprehensive medical report dated 12 June, 2008. He gave evidence at inquest.

4. Following admission to St Vincent's Private on 25 June, 2007, Ms Ryder was in Professor Cook's care.

5. Professor Cook had known Ms Ryder prior to her admission, though not seen her in the previous four years.

6. Professor Cook was aware of Ms Ryder's recent admission to Epworth Hospital. It was thought she had suffered an exacerbation of MS, believed related to a urinary tract infection.

7. A course of steroids had been administered, however, Ms Ryder continued to suffer leg pain, believed related to MS.

The Initial Assessment

8. Professor Cook saw Ms Ryder within hours of her admission. He witnessed an episode of leg spasm of which she was complaining. He described the episode as a flexor spasm of the right leg, with severe pain "and to palpation very tight and tender hamstring muscles on that side."

9. Professor Cook prescribed narcotic analgesia. The episodes were very painful and standard analgesics had been ineffective.

Professor Cook called to the ward

10. In the early evening (approximately 7.30pm) on 26th June, 2007, Professor Cook attended the ward, in response to a call from nursing staff.

His Assessment

11. Though unresponsive to voice, Professor Cook considered Ms Ryder:

> "only lightly unconscious as judged by response to brainstem stimulation and neurological examination otherwise."

12. He attributed the problem to oversedation in relation to narcotics and benzodiazepines, on the background of severe widespread central nervous system involvement through the MS.

Professor Cook knew nursing staff were concerned

13. Professor Cook knew nursing staff were concerned for Ms Ryder's welfare. In particular in respect to the "Lateralised neurological signs and weaknesses they had observed".

14. In evidence he explained that nursing staff were not familiar with Ms Ryder's situation prior to admission or that the signs observed by them were of long-standing.

15. In consideration of her clinical picture, he did not consider more aggressive management necessary. He considered the clinical priority was cardiovascular stability and was satisfied that she was stable. He did not consider ICU transfer was appropriate or necessary.

16. Professor Cook telephoned the ward at approximately 11.30pm and was advised that Ms Ryder was stable, though remained deeply asleep.

17. At approximately 2.00am he was advised that Ms Ryder had been found unresponsive. Upon his attendance, he explained:

> "... it was clear during the attempts to insert an IV line in the groin and there were problems with vessel patency, and the possibility of DVT was suggested. I had not considered this prior, as the signs were not those of DVT, and the paroxysmal spasm observed was more typical of MS."

18. Professor Cook considered Ms Ryder suffered a cardiac arrest, presumably as a result of pulmonary embolus, which was unexpected.

Communication between Professor Cook and Kelli Wain, Intensive Care Liaison Nurse and Critical Care Education Consultant

19. Kelli Wain referred to a communication problem between herself and Professor Cook. Having fully ventilated the issue, I am satisfied that despite Ms Wain's concerns to the contrary, Professor Cook had considered concerns raised by her. I accept however, that Ms Wain's concerns were genuinely held by her.

20. Professor Cook had not previously met Ms Wain nor was he aware of her role. He was unaware that the hospital had appointed an Intensive Care Liaison Nurse.

21. Ms. Wain believed Professor Cook was dismissive of her. Professor Cook had no knowledge that there had been a communication issue between himself and Kelli Wain.

22. Professor Cook had sought to explain to her that due to his neurological expertise and knowledge of Ms Ryder, the clinical picture posed by her did not cause him alarm.

The care of Ms Ryder was not compromised

23. Professor Cook assessed Ms Ryder in response to a call from ward staff. He examined her at approximately 7.30pm.

24. Further, he called the ward at 11.30pm to ascertain her progress and was advised she was stable, though deeply asleep.

25. Ms Wain performed her role with the utmost professionalism. Professor Cook was at pains to point out that he had absolute confidence in the nursing staff, both generally and specifically in respect of the care provided by them to Ms Ryder.

Professor Cook offered Ms Ryder appropriate medical care and attention

26. Professor Cook:

i. knew Ms Ryder;
ii. had no reasonable basis to consider DVT;
iii. was aware of her surgery approximately 5 to 6 weeks prior to her admission;
iv. explained a person suffering severe MS, is extremely unlikely to suffer DVT, in particular 5 to 6 weeks after surgery;
v. deposed there was no basis to assume that she suffered a DVT at admission or during his examination of her at 7.30pm on the 26th June;
vi. Explained that tragically, the nature of DVT is an event properly described as catastrophic.

27. Professor Cook frankly stated he had not considered DVT during the course of his treatment of Ms Ryder. He observed that Ms Ryder was wearing a stocking which was applied as a matter of course at the hospital.

Medication Regime

28. There is no reasonable basis to criticise the medication management of Ms Ryder by Professor Cook.

29. Although not relevant to the cause of death, the issue of medication was a concern to nursing staff.

30. I am satisfied that the addition of benzodiazepines identified by Professor Cook in evidence, reasonably explained her persistent drowsiness, subsequent to the administration of Narcan.

In Conclusion

31. Professor Cook explained:

- In 20 years he had never lost a patient in unexpected circumstances in a hospital setting;
- Until the medical emergency at 2am, he was confident Ms Ryder's clinical observations were well managed and fully expected her condition would be improved the following morning.
- He agreed with comments made by Ms Ryder's partner, Maria Mercurio, that a holistic approach was essential to the care of Ms Ryder.
- In evidence, he explained that he considered Ms Ryder would have a lengthy stay in hospital at which time the entire clinical issues could be addressed.

32. In his opinion, a new event had occurred which was not present the previous day.

33. Ms Ryder received appropriate care and attention throughout her admission.

34. There is no reasonable basis to find that the DVT suffered by her was evident until shortly prior to the catastrophic event leading to her death.

Post Mortem Medical Examination

35. On the 29th June, 2007, Dr Matthew Lynch, Forensic Pathologist at the Victorian Institute of Forensic Medicine, performed an autopsy.

36. Dr Lynch found the cause of death to be pulmonary embolus, right calf deep venous thrombosis with contributing factors multiple sclerosis.

37. Dr Lynch explained in his autopsy report:

a. "In lay terms she died as a result of a 'blood clot' passing to the lungs."

38. I find Wendy Ryder died of a pulmonary embolism, right calf deep venous thrombosis with contributing factor multiple sclerosis.

Signature:

John Olle
Coroner
Date: 8th April, 2010

Distribution:
Monahan and Rowell Lawyers
St Vincent's Private Hospital
Kelli Wain
Professor Mark Cook