IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2017 6116

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 60(2)
Section 67 of the Coroners Act 2008

Findings of:	**CORONER DARREN J BRACKEN**
Deceased:	**Valerie Margaret Fraser**
Date of birth:	23 January 1923
Date of death:	24 November 2017
Cause of death:	Complications of metastatic lobular carcinoma of the breast in a woman with dementia
Place of death:	Cabrini Hospital, 646 High Street, Prahran, Victoria

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HIS HONOUR:

BACKGROUND

1. Valerie Margaret Fraser **('Mrs Fraser')** was 94 years old when she died on 24 November 2017 whilst receiving palliative care in Cabrini Private Hospital in Prahran. Prior to her death, Mrs Fraser lived at unit 2, 9 Hopetoun Road, Toorak, with her son, Boyd Fraser **('Mr Fraser')**, and his wife, Veronika Fraser **('Mrs V Fraser')**. Mr Fraser was his mother's carer in the latter stages of her life and was clearly devoted to her.

2. Mrs Fraser's medical history included advanced dementia, gastro-oesophageal reflux disease, osteoarthritis, osteoporosis, aortic valve replacement, chronic ankle deformity, right lower leg ulcer/cellulitis requiring skin grafting, cholecystectomy, recurrent urinary tract infections and breast cancer which was treated with mastectomy and hormone therapy (Tamoxifen). Mrs Fraser used a four-wheel walker to move about at home.

3. In September 2017, Mrs Fraser was admitted to Cabrini Private Hospital in Malvern with vomiting and epigastric tenderness. Mrs Fraser was discharged and re-admitted twice more before being diagnosed with lobular carcinoma on 15 November 2017 and transferred to Cabrini Health's Prahran campus for palliative care.

THE CORONIAL INVESTIGATION

Coroners Act 2008

4. Mrs Fraser's death was a "*reportable death*" pursuant to section 4 of the *Coroners Act 2008* (Vic) (**the Act**) at least because a notice under section 37 (1) of the *Births Deaths and Marriages Act 1996* was not signed and is not likely to be signed.[1]

5. The Act requires a coroner to investigate reportable deaths such as Mrs Fraser's and, if possible, to find:

    (a) The identity of the deceased;

    (b) The cause of death; and

    (c) The circumstances in which death occurred.[2]

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[1] *Coroners Act 2008* (Vic) s 4.

[2] *Coroners Act 2008* (Vic) preamble and s 67.

6. For coronial purposes, "*circumstances in which death occurred*",[3] refers to the context and background to the death including the surrounding circumstances. Rather than being a consideration of all circumstances which might form part of a narrative culminating in death, relevant circumstances are limited to those which are sufficiently proximate to be considered relevant to the death.

7. The Coroner's role is to establish facts, rather than to attribute or apportion blame for the death.[4] It is not the Coroner's role to determine criminal or civil liability,[5] nor to determine disciplinary matters.

8. One of the broader purposes of coronial investigations is to contribute to a reduction in the number of preventable deaths, both through comments made in findings and by making recommendations.

9. Coroners are also empowered to:

   (a) Report to the Attorney-General on a death;[6]

   (b) Comment on any matter connected with the death investigated, including matters of public health or safety and the administration of justice;[7] and

   (c) Make recommendations to any Minister or public statutory authority on any matter connected with the death, including public health or safety or the administration of justice.[8]

Standard of Proof

10. Coronial findings must be underpinned by proof of relevant facts on the balance of probabilities, giving effect to the principles explained by the Chief Justice in *Briginshaw* v *Briginshaw*.[9] The strength of evidence necessary to so prove facts varies according to the nature of the facts and the circumstances in which they are sought to be proved.[10]

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[3] *Coroners Act 2008* (Vic) s 67(1)(c).
[4] *Keown v Khan* [1999] 1 VR 69.
[5] *Coroners Act 2008* (Vic) s 69 (1).
[6] *Coroners Act 2008* (Vic) s 72(1).
[7] *Coroners Act 2008* (Vic) s 67(3).
[8] *Coroners Act 2008* (Vic) s 72(2).
[9] (1938) 60 CLR 336, 362-363. See *Domaszewicz v State Coroner* (2004) 11 VR 237, *Re State Coroner; ex parte Minister for Health* (2009) 261 ALR 152 [21]; *Anderson v Blashki* [1993] 2 VR 89, 95.
[10] *Qantas Airways Limited v Gama* (2008) 167 FCR 537 at [139] per Branson J but bear in mind His Honour was referring to the correct approach to the standard of proof in a civil proceeding in a federal court with reference to section

The principles enunciated by the Chief Justice in *Briginshaw* do not create a new standard of proof; there is no such thing as a "*Briginshaw Standard*" or "*Briginshaw Test*" and use of such terms may mislead.[11]

11. Facts should not be considered to have been proved on the balance of probabilities by inexact proofs, indefinite testimony, or indirect inferences,[12] rather such proof should be the result of clear, cogent or strict proof in the context of a presumption of innocence.[13] Proof of facts underpinning a finding that would, or may, have an extremely deleterious effect on a party's character, reputation or employment prospects demands a weight of evidence commensurate with the gravity of the facts sought to be proved and the content of the finding based on those facts.[14]

MATTERS IN RELATION TO WHICH A FINDING MUST, IF POSSIBLE, BE MADE

Identity of the Deceased - Section 67(1)(a) of the Act

12. On 6 December 2017, Mr Fraser identified the deceased as his mother, Valerie Margaret Fraser, born 23 January 1923.

13. Mrs Fraser's identity is not in dispute and requires no further investigation.

Cause of death - Section 67(1)(b) of the Act

14. On 11 December 2017, Dr Melissa Baker, a Forensic Pathologist practising at the Victorian Institute of Forensic Medicine, conducted an autopsy upon Mrs Fraser's body. Dr Baker provided a written report, dated 17 July 2018, in which she opined that the cause of Mrs Fraser's death was *'complications of metastatic lobular carcinoma of the breast in a woman with dementia'*. I accept Dr Baker's opinion.

15. Dr Baker's report refers to the most significant finding at post-mortem examination as wide-spread metastatic cancer, the histological appearance of which was typical of metastatic lobular carcinoma of the breast.

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140 of the *Evidence Act 1995* (Cth); *Neat Holdings Pty Ltd v Karajan Holdings Pty Ltd* (1992) 67 ALJR 170 at pp170-171 per Mason CJ, Brennan, Deane and Gaudron JJ.

[11] *Qantas Airways Ltd v Gama* (2008) 167 FCR 537, [123]-[132].

[12] *Briginshaw v Briginshaw* (1938) 60 CLR 336, at pp. 362-3 per Dixon J.

[13] *Briginshaw v Briginshaw* (1938) 60 CLR 336, at pp. 362-3 per Dixon J.; *Cuming Smith & CO Ltd v Western Farmers Co-operative Ltd* [1979] VR 129, at p. 147; *Neat Holdings Pty Ltd v Karajan Holdings Pty Ltd* (1992) 67 ALJR 170 at pp170-171 per Mason CJ, Brennan, Deane and Gaudron JJ.

[14] *Anderson v Blashki* [1993] 2 VR 89, following *Briginshaw v Briginshaw* (1938) 60 CLR 336, referring to *Barten v Williams* (1978) 20 ACTR 10; *Cuming Smith & Co Ltd v Western Farmers' Co-operative Ltd* [1979] VR 129; *Mahon v Air New Zealand Ltd* [1984] AC 808 and *Annetts v McCann* (1990) 170 CLR 596.

Dr Baker's report goes on to say that a metastatic tumour in mesenteric fat caused extrinsic compression of the third part of the duodenum and likely explained Mrs Fraser's symptoms of anorexia and vomiting.

16. Post-mortem examination also revealed bilateral pneumonia. Dr Baker noted that pneumonia commonly develops in the terminal stages of life and Mrs Fraser's pneumonia is likely to have worsened as she approached the end of her life.

17. Other findings at post-mortem examination included:

    (a) Cardiomegaly[15] which is associated with increased myocardial oxygen demand and arrhythmia recognised as cause of sudden death.

    (b) A prosthetic aortic valve with adherent thrombus on two leaflets and mitral valve annular calcification.

    (c) Benign nephrosclerosis, a simple cortical cyst of the left kidney and vascular amyloidosis.

    (d) Vascular amyloidosis with minimal parenchymal and interstitial involvement. Whilst it is an incidental finding in this case, it is interesting in view of Mrs Fraser's diagnosis of dementia as cerebral amyloid angiopathy is a common finding in dementia of Alzheimer's type.

18. The autopsy did not identify any evidence of injuries that may have caused or contributed to Mrs Fraser's death and Dr Baker commented that there was no evidence to suggest that Mrs Fraser's death was due to anything other than natural causes.[16]

Circumstances in which the death occurred - Section 67(1)(c) of the Act

First admission to Cabrini Hospital

19. On 14 September 2017, Mrs Fraser was admitted to Cabrini Hospital in Malvern under the care of the General Medical Unit (**GMU**) and was treated for acute pancreatitis secondary to gallstones. An abdominal ultrasound was conducted, the result of which was consistent with the clinical impression of pancreatitis. No ascites (excess fluid in the abdomen) was seen nor were any abnormal liver or pancreatic lesions identified.[17]

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[15] This indicates an enlarged heart with the weight being above that expected for a woman of the deceased's height and weight.
[16] Medical Examiner's Report by Dr Baker re Valerie Margret Fraser dated 17 July 2018 page 7 paragraph 10.
[17] Statement of Drs Ruth Chin and Chris Yeo, Coronial Brief, p.17.

Mrs Fraser was assessed by hepatobiliary surgeon, Dr Kay Bowers, who recommended no surgical intervention and that Mrs Fraser be conservatively managed because of her frailty, advanced age and cognitive impairment.[18]

20. Mr Fraser was dissatisfied with Dr Bowers' recommendation and, independent of treating physicians consulted Dr Leon Fisher, a gastroenterologist. On 19 September 2017 Dr Fisher performed an endoscopic retrograde cholangiopancreatography (**ERCP**) sphincterotomy on Mrs Fraser during which pancreatic duct stones were removed.[19] Mrs Fraser recovered well post-operatively and was discharged home on 25 September 2017.[20]

Second admission

21. On 16 October 2017, Mrs Fraser returned to Cabrini Hospital with intermittent vomiting and was described as *'failing to thrive'*. Chest and abdominal x-rays identified moderate faecal loading (constipation) and some mildly dilated small bowel loops. No free gas or focal lung changes were noted, and blood tests were unremarkable. Another abdominal ultrasound[21] was performed and showed pneumobilia (gas in the biliary system) which was considered to be consistent with Mrs Fraser's recent surgery. There was no pancreatic lesion seen and the bile duct was seen to be normal. Mrs Fraser's radiology was reviewed by senior radiologist, Dr Nick Gelber, and in the GMU weekly radiology review session; no evidence of obstruction was identified.[22]

22. On 17 October 2017, hospital staff met with Mr Fraser to discuss his mother's clinical management and staff told Mr Fraser that the cause of his mother vomiting was probably multi-factorial and that gastroparesis[23] may have contributed.[24] Mrs Fraser's care plan included the cessation of Fosfomycin[25] and Tamoxifen[26] which, it was thought, may have been contributing to her vomiting. Despite these medications being subsequently ceased Mrs Fraser continued vomiting and on the evenings of 17 October 2017 and 18 October 2017 her vomitus included '*coffee ground liquid*' – an indication of blood in the vomitus.

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[18] Statement of Drs Ruth Chin and Chris Yeo, Coronial Brief, p.17.Letter from Dr Peter Lowthian to Boyd Fraser dated 31 January 2018, Coronial Brief, p.35.
[19] Statement of Drs Ruth Chin and Chris Yeo, Coronial Brief, p.18; Endoscopy Report, Dr Leon Fisher dated 19 September 2017, Cabrini Medical Records.
[20] Letter from Dr Peter Lowthian to Boyd Fraser dated 31 January 2018, Coronial Brief, p.35.
[21] One having previously been conducted on 14 September 2017.
[22] Statement of Drs Ruth Chin and Chris Yeo, Coronial Brief, p.18.
[23] A disease that prevents the stomach emptying itself normally.
[24] Cabrini Medical Records
[25] An antibiotic used to treat urinary tract infections.
[26] A medication used to treat breast cancer.

23. Antiemetics did not help and on 23 October 2017 Mr Fraser raised concerns about his mother's ongoing vomiting with nursing staff. Staff contacted Dr Chris Yeo of the GMU who ordered a further abdominal x-ray which was performed the next day.

24. On 25 October 2017, Mrs Fraser's dose of Aricept[27] was ceased which improved her nausea and vomiting.

25. On 26 October 2017, and again independent of advice of Mrs Frasers's treating team, Mr Fraser informed nursing staff he wanted gastroenterologist Dr Chris Desmond to review his mother and the GMU contacted Dr Desmond that day.[28]

26. On 27 October 2017, GMU staff met with Mr Fraser to discuss changes to his mother's medication.[29] Staff told Mr Fraser his mother had stopped vomiting since Aricept had been ceased[30] and again raised gastroparesis.

27. On 28 and 30 October 2017, Dr Desmond reviewed Mrs Fraser and opined that Mrs Fraser should be treated conservatively and that further investigations were not in her best interest. This opinion coincided with GMU recommendations that further investigations would not change Mrs Fraser's overall management and outcome.[31]

28. Over the course of her stay in hospital from 16 – 30 October 2017, Mrs Fraser was increasingly bed-bound, could not communicate and needed to be turned regularly. Clinicians formed the view that she was approaching the end of her life.[32] Mrs Fraser was considered a high risk of aspiration pneumonia due to advanced frailty, dementia and immobility.[33] GMU staff told Mr Fraser on a number of occasions that his mother was at extreme risk of aspiration. Mr Fraser wanted to take his mother home.[34]

29. By 30 October 2017 Mrs Fraser's condition had stabilised, her vomiting had ceased and after consultation with a dietician and with a prescription for antiemetics she was discharged home[35] to Mr Fraser's care.[36]

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[27] Aricept is the trade name for donepezil, a drug used to treat confusion (dementia) related to Alzheimer's disease.
[28] Statement of Drs Ruth Chin and Chris Yeo, Coronial Brief, p.18
[29] Cabrini Medical Records.
[30] Cabrini Medical Records.
[31] Statement of Drs Ruth Chin and Chris Yeo, Coronial Brief, p.18.
[32] Cabrini Medical Records; Statement of Drs Ruth Chin and Chris Yeo, Coronial Brief, p.18.
[33] Statement of Drs Ruth Chin and Chris Yeo, Coronial Brief, p.18.
[34] Statement of Drs Ruth Chin and Chris Yeo, Coronial Brief, p.18.
[35] Cabrini Medical Records.
[36] Cabrini Discharge summary.

Third admission

30. On 3 November 2017, an ambulance took Mrs Fraser from home to Cabrini Hospital after she had repeatedly vomited '*brown liquid*' overnight.[37] The initial clinical impression was possible gastroparesis and Mrs Fraser was again admitted into the care of the GMU. Mrs Fraser was diagnosed with aspiration pneumonia and severe electrolyte disturbance (hypernatremia) resulting from dehydration.[38] An abdominal x-ray revealed faecal loading and a moderately distended stomach. A chest x-ray showed mild non-specific changes and in accordance with Mr Fraser's wishes Mrs Fraser was treated with intravenous fluids and antibiotics.[39]

31. On 6 November 2017, Mr Fraser asked GMU clinicians whether an abdominal computed tomography (**CT**) scan was necessary. Clinicians told Mr Fraser that one had recently been done, that there was no clinical indication of a need for another,[40] that Mrs Fraser's constipation would be treated and that a review of the need for a further CT scan would be undertaken in "*…a few days*".[41] The consensus opinion of the GMU doctors was that Mrs Fraser should receive palliative care; an opinion with which Mr Fraser disagreed.[42]

32. Mrs Fraser continued to experience episodic vomiting and regurgitation, but her condition improved slightly until on 10 and 11 November 2017 her vomitus was black, suggestive of upper gastro-intestinal bleeding, although no melena (blood in stools) was identified; Mrs Fraser's haemoglobin level was stable.[43]

33. On 11 November 2017, Mrs Fraser appeared alert and clinicians told Mrs V Fraser that the source of her mother-in-law's vomiting was unclear and that further investigation, such as a gastroscopy, may cause additional harm, such as perforation. Clinicians told Mrs V Fraser that considering Mrs Fraser's frailty, vulnerability to stressors and co-morbidities, treatment should be limited to symptomatic care. Mrs V Fraser told clinicians that Mr Fraser wanted a third opinion from gastroenterologist Associate Professor Henry Debinski.

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[37] Cabrini Medical Records.
[38] Statement of Drs Ruth Chin and Chris Yeo, Coronial Brief, p.19.
[39] Statement of Drs Ruth Chin and Chris Yeo, Coronial Brief, p.19; Letter from Dr Peter Lowthian to Boyd Fraser dated 31 January 2018, Coronial Brief, p.36.
[40] Cabrini Medical Records.
[41] Cabrini Medical Records. In his letter to Mr Fraser dated 31 January 2018 Dr Peter Lowthian, Executive Director Medical Services and Clinical Governance at Cabrini Health, referred to those "*…few days…*" as being "*…48 hours*".
[42] Letter from Dr Peter Lowthian to Boyd Fraser dated 31 January 2018, Coronial Brief, p.36; Statement of Drs Ruth Chin and Chris Yeo, Coronial Brief, p.19.
[43] The protein in red blood cells that carries oxygen from the lungs to the body.

34. GMU staffed contacted Associate Professor Debinski's office to be told that Dr Fisher was *'standing in'* for Associate Professor Debinski who was away and could not be contacted until 15 November 2017.[44] Dr Fisher explained to GMU staff that Mr Fraser had previously terminated his services in relation to Mrs Fraser and he considered it inappropriate that he review Mrs Fraser.[45]

35. On the afternoon of 14 November 2017, Mrs Fraser's family attended a two-hour meeting with her treating team including:

    (a) medical staff;

    (b) an occupational therapist;

    (c) a physiotherapist, dietician, speech pathologist, social worker, psychologist; and

    (d) a nurse.

    The treating team advised her family that Mrs Fraser was dying and that her current treatment regime may not be providing the palliative care that, in their view, she required.[46] At the request of Mr Fraser, clinical staff contacted the Alfred Hospital and spoke to a gastroenterology registrar enquiring about alternative care options and canvassing Mrs Fraser being transferred to the Alfred. The registrar declined to transfer Mrs Fraser to the Alfred because, it was said, the Alfred could provide no alternative to palliative care.[47] Mr Fraser agreed to palliative care.[48]

36. On 15 November 2017, Mrs Fraser saw Associate Professor Natasha Michael, the director of Palliative Care. Mrs Fraser's *'treating team'* told Associate Professor Michael that Mrs Fraser had previously undergone an abdominal CT which had not identified any serious pathology. Associate Professor Michael sought to review that scan only to find that no such scan had been undertaken; hospital records contained no reference to one. Associate Professor Michael ordered an abdominal CT scan.[49]

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[44] Letter from Dr Peter Lowthian to Boyd Fraser dated 31 January 2018, Coronial Brief, p.36. A. Prof Debinski later confirmed that he was back at work on 13 November 2017, not 15 November 2017.
[45] Statement of Drs Ruth Chin and Chris Yeo, Coronial Brief, p.19. Letter from Dr Peter Lowthian to Boyd Fraser dated 31 January 2018, Coronial Brief, p.36.
[46] Letter from Dr Peter Lowthian to Boyd Fraser dated 31 January 2018, Coronial Brief, p.37.
[47] Statement of Drs Ruth Chin and Chris Yeo, Coronial Brief, p.19; Letter from Dr Peter Lowthian to Boyd Fraser dated 31 January 2018, Coronial Brief, p.37.
[48] Statement of Drs Ruth Chin and Chris Yeo, Coronial Brief, p.19.
[49] Statement of Dr Natasha Michael, Coronial Brief, p.24; Cabrini Medical Records.

37. Cabrini medical records dated 6 November 2017 record Mr Fraser asking if an abdominal CT scan was necessary and a clinician writing that:

> '*...discussed she recently had a CT abdo & no suspicious lesion therefore for the moment get her [bowel working] & re discussion of CT abdo is required in few days.*'

38. In his letter to Mr Fraser dated 31 January 2018, Dr Lowthian refers to the medical notes of 6 November 2017 recording that Mr Fraser asked if a CT scan of Mrs Fraser's abdomen was required and him being told that it had previously been undertaken. In his letter Dr Lowthian refers to the notes saying that the plan was to treat Mrs Fraser's faecal loading and at that time there was no immediate clinical indication for a CT scan. The medical plan, according to Dr Lowthian and the notes, was to review that decision within '*48 hours*' and '*a few days*' respectively. Whilst Dr Lowthian's account of the medical notes of 6 November 2017 may have been accurate those notes themselves were not. As at 6 November 2017, a CT scan had not been conducted; the medical notes contain no account of it having been undertaken[50] or a resultant report.

39. The medical notes of post 6 November 2017 contain no reference to a reconsideration of whether an abdominal CT scan was required.

40. In any case, the members of the '*treating team*' who briefed Associate Professor Michael prior to her examining Mrs Fraser on 15 November 2017 and told her that a CT scan of Mrs Fraser's abdomen had been undertaken were clearly wrong.[51] It is at least possible that the '*treating team*' were or included Drs Chin or Yeo or both of them. In her statement dated 30 May 2019 Associate Professor Michael refers to discussing "*...the above...*" with Dr Yeo. It is unclear whether this discussion included Dr Yeo telling Associate Professor Michael that Mrs Fraser had had an abdominal CT scan prior to 15 November 2017 and Associate Professor Michael's inability to find such a scan or any record of it in hospital records or in Mrs Fraser's treatment generally. In any case Associate Professor Michael ordered such an abdominal CT scan on 15 November 2017. That CT scan was performed and reviewed by Associate Professor Michael who noted:

[50] Other than the reference in the 6 November 2017 'Progress Notes'.
[51] Statement of Dr Natasha Michael, Coronial Brief, p.24.

(a) *'Acute infective change in both lungs, more prominent on the right. Small bilateral pleural effusions. Mediastinal and hilar lymphadenopathy likely reactive in nature;*

(b) *Enlarged abnormal right axillary lymph node suspicious for metastatic disease in the setting of known past history of breast carcinoma;*

(c) *A 6.2 centimetre right adnexal lesion significantly increased in size from the previous study, suspicious for malignant transformation of a dermoid. Associated obstruction of the right ureter resulting in moderate right hydronephrosis and ureteric dilation;*

(d) *Left adrenal lesion and mesenteric nodularity in the upper abdomen suspicious for metastatic disease. There is suspicious secondary occlusion D3 of the duodenum resulting in proximal obstruction.'*[52]

41. The scan confirmed that Mrs Fraser had a bowel obstruction, suggested that the obstruction was high-grade, involved the distal duodenum[53] and was due to an extrinsic tumour and associated swollen lymph nodes. Further it suggested that Mrs Fraser's breast carcinoma had metastasised.[54] Such a suggestion was consistent with the view of Mrs Fraser's clinicians who considered that the metastasies was related to her breast cancer.[55] The senior radiologist suspected an infiltrating lesion within Mrs Fraser's stomach.[56]

42. Associate Professor Debinski contacted Mr Fraser telling him of the CT scan findings and that Mrs Fraser's bowel obstruction was a recent event. Associate Professor Debinski recommended the continuation of palliative care and insertion of a nasogastric tube (**NGT**).

43. Associate Professor Michael had a lengthy discussion with Mr Fraser about the result of the CT scan. She suggested the insertion of an NGT as an interim measure. Taking into account Mrs Fraser's frail state, Associate Professor Michael considered that an NGT was preferable to a duodenal stent.[57]

44. On 16 November 2017, clinicians inserted Mrs Fraser's NGT. She was noted to have been tachycardic overnight and was commenced on antibiotics.

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[52] Statement of Dr Natasha Michael, Coronial Brief, p.25.
[53] The first part of the small intestine.
[54] Statement of Dr Henry Debinski, Coronial Brief, p.22; Statement of Dr Robert Stanley, Coronial Brief, p.24, 27.
[55] Statement of Dr Robert Stanley, Coronial Brief, p.27.
[56] Letter from Dr Peter Lowthian to Boyd Fraser dated 31 January 2018, Coronial Brief, p.37.
[57] Statement of Dr Natasha Michael, Coronial Brief, p.25.

In her statement dated 30 May 2019 Associate Professor Michael said that, as at 16 November, Mrs Fraser was not suitable for further aggressive intervention and that further treatment should be limited to supporting symptoms and improving Mrs Fraser's quality of life.[58]

45. On 17 and 19 November 2017, Mr Fraser and Associate Professor Michael discussed the insertion of a duodenal stent to relieve Mrs Fraser's intestinal obstruction. Associate Professor Michael told Mr Fraser that the risks associated with surgical insertion of such a stent likely outweighed the possible benefits, including:

    (a) In light of Mrs Fraser's frailty, a stent could potentially increase the risk of aspiration and cause a perforation or even migrate;

    (b) The likely benefit was minimal as Mrs Fraser had responded to the insertion of the NGT.[59]

46. Mr Fraser also discussed the stent option with Associate Professor Debinski who advised it would be difficult taking into account:

    (a) The obstruction was quite remote in the duodenum and insertion would be technically difficult;

    (b) It was possible the stent would have nothing to grip onto and it could migrate into the bowel which might create a new site of obstruction or perforation;

    (c) Patients who have stents inserted with advanced cancer (such as Mrs Fraser) would live on average an extra 30 days.60

47. In her statement Associate Professor Michael referred to Mrs Fraser becoming increasingly cachectic[61] and to her having subcutaneous metastatic disease nodes that were palpable on her abdomen. Mr Fraser agreed to transfer Mrs Fraser to the Cabrini Health hospital in Prahran for palliative care.

48. On 20 and 22 November 2017, at the request of Associate Professor Debinski, Dr Robert Stanley reviewed Mrs Fraser to consider further management options.

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[58] Statement of Dr Natasha Michael, Coronial Brief, p.25.
[59] Statement of Dr Natasha Michael, Coronial Brief, p.25.
[60] Statement of Dr Henry Debinski, Coronial Brief, p.23.
[61] A state of extreme weight loss and muscle wasting, Coronial Brief, p.25.

Dr Stanley discussed the decision not to insert a duodenal stent with Mrs Fraser's family explaining that he saw no role for surgery, radiation therapy or chemotherapy. Dr Stanley was of the view that the only viable option, a trial of hormonal therapy, was likely to be futile given Mrs Fraser's condition. Dr Stanley and the family agreed to administer an intramuscular injection of Faslodex[62] which occurred on 22 November 2017.

49. Mrs Fraser was kept comfortable until she passed away on 24 November 2017.

Cabrini Hospital Review

50. Cabrini Health undertook an investigation into Mrs Fraser's care and treatment at Cabrini Hospital. The review was overseen by Dr Peter Lowthian, Executive Director of Medical Services and Clinical Governance. The results of Dr Lowthian's investigation were provided to Mr Fraser by letter dated 31 January 2018.

51. In that letter Dr Lowthian referred to:

    (a) Mrs Fraser having had a mechanical gastric outlet obstruction which was not appreciated until her abdominal CT scan on 15 November 2017;

    (b) In retrospect, Mrs Fraser's first, and possibly second, admission appeared to have been managed appropriately and bile duct stones were probably not the cause of Mrs Fraser's symptoms as believed;

    (c) The GMU erroneously believed that a CT scan had been performed when in fact it was an abdominal ultrasound that was performed. This was a genuine misunderstanding that GMU clinicians acknowledged and apologised for;

    (d) Decisions around Mrs Fraser's treatment were based not on her age but on her baseline function and the likely benefit;

    (e) The early diagnosis of metastatic cancer would not have changed Mrs Fraser's management;

    (f) Based on Associate Professor Debinski's advice a procedure to insert a stent would not have been performed even if the diagnosis of the cancer had been made in September 2017; and

[62] Faslodex (a liquid injection of fulvestrant) is a hormone therapy used to treat women with cancer.

(g) Cancer specific treatment such as chemotherapy and radiotherapy would not have been recommended in Mrs Fraser's case.[63]

52. On 20 March 2018, Dr Lowthian met with Mr Fraser and Mrs V Fraser and they discussed the results of Cabrini's investigation.[64] Dr Lowthian told Mr and Mrs V Fraser that Cabrini Health would not be able to compensate Mr and Mrs V Fraser over Mrs Fraser's death—Mr Fraser having previously written to Cabrini Health requesting compensation on an '*ex gratia basis*' in the order of $50,000. Dr Lowthian offered Mr and Mrs V Fraser support counselling[65] and canvassed long-term and then current service improvements that Cabrini Health was undertaking associated with concerns that Mr and Mrs V Fraser had raised about Cabrini Health's care and treatment of Mrs Fraser. Subsequent to the meeting Dr Lowthian referred to these improvements in a letter to Mr Fraser and Mrs V Fraser dated 4 April 2018, specifically:

Current activities

(a) Care of complex elderly patients has been placed on the Cabrini Risk Register, with initiatives discussed at the highest level within the organisation to address any gaps in our services;

(b) Development of a dedicated cognitive/dementia service at Cabrini Health;

(c) Empowering patients and families to escalate their concerns through the Call and Respond Early (CaRE) initiative;

(d) Implementation of the new *Medical Treatment Decision and Planning Act 2016* (Vic) which came into effect on 12 March 2018;

Long-term activities

(a) A strategic plan to expand Cabrini Health's home-based services to facilitate comprehensive care in the home for elderly complex patients;

(b) Continuing development of the Cabrini Palliative Home Care service; and

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[63] Letter from Dr Peter Lowthian to Boyd Fraser dated 31 January 2018, Coronial Brief, pp.37-38.
[64] Statement of Dr Peter Lowthian, Coronial Brief, p.29.
[65] Letter from Dr Peter Lowthian to Boyd Fraser dated 4 April 2018, Coronial Brief, pp.42.

(c) Engaging general practitioners to facilitate effective continuity of care for patients following discharge from hospital[66]

Australia Health Practitioners Regulation Agency (AHPRA) Review

53. In early 2018, Mr Fraser referred his mother's case to AHPRA. After investigating the referral AHPRA decided to take no regulatory action on the basis that Mrs Fraser's care was *'appropriate and reasonable in all the circumstances'*.[67] AHPRA concluded that earlier diagnosis [of the carcinoma] would *'not likely have changed the treatment plan'*.[68]

Family Concerns

54. Mr Fraser wrote the court setting out concerns by letters dated 28 December 2017, 6 February 2018, 23 February 2018, 8 March 2018, 16 March 2018, 2 May 2018, 18 May 2018, 3 July 2018, 13 February 2019 and 5 June 2019.[69] Mr Fraser also forwarded to the court email correspondence between him and Cabrini Health, the Department of Health and Human Services and the Department of Veterans Affairs and media clips dealing with his concerns.

55. In his letters of 13 February 2019 and 5 June 2019 Mr Fraser explicitly raised concerns relating to:

    (a) His difficulties communicating with the GMU;

    (b) The GMUs mistaken belief that an abdominal CT scan had been performed (prior to the one ordered by Associate Professor Michael on 15 November 2017) when no such scan had been undertaken;

    (c) The delay in Cabrini Health performing the CT scan and Mrs Fraser's misdiagnosis;

    (d) That early diagnosis of Mrs Fraser's cancer would have provided an opportunity to explore other treatment modalities, such as hormone treatment.

56. In these letters Mr Fraser also disputed the assertions in Dr Lowthian's letter dated 31 January 2019 that:

    (a) Mrs Fraser was bed-bound;

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[66] Letter from Dr Peter Lowthian to Mr and Mrs V Fraser, dated 4 April 2018, Coronial Brief, pp.42-43.
[67] Letter from AHPRA to Boyd Fraser dated 5 June 2018.
[68] Letter from AHPRA to Boyd Fraser dated 5 June 2018.
[69] A concerted effort has been made to capture all correspondence with the court in which Mr Fraser raised concerns about his mother's treatment, however Mr Fraser's communications were extensive and complex.

(b) Mr Fraser maintained that Associate Professor Debinski, whom he, himself engaged, had ordered the scan that ultimately took place on 15 November 2017 and not Associate Professor Michael as Dr Lowthian indicated;

(c) Mr Fraser's understanding that Associate Professor Debinski was prepared to insert a duodenal stent to treat Mrs Fraser after he reviewed her on 15 November 2017 contrary to the content of Dr Lowthian's statement.

57. On 5 February 2020 Mr Fraser telephoned the court to discuss his concerns with the material on the Coronial Brief with which he had been provided. He reiterated these concerns in writing in a letter dated 6 February 2020, stating his *'chief'* concern was *'the regrettable failure to investigate or prioritize, the fact that the members of the General Medical Unit of the Cabrini Hospital believed that a CT scan had been performed on my late mother'*.

58. In subsequent correspondence to the court including telephone calls and emails dated 24 March 2020, 14 April 2020, 20 April 2020, 14 May 2020, 5 June 2020, 26 June 2020 and 3 September 2020, Mr Fraser raised further concerns about Cabrini Heath's compliance with the National Safety and Quality Health Service (**NSQHS**) Standards, with particular reference to the Clinical Governance Standards which concerns the implementation of an open disclosure process.

Coronial Investigation

Information contained in the Coronial Brief of Evidence

59. The court obtained a 'joint statement' from GMU clinicians Drs Ruth Chin and Chris Yeo[70] as well as individual statements from Associate Professor Debinski, Associate Professor Michael, Dr Stanley and Dr Lowthian in relation to Mrs Fraser's care and treatment dealing with the concerns raised by Mr Fraser. The court also obtained medical records from Cabrini Hospital.

60. Mrs Fraser's medical records detail Mrs Fraser's clinicians regularly updating Mr and Mrs V Fraser about Mrs Fraser's condition and treatment including explicit reference to the two-hour meeting with the extended treatment team held on 14 November 2017.

61. In their joint statement dated 29 April 2019, Drs Chin and Yeo stated they believed Mrs Fraser was suffering from gastroparesis caused by a number of things which, they said, was common

[70] It is to be noted that 'joint statements' are inapposite for coronial investigations.

in patients suffering metastatic cancer.

They stated that in retrospect, gastroparesis likely contributed to Mrs Fraser's symptoms, in addition to her advance frailty and dementia. On one view this may not completely coincide with findings in Dr Baker's autopsy report that Mrs Fraser's vomiting symptoms were likely due to her tumour causing extrinsic compression on the duodenum.

62. The apparent contradiction was put to Dr Chin who submitted in response that the two diagnoses of gastroparesis and gastric outlet obstruction (due to the tumour) were not mutually exclusive.[71] Dr Chin maintained that gastroparesis of malignancy was also a likely contributor to Mrs Fraser's symptoms over the course of her admissions, especially earlier in her admissions when the radiology performed (i.e. abdominal x-rays) did not indicate a mechanical obstruction and she was continuing to open her bowels.

63. Surprisingly Drs Chin's and Yeo's statement contains no reference to the medical notes dated 6 November 2017 which refer to the abdominal CT scan. They do however refer in later paragraphs to *'multiple doctors within the GMU'* having formed the mistaken view that the abdominal CT scan had been performed prior to 15 November 2017, that this error was never contested and that an apology was provided to Mr Fraser. Further, the statement does not refer to Dr Yeo's discussion with Associate Professor Michael on 15 November 2017 nor reference to any briefing provided by the *'treating team'* to Associate Professor Michael.

64. In their statement Drs Chin and Yeo asserted that had a CT abdomen scan been performed two weeks earlier than it was, as it was thought that it had been, Mrs Fraser's cancer would then have been diagnosed; however, they maintain that given her poor baseline state, profound irreversible dementia and Eastern Cooperative Oncology Group (**ECOG**) status of four,[72] the clinical recommendation for treatment, symptomatic and palliative care, would not have changed.

65. In her statement dated 30 May 2019, Associate Professor Michael expressed her view that appropriate decisions were made at each juncture of Mrs Fraser's care in light of her advanced dementia, frailty and the advanced nature of her malignancy.[73] Associate Professor Michael

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[71] Joint statement of Dr Michelle Lewicki and Dr Ruth Chin dated 3 September 2020.

[72] The ECOG scale is used by clinicians assess how a patients' disease is progressing and to assess how the disease affects the daily living abilities of the patient. An ECOG of four denotes Mrs Fraser was completely disabled, could not carry out self-care and was totally confined to her bed or chair.

[73] Statement of Dr Natasha Michael, Coronial Brief, p.25.

opined that Mrs Fraser's cancer was too advanced and her performance status too poor for her to have benefited from any other treatment.

66. In his statement dated 5 June 2019, Dr Stanley opined that even if Mrs Fraser's advanced cancer had been diagnosed one or two months earlier, during her earlier admissions, from a medical oncology point of view the treatment options would have been similar; nothing other than a trial of hormonal therapy would have been tolerable or appropriate.[74] Dr Stanley stated that such treatment may have been slow to work and would have had no impact on Mrs Fraser's outcome. Dr Stanley could not say whether the insertion of a duodenal stent a month before Mrs Fraser's death would have been possible or appropriate.

67. In his statement dated 30 May 2019, Dr Lowthian explained that he had received advice from Associate Professor Debinski and from an unidentified upper gastrointestinal surgeon, who was not involved in Mrs Fraser's care, that earlier diagnosis in the time frame described in the reports may have resulted in Mrs Fraser being referred for palliative care earlier, but would not have had an effect on her ultimate prognosis. In the absence of detail of this surgeon's qualifications, experience and work circumstances this opinion is of very limited value.

68. Dr Lowthian noted that Mrs Fraser's Tamoxifen had been ceased by the GMU during their rationalisation of Mrs Fraser's medications and that the *'hormone'* provided by Dr Stanley was Faslodex. Considering the timing of the Tamoxifen cessation and the hormone used by Dr Stanley, neither, according to Dr Lowthian, would have had any effect on the prognosis of Mrs Fraser's metastatic carcinoma.

69. Dr Lowthian's statement also addressed concerns raised by Mr Fraser in relation to the content of Dr Lowthian's letter dated 31 January 2019 noting that:

    (a) The conclusion that Mrs Fraser was bed-dependent was based on her medical records and discussion with her clinicians. Mrs Fraser's medical record indicates that with the exception of some limited mobilisation with the assistance of allied health staff, Mrs Fraser essentially remained bed bound during her November 2017 hospitalisation;

    (b) The CT scan report confirms that Associate Professor Michael was the doctor who ordered the CT scan;

[74] Statement of Dr Robert Stanley, Coronial Brief, p.28.

70. Dr Lowthian's assertion that Associate Professor Debinski was not prepared to insert a stent was based on direct discussions between them on 6 December 2017 and 28 February 2018, and Dr Lowthian's contemporaneous notes of those discussions to the effect that Associate Professor Debinski did not think that a stent was, or ever had been, appropriate in Mrs Fraser's case due to the high risk of migration. Associate Professor Debinski had confirmed that even if the diagnosis of carcinoma had been made three to four weeks before 15 November 2017, he would not have inserted a duodenal stent. This is reflected in Associate Professor Debinski's statement dated 30 May 2019. Associate Professor Debinski told Dr Lowthian he did not propose a stent as a viable option to Mr Fraser; he said he mentioned it in the list of options only to advise against it.

First request for further information from Cabrini Health

71. By letter dated 5 February 2020, I requested a further statement from Cabrini Health addressing:

    (a) Any explanation as to how the GMU formed the mistaken view than an abdominal CT scan had been performed on Mrs Fraser before 15 November 2017;

    (b) What, if any, treatment plans would have been available had Mrs Fraser's cancer been diagnosed earlier (for example, hormone therapy of the kind ultimately adopted by Dr Stanley) and the likelihood that they would have been pursued or impacted the ultimate outcome.

72. The court followed up the request by phone on 7 February 2020 and requested that the response also set out any action taken by Cabrini Health to amend relevant processes and practices following Mrs Fraser's death.

73. On 4 March 2020, the court received a response from Cabrini Hospital by couriered post that included a statement from Dr Fergus Kerr, Group Director Medical Services and Clinical Governance dated 4 March 2020 and a letter from GMU clinicians Dr Ruth Chin and Dr Chris Yeo dated 25 February 2020 in support of Dr Kerr's statement.

74. The statement provides no explanation about how or why *'it was thought'* that Mrs Fraser had undergone an abdominal CT scan, implicitly before 15 November 2017. Significantly there is no explanation about who – which doctor or doctors – thought that the CT scan had occurred and why he, she or they thought that.

75. The letter from Drs Chin and Yeo simply 'cut and pasted' the content of their previous joint statement and was unhelpful.

Second request for further information from Cabrini Health

76. A further request was made of Cabrini Health for a statement explaining the note in Mrs Fraser's medical record made on 6 November 2017 (above paragraph 36) that refers to Mr Fraser querying whether a CT scan of Mrs Fraser's abdomen was necessary and Mr Fraser being told that this had recently been done with no suspicious lesions identified. The request sought that statement explicitly address the basis for the belief that an abdominal CT scan had been performed.

77. On 1 May 2020, Cabrini Health provided the court with a statement from Dr Michelle Lewicki, consultant physician and nephrologist, who conducted the 'consultant ward round' on 6 November 2017 with senior registrar Dr Po'ouli Funaki who 'scribed medical notes'. Dr Lewicki explained that:

> *'My error was that I mistakenly informed Mr Fraser that a CT scan had been performed in a previous admission and hadn't shown any pathology. In fact, it was an Abdominal Ultrasound scan that had been performed on 2 occasions previously. I went on to correctly state that there was no clinical indication for a CT scan on that day (6 November 2017) and that we would revisit the matter in 48 hours or at any time if her symptoms recurred, which I believe was a clinically appropriate decision-making paradigm.*
>
> *I find it difficult to fully explain the basis for my misreading of the records... Having reviewed the medical record I am unable to identify any aspect of the results or clinical records which would have misled me into thinking such a scan had been performed, and my belief came, as it were, 'out of nowhere' and was quite clearly erroneous... I acknowledge and apologise for the fact that Mr Fraser was given incorrect information on that day.'*[75]

78. Dr Lewicki also noted, as Cabrini Health have communicated previously, that Drs Chin and Yeo, as senior members of the GMU, communicated an apology to Mr Fraser on behalf of the team and attempted to meet with him in person for a discussion. Mr Fraser cancelled that meeting.

[75] Statement of Dr Michelle Lewicki dated 1 May 2020.

79. Dr Lewicki advised that subsequent to the incident and to further her skills in effective communication, in 2018 she undertook a program of education that included a course in Effective Communication, Gathering Diagnostic Information and Communication Strategies for Challenging Patient Behaviours. She advised she has reviewed a document on managing patient expectations and re-familiarised herself with the Medical Board of Australia Practitioners Code of Conduct.

Further joint statement of Drs Chin and Lewicki dated 3 September 2020

80. The doctors of the GMU were given notice of my intention to comment upon their failure to provide any detailed explanation of the mistake regarding the abdominal CT scan in their initial statements and in their responses to subsequent requests by the court to explain the error in the medical notes of 6 November 2017. In response, Drs Chin and Lewicki provided a joint statement dated 3 September 2020 in which they acknowledged that *'in retrospect'* the initial statement of Drs Yeo and Chin '*could have been worded clearer and greater explanation provided as to how this mistaken belief came about*' and stated that '*at the time we were focussed on providing a clinical chronology of the key events as they unfolded.*'

81. Drs Chin and Lewicki stated further:

'*We would like to emphasise to the Coroner there was no intent on the part of the doctors to withhold information from the Coroner or to be anything less than forthcoming with key information to assist the Coroner's investigation.*'[76]

Further statement of Associate Professor Debinski dated 13 August 2020

82. Associate Professor Debinski was also provided an opportunity to provide further material to the court which he did in further submissions dated 13 August 2020. He stated his submissions were intended to establish his recollection of what occurred in more detail. His submissions clarify the disputes around who ordered the CT scan on 15 November 2017 and whether he was prepared to insert a stent to treat Mrs Fraser.

83. With regard to the CT scan, Associate Professor Debinski stated that after his review of Mrs Fraser on 15 November 2017 he requested nursing staff to organise a CT scan urgently as he felt that she likely had a gastric outlet obstruction based on:

(a) The clinical history.

[76] Joint submissions of Dr Michelle Lewicki and Dr Ruth Chin dated 3 September 2020.

(b) Previous x-ray findings that she had marked gastric distention at the time that she aspirated.

(c) She had clinical evidence of a succession splash.

84. He says that after making the request he returned to his rooms to commence consulting. In the course of the afternoon he checked '*online*' to see whether the tests had been completed and once he saw it, he returned to the X-ray department to speak with the radiologist. He then contacted Associate Professor Michael to explain what had been identified and also spoke with Mr Fraser about the findings.

85. As noted by Dr Lowthian, Associate Professor Michael is named in the report of the CT scan as the clinician who ordered it. Further, her medical notes of 15 November 2017 record her plan for a '*CT scan T/A/Pelvis*' and state '*I will review post scans*'. They also note that '*Henry Debinski to review today*'.

86. Whilst I am satisfied that Associate Professor Michael ordered the abdominal CT scan that was performed on 15 November 2017, I accept that A Prof Debinski also requested a CT scan after his review that afternoon.

87. With regard to whether he was prepared to insert a stent, Associate Professor Debinski stated that his recollection of the discussions was as follows:

'My initial conversations with Mr Fraser [regarding to a treating plan for Mrs Fraser] were in the setting of having merely seen the scan and we had not had a broad discussion about what direction to take with this. As per my previous correspondence, I presented him with a range of options that could be employed to deal with this problem, mindful of the fact that we would need to take Mrs Fraser's clinical state into account before making a difficult decision.

This was a conversation we continued to have over the ensuing day or so and my advice was that although a stent could be attempted, I felt that it would be potentially dangerous for the reasons that I have also outlined.

I made a recommendation that we get Rob Stanley involved, which occurred later in the piece and my understanding is that Mr Fraser continued to make enquiries about the possibility of a stent insertion which of course was his prerogative.

There has also been some mention relating to the potential for inserting a stent in September. I do not recall that conversation ever took place and it is clearly a 'hypothetical'. In September, there was no evidence of obstruction on any imaging. In fact an ERCP was performed with stone extraction from the common bile duct, which would suggest that there was no established clinical outlet obstruction which would clearly have been problematic in the setting of performing an ERCP at that time. Any discussion about stent insertion then is clearly something that would not have been contemplated and I am not sure that I even have an opinion about the feasibility of performing such a procedure back in September of 2017.

I can say though that a CT scan would definitely have been performed prior to considering a stent so one would assume the conversation relating to outcome would have been similar.'

Coroner's Court –Health and Medical Investigation Team Coroner's Prevention Unit Review of Care

88. Upon review of the circumstances of Mrs Fraser's death and taking into consideration the concerns raised by Mr Fraser, I requested that the Health and Medical Investigation Team (**HMIT**) of the Coroner's Prevention Unit[77] (**CPU**) review Mrs Fraser's medical care.

89. The HMIT advised that their review identified no concerns regarding Mrs Fraser's treatment; her death was due to natural causes. The HMIT noted that Mrs Fraser was an extremely frail 94-year-old woman with multiple co-morbidities. They concluded that whilst there was a delay in diagnosis, this would not have affected either management or eventual outcome. Mrs Fraser was not a candidate for surgery, chemotherapy or stents. Of note, the HMIT said, was that at least seven separate teams and/or clinicians concurred that palliative treatment was the most appropriate treatment option for Mrs Fraser including:

    (a) The GMU staff during Mrs Fraser's second admission.[78]

    (b) Mrs Fraser's treatment team, including allied health staff, during her second admission.[79]

    (c) Dr Desmond after reviewing Mrs Fraser on 28 and 30 October 2017.[80]

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[77] The Coroners Prevention Unit (CPU) was established in 2008 to strengthen the prevention role of the coroner. The unit assists the Coroner with research in matters related to public health and safety and in relation to the formulation of prevention recommendations. The CPU also reviews medical care and treatment in cases referred by the coroner. The CPU is comprised of health professionals with training in a range of areas including medicine, nursing, public health and mental health.
[78] Letter from Dr Peter Lowthian to Boyd Fraser dated 31 January 2018, Coronial Brief, p.35.
[79] Letter from Dr Peter Lowthian to Boyd Fraser dated 31 January 2018, Coronial Brief, p.35.
[80] Letter from Dr Peter Lowthian to Boyd Fraser dated 31 January 2018, Coronial Brief, p.35.

(d) Staff at the Alfred Hospital on 15 November 2017.[81]

(e) Associate Professor Michael on 15 November 2017.[82]

(f) Associate Professor Debinski on 15 November 2017.[83]

(g) Dr Stanley on 22 November 2017.[84]

Cabrini Health's compliance with the NSQHS Standards

90. The current iteration of the NSQHS Standards[85] are a set of eight standards encompassing 148 *'actions'* developed by the Australian Commission on Safety and Quality in Health Care (**the Commission**) to provide '*a nationally consistent statement of the level of care consumers can expect from health organisations*'.[86] Mr Fraser's concerns relate in particular to Cabrini Health's compliance with the first standard, Clinical Governance, which requires the implementation of a so-called 'open disclosure' process. According the Commission's website, open disclosure refers to '*the open discussion of incidents that result in harm to a patient while receiving health care with the patient, their family, carers of other support person*'.[87]

91. In order to address Mr Fraser's concerns, I referred the issue of compliance with these standards to SaferCare Victoria[88] as they refer in particular to the regulation of private hospitals against the NSQHS standards specifically with reference to open disclosure. SaferCare Victoria provided a written response dated 6 May 2020 in which they explained the application of the standards.

92. SaferCare advised that the Commission developed an Australian open disclosure framework outlining key principles of open disclosure, with a view to providing a nationally consistent basis for communication following a healthcare incident or adverse event. The framework specifies:

[81] Letter from Dr Peter Lowthian to Boyd Fraser dated 31 January 2018, Coronial Brief, p.37.
[82] Statement of Dr Natasha Michael, Coronial Brief, p.25.
[83] Statement of Dr Henry Debinski, Coronial Brief, p.23; Statement of Dr Peter Lowthian, Coronial Brief, p.31.
[84] Statement of Dr Robert Stanley, Coronial Brief, p.27.
[85] The current (second) edition of the NSQHS Standards was released in November 2017 with Victorian health service organisations assessed against this edition from 1 January 2019.
[86] http://www.safetyandquality.gov.au/standards/nsqhs-standards.
[87] https://www.safetyandquality.gov.au/our-work/clinical-governance/open-disclosure.
[88] SaferCare Victoria provides advice and support to Victorian health services in relation to continuous improvement and provides a conduit across health services to share information and approaches to the standards. It has no regulatory role in monitoring compliance with the standards.

(a) Open and timely communication.

(b) Acknowledgement.

(c) Apology or expression of regret.

(d) Recognition of reasonable expectations.

(e) Staff support.

(f) Integrated risk management and systems improvement.

(g) Good governance.

(h) Confidentiality.

93. Health organisations, including public and private hospitals, day surgery units and dental clinics are required to be accredited to the NSQHS Standards. From 2019, health organisations are subject to a three-year assessment cycle; that is,[89] effectively, every three years the operation of the health organisation is assessed against the standards and the health organisations' compliance with the standards are nominated as '*met*' or '*not met*'. If a health organisation is found to have large numbers of *'not met'* results assessment and is still accredited, they will be reassessed within six months of the assessment at which the '*not met'* results occurred.

94. SaferCare confirmed that whilst private hospitals are accredited to the NSQHS Standards, the Standards are not externally monitored and not audited other than every three years when they seek re-accreditation. Health services do conduct their own audits across the period as part of their continuous improvement cycles.

95. Mr Fraser complains that that Cabrini Health failed to comply with the requirement of open disclosure after his mother's death, in that Cabrini Health didn't fulsomely explain to him how it was that the doctors of the GMU believed that his mother had undergone an abdominal CT scan when she had not, other than referring to 'human error'. To this complaint Cabrini Health responds that the GMU apologised in a letter to Mr Fraser dated 18 April 2018 and had also arranged to apologise to Mr Fraser in person in a meeting shortly after Mrs Fraser's death. Regrettably this meeting did not occur as planned.

96. Compliance with the Clinical Governance Standard and the implementation of open disclosure is significant, but a failure to comply was neither a cause of Mrs Fraser's death nor a proximate circumstance. That said it was not inappropriate for Mr Fraser to raise the issue.

[89] Previously there had been a mid-cycle review however this was abolished from 2019.

There appears to be no process in place facilitating the real-time monitoring of compliance with the Standards. I will make a recommendation that the Commission and SaferCare Victoria consider whether more frequent evaluation of compliance is required.

COMMENTS PURSUANT TO SECTION 67(3) OF THE ACT

97. I reviewed Mr Fraser's concerns on the background of my obligations under section 67(1) of the *Coroners Act 2008*, to find, if possible, the identity of the deceased, the cause of death and with the circumstances in which the death occurred. I note that the coronial jurisdiction is not about finding blame or determining guilt or liability; it is about establishing facts.

98. I also note Mr Fraser's dissatisfaction with not being able to obtain compensation from Cabrini Hospital and his allegation that the treatment of his mother was negligent.[90] Compensation and the evidence by which applications or claims may be underpinned is not a matter for this court.

99. Whilst I acknowledge the grief and distress that Mrs Fraser's death caused her family, I am satisfied by the evidence before me that I am able to make the findings I am required to make pursuant to section 67 of the *Coroners Act 2008*.

100. It is regrettable that on 6 November 2017, the GMU mistakenly informed Mr Fraser that an abdominal CT scan had been performed when it had not been. The timely performance of the CT scan may have enabled clinicians to correctly diagnose Mrs Fraser earlier as a result of which she may have avoided her protracted stay at Cabrini Hospital and her family would have been spared the subsequent distress. That said, I accept that early diagnosis of Mrs Fraser's cancer would not have changed her treatment or the ultimate outcome. The error in and of itself also clearly contributed to the distress Mr Fraser and his family experienced as a result of his mother's death.

101. I am satisfied, having considered all of the available evidence, that no further investigation into Mrs Fraser's death is required.

[90] See as one example the document attached to Mr Fraser's Application for Access to Coronial Documents dated 5 September 2019.

RECOMMENDATION

102. The Australian Commission on Safety and Quality in Health Care and SaferCare Victoria consider the need for a body external to health organisations to conduct periodic audits within the three-year assessment windows for ongoing compliance with the National Safety and Quality Health Service Standards.

FINDINGS AND CONCLUSION

103. Having investigated the death, without holding an inquest, I make the following findings pursuant to section 67(1) of the *Coroners Act 2008*:

    (a) The identity of the deceased was Valerie Margaret Fraser, born 23 January 1923;

    (b) Mrs Fraser's death occurred;

        i. on 24 November 2017 at Cabrini Hospital, 646 High Street, Prahran, Victoria

        ii. from complications of metastatic lobular carcinoma of the breast in a woman with dementia, and

        iii. in the circumstances described in paragraphs 19 - 49 above.

104. Pursuant to section 73(1) of the Coroners Act 2008, I order that this finding be published on the internet.

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

    (a) Boyd Fraser, senior next of kin

    (b) Jennifer Radnell, Cabrini Health

    (c) The Australian Commission on Safety and Quality in Health Care

    (d) SaferCare Victoria

    (e) LSC Tracey Ramsey, Coroner's Investigator, Police Coronial Support Unit

Signature:

DARREN J BRACKEN

CORONER

Date: 30 October 2020