FORM 37

Rule 60(1)

FINDING INTO DEATH WITH INQUEST

Section 67 of the Coroners Act 2008

Court reference: 3476/07

Inquest into the Death of MICHAEL PEYSACK

Delivered On:	25th February, 2011
Delivered At:	Coroners Court of Victoria Level 11, 222 Exhibition Street, Melbourne, Victoria 3000
Hearing Dates:	26, 27, 28th July, 2010
Findings of:	Coroner Paresa Antoniadis SPANOS
Representation:	Leading Senior Constable King TAYLOR Police Coronial Support Unit, assisting the Coroner. Mr A. PALMER representing Ms Pauline Hyde, Mr Peysack's partner. Mr J. SNOWDEN representing Southern Health.

FORM 37

Rule 60(1)

FINDING INTO DEATH WITH INQUEST

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

Court reference: 3476/07

In the Coroners Court of Victoria at Melbourne

I, PARESA ANTONIADIS SPANOS, Coroner,

having investigated the death of:

Details of deceased:

Surname: PEYSACK
First name: MICHAEL
Address: 4 Errol Close, Aspendale Gardens, Victoria 3195

AND having held an inquest in relation to this death on 26th, 27th & 28th July, 2010 at Melbourne Magistrates Court

find that the identity of the deceased was MICHAEL PEYSACK born on the 26th April, 1938

and that death occurred on the 1st September, 2007

at Monash Medical Centre, 246 Clayton Road, Clayton, Victoria 3168

from 1a. HEAD INJURY POST COLLAPSE
1b. VENTRICULAR TACHYCARDIA
1c. ISCHAEMIC CARDIOMYOPATHY

in the following circumstances:

INTRODUCTION[1]

1. Mr Peysack was a sixty-nine year old self-employed man with a complex medical history and multiple medical problems. These included complex cardiac disease (myocardial infarction, coronary artery bypass graft surgeries, biventricular failure, ventricular arrhythmias, atrial fibrillation), hypercholesterolaemia, transient ischaemic attacks, chronic obstructive airways disease, and dialysis dependent renal failure secondary to mesangiocapillary glomerulonephritis. In 2002, Mr Peysack had a Biventricular Automated Implantable Cardiac Defibrillator implanted.

1 This is a brief summary of the circumstances which will be discussed in more detail below.

Mr Peysack's regular prescription medications as at 18 July 2007 were Lipitor, Avapro, Digoxin and the anticoagulant Warfarin.

2. After collapsing at work on 18 July 2007, Mr Peysack was taken by ambulance to Dandenong Hospital Emergency Department where he remained for almost 24 hours awaiting transfer to a coronary care bed at Monash Medical Centre. Apart from an episode of hypotension and complaints of headache treated with first line analgesics, Mr Peysack was essentially stable while he was in the Emergency Department. Interrogation of his implantable defibrillator indicated two episodes of rapid ventricular tachycardia, a shock and reversion to sinus rhythm. Mr Peysack was commenced on an intravenous infusion of the anti-arrhythmic drug Amiodarone.[2]

3. On the morning of 19 July 2007, Mr Peysack was transferred to the Monash Medical Centre Coronary Care Unit. He was assessed by the Renal Unit in preparation for haemodialysis that afternoon and then assessed by Cardiology Registrars. After ward rounds, the treatment plan was to introduce oral Amiodarone and to discharge him home in 24-48 hours, presumably if all went well. Haemodialysis occupied most of the afternoon. Mr Peysack remained relatively stable from a cardiological perspective. However, that evening he began complaining of headache again. He was given Panadol and, after consultation with the on-call Cardiology Registrar, Ibuprofen.

4. Mr Peysack was well enough at 9:00pm but deteriorated rapidly thereafter, and by 11:00pm required a Medical Emergency Team (MET) call. He was intubated and an urgent CT scan of the head confirmed intracranial haemorrhage at various sites. After emergency craniotomy, evacuation and drainage of the haemorrhage, Mr Peysack was admitted to the Intensive Care Unit. He never regained consciousness. Ultimately, and over the objection of Ms Hyde, a decision for palliative care was made. Mr Peysack was transferred to McCulloch House where he died on 1 September 2007.[3]

5. This finding is based on the totality of the material the product of the coronial investigation of Mr Peysack's death, that is the inquest brief compiled by my assistant Leading Senior Constable King Taylor from the Police Coronial Support Unit, additional statements facilitated by Mr John Snowden, Counsel for Southern Health, the statements and testimony of those witnesses who testified and any documents tendered through them during the inquest, and the submissions of counsel. All this material, together with the inquest transcript, will remain on the coronial file.[4] I do not purport to summarise all the material/evidence in this finding, but will refer to it only in such detail as is warranted by its forensic significance and the interests of narrative clarity.

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2 After consultation with Dr Robert Gelder, Mr Peysack's treating Cardiologist.

3 From 23 July, Mr Peysack was subject to a "not for resuscitation" order. On 27 July the Renal Unit withdrew ongoing dialysis support. On 3 August he was transferred back to the Coronary Care Unit. Review by the Neurology Unit on 13 August indicated no change to his neurological functioning and confirmed a dire prognosis. The decision for palliation was made on 28 August. On 30 August, the tracheostomy and nasogastric tubes were removed.

4 Access to the coronial file may be sought pursuant to section 115 of the *Coroners Act 2008.*

PURPOSES OF A CORONIAL INVESTIGATION

6. The purpose of a coronial investigation of a *reportable death*[5] is to ascertain, if possible, the identity of the deceased person, the cause of death, and the circumstances in which the death occurred.[6] The *cause* of death refers to the *medical* cause of death, incorporating where appropriate the *mode* or *mechanism* of death. For coronial purposes, the *circumstances* in which death occurred refers to the context or background and surrounding circumstances, but is confined to those circumstances sufficiently proximate and causally relevant to the death, and not merely all circumstances which might form part of a narrative culminating in death.[7]

7. The broader purpose of coronial investigations is to contribute to the reduction of the number of preventable deaths through the findings of the investigation and the making of recommendations by coroners,[8] generally referred to as the "prevention" role. Coroners are also empowered to report to the Attorney-General on a death; to comment on any matter connected with the death they have investigated, including matters of public health or safety or the administration of justice; and to 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.[9] These are effectively the vehicles by which the prevention role is advanced.[10]

UNCONTENTIOUS MATTERS

8. In relation to Mr Peysack's death, a number of the matters required to be ascertained if possible were uncontentious from the outset, others were clearly uncontentious by the conclusion of the inquest. Mr Peysack's identity, the date and place and medical cause of death were never at issue. I find, as a matter of formality, that Michael Peysack born on 26 April 1938, late of 4 Errol Close, Aspendale Gardens 3195, died at Monash Medical Centre, 246 Clayton Road Clayton 3168 on 1 September 2007.

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5 The *Coroners Act 2008,* like its predecessor the *Coroners Act 1985* requires certain deaths to be reported to the coroner for investigation. Apart from a jurisdictional nexus with the State of Victoria, the definition of a reportable death in section 4 includes all deaths that appear *"to have been unexpected, unnatural or violent or to have resulted, directly or indirectly, from accident or injury".* Clearly, Mr Peysack's death falls within this definition.

6 Section 67(1) of the *Coroners Act 2008,* which applies to the coronial investigation of Mr Peysack's death. All references to legislation which follow are to the provisions of the *Coroners Act 2008* unless otherwise stipulated.

7 See for example *Harmsworth* v *The State Coroner [1989] VR 989; Clancy v West (Unreported 17/08/1994, Supreme Court of Victoria Harper, J.)*

8 This "prevention role" is now explicitly articulated in the Preamble and Purposes of *the Act* - see section 1(c). Whilst the Coroners Act 1985 did not explicitly refer to the coroner's prevention role, the implicit and generally accepted purpose of coronial investigations under that Act was the prevention of similar deaths in the future.

9 See sections 21(1), 19(2) and 21(2) of the *Coroners Act 1985* regarding "reports" "comments" and "recommendations" respectively.

10 See also sections 73(1) & 72(5) of *the Act* which requires publication of coronial findings, comments & recommendations and responses respectively; sections 72(3) & (4) which oblige the recipient of a coronial recommendation to respond within 3 months specifying a statement of action which has or will be taken in relation to the recommendation.

9. There was no autopsy as I allowed the family's objection to autopsy on religious grounds, pursuant to section 29 of the *Coroners Act 1985,* which applied at the time of Mr Peysack's death. However, Forensic Pathologist Dr Michael Burke from the Victorian Institute of Forensic Medicine performed an external examination in the mortuary; reviewed the circumstances as reported by the police, postmortem CT scanning of the whole body, the medical deposition and records provided by Southern Health and provided a written report advising of a reasonable formulation of the cause of death, in the absence of an autopsy. Based on Dr Burke's advice, I find that the medical cause of Mr Peysack's death was *head injury post-collapse secondary to ventricular tachycardia due to ischaemic cardiomyopathy.*[11]

THE CIRCUMSTANCES IN WHICH DEATH OCCURRED

10. In common with many inquests, the main focus of this inquest was on aspects of the circumstances in which death occurred. What was somewhat unusual, was the extent to which the circumstances were agreed between the parties, if not at the commence of the coronial investigation, certainly by the time the parties had considered the medical records and the various witness statements, in particular those from the independent expert witnesses.

11. Significantly, it was conceded by Southern Health, that given the known history and his presentation, Mr Peysack should have been investigated by an urgent CT scan of the head within one hour of presentation, in accordance with the applicable Southern Health protocol.[12] It was also clear, that this was not an instance of the absence of an appropriate protocol within an institution, but of an apparent failure to comply with that protocol.

12. In light of this, the focus of the inquest in terms of timeframes, was on the first 40 hours or so post-collapse, encompassing Mr Peysack's admission across both campuses, on the basis that it was during this period that the die was cast. In terms of substance, the focus was on understanding why the protocol was not abided on this occasion, and exploring how patient safety might be improved in this regard in future. A more detailed chronology is required to contextualize the relevant evidence.

THE COLLAPSE - 18 JULY 2007

13. At about 8:30am on 18 July 2007, Mr Peysack suffered an unwitnessed collapse/fall whilst attempting to lift a roller-door at his business premises. According to a friend who had left only briefly to get a coffee, when he returned Mr Peysack was on the ground and unconscious for an estimated two minutes before slowing returning to a normal conscious state.[13]

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11 Exhibit "O" Dr Burke's report, originally at pages 1-4 of the inquest brief. Also transcript at pages 254-258 where Dr Burke clarifies aspects of this report.

12 Exhibit" statement of Dr Bucahanan and Exhibit "G" tendered through, the protocol itself which took the form of an "Adult Head Injury Imaging Request (>16 years)"

13 Exhibit "A" statement of Ms Amy May, Ambulance Paramedic. NOTE: Emphasis added so that relevant information about Mr Peysack's head injury can be easily tracked through this finding.

14. Emergency services were called, an ambulance was dispatched at 8:38am and arrived at 8:45am. Ambulance officers found Mr Peysack confused and this made it difficult to elicit past medical history, current medications and any allergies. His heart rate was 82 beats per minute and the cardiac monitor showed evidence of pacing spikes, but Mr Peysack was unable to confirm if he had a pacemaker. As well as a full set of observations,[14] ambulance officers noted a superficial occipital laceration with no active bleeding and minimal blood loss, and a complaint of headache. They were unsure as to the cause of his collapse; applied oxygen via a Hudson mask and transported him to Dandenong Hospital, arriving at 8:59am.

DANDENONG HOSPITAL EMERGENCY DEPARTMENT

15. The medical records from Dandenong Hospital commence with a triage assessment at 9:20am which includes the following - "Collapse at work with witnessed loss of consciousness of approximately two minutes. Complains of headache. Denies chest pain. Laceration to back of head."[15] The cubicle nurse's assessment is broadly consistent with the triage assessment and includes the following relevant notes - "Unconscious collapse two minutes. Altered conscious state on arrival. Complains of headache. Hit head."[16] Thereafter, a series of nursing entries reveal persistent complaints of headache between his arrival and about 4:00am the following morning; the administration of Panadol PRN; occasions when Mr Peysack reports being painfree; and after input from Emergency Registrar Dr Hussein Alabodi, the administration of Ibuprofen at about 3:40am.[17]

16. Dr Sclera Manansala was the Hospital Medical Officer in the Emergency Department who first reviewed Mr Peysack at 10:30am. According to her note which was difficult to read and/or illegible in parts,[18] she was aware of following salient information - sudden onset of loss of consciousness for two minutes, right occipital laceration, neurologically unremarkable, current medications including Warfarin (INR noted at 2.2). Pursuant to the protocol, the combination of a head injury, any loss of consciousness, and coagulopathy (in Mr Peysack's case due to current Warfarin therapy which was specifically mentioned in the protocol) in a patient who is over sixty-five indicated an urgent CT scan of the head, to be undertaken within one hour and reported immediately.[19]

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14 GCS 14 losing one point for confusion, heart rate 82 bpm, blood pressure 105/50, well perfused, temperature 35.1°C tympanic, respiratory rate 16bpm with a clear chest and no respiratory distress, pupils were normal and reactive, blood sugar level was 5.5mmol, no facial droop, strong & equal grip strength, normal speech and no altered sensations, no pain in chest, neck, abdomen & limbs, no dizziness, no abdominal guarding or incontinence. Exhibit "A" and Ambulance Patient Care Record pages 48-52 of Exhibit "P" the balance of the brief.

15 This is an expanded version of the entry made using abbreviations - see page 53 of Exhibit "P" the balance of the brief. There was no issue taken with this interpretation during the inquest.

16 This is an expanded version of the entry made using abbreviations - see page 58 of Exhibit "P" the balance of the brief. There was no issue taken with this interpretation during the inquest.

17 See paragraph 20 below.

18 Transcript pages 94 and following where Dr Dr Mary Buchanan, Director Emergency Medicine, Dandenong Hospital "interprets" Dr Manansala's note.

19 Exhibit "G" and Dr Buchanan's evidence at transcript page 101.

17. By the time of the inquest, Dr Manansala had returned to the Philippines and was unavailable to provide a statement or testify.[20] The reason for her failure to comply with the protocol remains unexplained. Even if she were unaware of the protocol in terms, the weight of the evidence before me supports a finding that a doctor in her position, albeit relatively junior, should have recognised the risk of an intracranial bleed in Mr Peysack as a matter of basic competency, and should have addressed this risk in any treatment plan.[21]

18. Emergency Physician Dr Daniel McGannon was Dr Manansala's consultant/supervisor. While he made no entries in the medical records himself, the clear inference from Dr Manansala's notes is that he was consulted at 1:45pm and advised her to "repeat troponin now" and to arrange for "Medtronics to check the pacemaker".[22] The nursing notes record as at 3:50pm that Mr Peysack complained of a headache and requested panadol and Dr McGannon was "happy for the patient to have Panadol".[23]

19. At inquest, Mr McGannon testified about the realities of work pressures in a busy Emergency Department, and in particular about the reliance on junior doctors' verbal "presentation" of the patient.[24] He did recall seeing Mr Peysack in the cubicle, being aware that he had had a collapse and required a pacemaker check. He did not recall and did not believe that he could have known, at any material time, that Mr Peysack had suffered a head strike/minor scalp laceration and was on Warfarin. At least in part, this belief was based on his inability to accept that he would not have arranged a CT scan of the head, had he known that Mr Peysack presented with this combination of factors. While Dr McGannon was aware of a brief loss of consciousness, he attributed this to a cardiac cause.[25]

20. At the conclusion of the day shift, Dr McGannon handed over to Emergency Physician Dr Susan Tucker. Mr Peysack was among the patients requiring minimal attention, handed over to her directly as the on-duty consultant.[26] Dr Tucker was to follow-up the defibrillator check. This confirmed two episodes of rapid ventricular tachycardia which reverted with internal defibrillation to sinus rhythm. Accordingly, she organised his admission under cardiology and alerted the renal unit that he required haemodialysis. Dr Tucker did not recall any complications with Mr Peysack's clinical course during her shift, and testified that she would not routinely have recourse to the medical records (wheresoever located) unless there was a perceived need, such as a deterioration in a patient's condition.[27]

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20 Dr Buchanan explains this in her statement Exhibit "E".

21 Transcript pages 67-70, 74-77, 87-88 for Dr Paul Antonis' evidence to this effect; Dr David Eddey's statement Exhibit "N" and transcript pages 236 and following for his evidence on this issue; Professor George Braitberg's evidence at transcript page 198. Professor Gavin Fabinyi's statement Exhibit "M" and transcript pages 227 and following.

22 Exhibit "P" page 55.

23 Exhibit "P" page 60.

24 Transcript page 160-164. There was other evidence to this effect - see transcript pages 59-63.

25 Dr McGannon's statement Exhibit "K", transcript pages 168,170. See also page172 and following where he gives a somewhat tortured an impractical interpretation of the protocol as regards the significance of loss of consciousness which I have disregarded as being against the weight of the evidence. See for example transcript page 249.

26 Transcript page 134.

27 Exhibit "I", Exhibit "P" page 57 and transcript pages 134-139.

21. Dr Tucker in due course handed over to Dr Alabodi mentioned above[28] who was the Emergency Registrar on duty when nursing staff sought additional analgesia to treat Mr Peysack's complaint of headache at 3:00am on 20 July. Dr Alabodi ordered Ibuprofen 400mg which was apparently administered at 3:40am.[29] From his perspective, he was being asked if nursing staff could try something different as Mr Peysack's headache had only improved slightly, and he expected to be informed if Ibuprofen did not resolve the headache.[30] When he testified at inquest, he denied being aware that Mr Peysack's headache was ongoing or persistent, and said that this might have changed his approach. Had he been aware that he was on Warfarin, had suffered a head strike and was complaining of a headache, he would have ordered a CT scan of the head in accordance with the protocol.[31]

MONASH MEDICAL CENTRE - CORONARY CARE UNIT - 19 July 2007

22. The medical records from Dandenong Hospital accompanied Mr Peysack to Monash Medical Centre where he was admitted to the Coronary Care Unit as arranged. After review by a Renal Registrar in preparation for haemodialysis in the afternoon, he was seen by Cardiology Registrars Dr Logan Bittinger and Dr Siobhan Lockwood some time later that morning. Dr Bittinger was unavailable to attend the inquest but provided a statement,[32] consistent in all material respects with Dr Lockwood's statement and evidence at inquest. In brief, they were aware of the findings on interrogation of the defibrillator, found his cardiovascular examination unremarkable and planned to continue intravenous Amiodarone, introduce oral Amiodarone, and discharge him home within the next day or two. As Mr Peysack was awake and alert and did not mention a headache, they did not examine him specifically for a head injury. Ms Hyde was present during their review.[33]

23. In addition, as indicated in her statement, Dr Lockwood maintained at inquest that when Mr Peysack's transfer was being arranged the previous afternoon, she had specifically asked of the referring doctor if Mr Peysack had any form of head injury or any indication of neurological instability and was reassured that he had not.[34] Dr Lockwood also testified that following Mr Peysack's death she has a lowered threshold for investigating head strike in any of her patients and has adopted a practice of reviewing Emergency Department notes in order to ensure that any non-cardiological issues have been addressed.[35]

24. During late morning ward rounds, Cardiology Registrar Drs Bittinger and Lockwood presented Mr Peysack's case to Dr Paul Antonis, Head of Acute Cardiac Services. Dr Antonis

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28 See paragraph 15.
29 Exhibit "P" page 61.
30 Dr Alabodi's statement Exhibit "J" and transcript page 150-151.
31 Transcript page 154.
32 Dr Bittinger's statement Exhibit "P" page 35-36.
33 Dr Lockwood's statement Exhibit "C".
34 Exhibit "C" and transcript page 16-18. This was a phone call made by Dr Tucker (presumably) or at her behest. The account from Dr Lockwood is in keeping with Dr Tucker's state of knowledge of Mr Peysack.
35 Transcript page 17 and following.

met Mr Peysack briefly during the ward round, asked him how he was feeling and reassured him that the management plan initiated by his registrars was appropriate. While he did not undertake a formal examination, he did not note any head injury and Mr Peysack did not complain of any symptoms at the time.[36]

25. The nursing notes commencing from 9:15am show no complaint of headache until a detailed note made at 2:20pm by the ward nurse, having apparently reviewed Mr Peysack while haemodialysis was in progress, and noting a complaint of headache for which Panadol was given.[37] The next entry at 6:00pm notes that "headache remains...frontal and back of neck", Panadol was given again and the Hospital Medical Officer covering cardiology was paged. As at 8:15pm Mr Peysack still has a headache involving frontal and neck pain, and is given Ibuprofen 400mg and placed on 6 hourly neurological observations in accordance with orders from Dr Cheah who responded to the earlier page.[38]

26. Dr Cheah's detailed "additional" note made at 7:30pm or shortly thereafter indicates an awareness of the possibility that Mr Peysack may have suffered an intracranial haemorrhage but a failure to investigate the possibility at that time. He notes, inter alia, that - "Patient complains of headache since admission yesterday, 6/10 severity, across forehead, constant, minimal relief with paracetamol, headache no worse than yesterday, on Warfarin, superficial abrasion small haematoma - temporo-occipital area right side of scalp; Assessment: Headache secondary to fall/contusion; Plan: Will chart analgesia, Monitor - Four per day neurological observations; Home team to review tomorrow; No further investigations now".[39] Dr Cheah did not testify and the rationale for his plan was not able to be ascertained.

27. Nurse Mary Newby provided a statement and testified at inquest.[40] She was on duty in the Coronary Care Unit from 9:00pm on 19 July 2007 and Mr Peysack was one of three patients in her care. Following handover, she was aware that he had an ongoing headache, was being given analgesia and had been reviewed by a doctor. Although the ongoing headache flagged the possibility of a more serious underlying cause, she was comforted by the fact that Mr Peysack had been medically reviewed recently and offered him a massage to help with any muscular component to the headache. Nurse Newby intended to return to Mr Peysack after settling a more difficult post-operative patient. As she passed his room between 9:00pm and 11:00pm, she saw he was in a semi-reclined position and appeared settled. Her first note in the medical records is of Mr Peysack's rapid deterioration at 11:00pm.[41]

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36 Exhibit "D" and Exhibit "P" page 70 where there is a note of the ward round & plan.

37 Haemodialysis proceeded without complications, apart from a swab taken at permacath site for investigation of a suspicious "ooze" - see pages 70 and 75 of Exhibit "P".

38 Exhibit "P" page 75. I note that at 7:25pm Mr Peysack is given 2.5mg Warfarin ("Marevan").

39 Exhibit "Q". Again abbreviations were used but I have written the entry out in full for clarity.

40 Exhibit "H" and transcript pages 119 and following.

41 Nurse Newby gives an interesting insight at transcript page 130 "there's no luxury of time to be writing notes when you have people to settle ...it's been my habit to always look at histories and also to go back through the notes and I suppose the great thing about night duty is that you've got a little bit more time to be doing that ..."

28. It will be apparent from this expanded chronology, that the reason why the protocol requiring urgent CT scan of the head was not complied with, was that although clearly and repeatedly documented in Mr Peysack's medical records, the fact of a head strike during his collapse and continuing anticoagulation were either not known, or not addressed by all treating clinicians in the chain from Dr Manansala to Dr Cheah. Apart from those treating clinicians who testified at inquest, there was also a body of expert opinion before me which sought to explain or shed light on how this could happen.

29. One such witness was Professor George Braitberg, Emergency Physician and Director of Emergency Medicine at Southern Health at the time of the inquest but not at the time of Mr Peysack's death. He agreed with the opinions of Dr David Eddey, Emergency Physician, and Professor Gavin Fabinyi, Neurosurgeon, both of whom provided independent expert opinions at my request.

30. Specifically, Prof Braitberg agreed with Prof Fabinyi's observation that attention directed to Mr Peysack's cardiac state seems to have totally distracted the treating team away from his ongoing symptoms and the fact that he had a documented head injury and was receiving and continued to receive anticoagulation.[42] Prof Braitberg posits a process of dilution of information whereby reference to the head strike and laceration is progressively omitted from the notes as various specialist unit members examined Mr Peysack from the narrow perspective of their specialty and not holistically.[43] This is compounded by a tacit reliance on the initial assessment and decision to admit Mr Peysack under cardiology as carrying an inference that he is not unwell otherwise. Prof Braitberg also noted that published research data, links the length of Emergency Department stays to increases in morbidity and mortality.[44]

31. Neurosurgeon Professor Gavin Fabinyi placed Mr Peysack in the category of patients who "talk and die" referring to the fact that he remained lucid for many hours after the original injury which was compounded by ongoing anticoagulation, and the failure of staff to recognise the lethal combination of age, anticoagulation, head injury and headaches. He recognised that Mr Peysack fulfilled the criteria for urgent CT scan of the head not only in the Emergency Department but at any number of points thereafter. In his opinion, a CT scan performed at an early stage, particularly in the first 12 hours following injury, would have demonstrated a subdural haematoma and informed clinical management. In his expert opinion, he outlined a number of possible treatmentspaths which may have ensued.[45] At inquest he testified that all things being equal, with early detection and intervention, with his cardiac status stable, even with his co-morbidities, Mr Peysack would probably have survived neurosurgical intervention.[46]

32. Dr David Eddey's opinion was that the failure to appreciate or exclude the possibility of intracranial bleeding in an anticoagulated patient with a relatively minor head injury resulted in a

42 Exhibit "L" and transcript page 196.
43 Exhibit "L" and transcript page 199 where he describes this "compartmentalisation" of the patient.
44 Exhibit "L" and transcript page 202.
45 Exhibit "M".
46 Transcript page 230.

poor outcome. The head injury was either missed with the focus on Mr Peysack's cardiac issues, or was lost in repeated handovers and the transfer between hospitals. He identified numerous opportunities for effective intervention with the potential for a changed outcome.[47] At inquest, he testified that it was more likely than not that Mr Peysack would have survived had the intracranial bleed been detected in the 36 hours or so following his initial collapse and before his catastrophic collapse at 11:30pm on 19 July 2007, and obviously the earlier it was detected the better the probable outcome.[48]

VERBAL HANDOVER OF PATIENTS

33. The practice of verbal handover of patients between outgoing and incoming medical and nursing staff is clearly entrenched in medical and nursing practice. It is beyond my scope here to investigate the merits of this practice. Having said that, adverse comment is warranted in circumstances where Dr Manansala was appraised of all the salient facts necessary to request an urgent CT scan of the head, verbally presented Mr Peysack's case to Dr McGannon, apparently omitting some of those salient facts, and where he testified that he would certainly have ordered a scan if he had known of the head strike and anticoagulation. The consultant's reliance on the verbal presentation of a patient by a less experienced doctor is fraught with just this difficulty - that significant facts may not be communicated, either because they are not elicited from the patient or gleaned from the records, or because their significance is not appreciated, or otherwise.

RECOURSE TO MEDICAL RECORDS

34. A corollary of the practice of verbal handover is the lack of referral to the medical records. A number of witnesses testified that they did not routinely consult the medical records and would only do so where the verbal handover was obviously deficient or the patient's clinical condition deteriorated. I accept that resources are stretched and there can be logistical difficulties in accessing all the medical records or all the relevant information in a voluminous medical record. However, adverse comment is warranted in circumstances where a reading of a few pages of notes relating to the current admission by any of the treating senior clinicians, would probably have changed the outcome for Mr Peysack.

CONCLUSION

35. The weight of the evidence supports a finding that Mr Peysack's death was preventable in the sense that a timely and appropriate clinical response to all aspects of his presentation on admission would probably have resulted in his survival. From the outset, the medical records relating to his last admission which were available to all treating clinicians, and clearly documented all factors which should have led to an urgent CT scan of the head. In all likelihood such a scan would have demonstrated intracranial haemorrhage amenable to treatment, the earlier the better.

47 Exhibit "N".
48 Transcript page 242.

36. The failure to use the medical records optimally occurred in the setting of a culture where verbal handover and even the re-taking of a history from the patient, are preferenced over recourse to written medical records. Although it has to be said that these may be voluminous, not readily accessible, in disparate locations and difficult to read.

COMMENTS:

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

1. The circumstances in which Mr Peysack died serve as a salutary reminder of the potential for intracranial haemorrhage in patients on anticoagulation therapy who suffer a head strike or head injury, particularly older patients.

2. All medical and nursing staff should be mindful of the possibility that a persistent headache may be symptomatic of a developing neurological or other serious problem.

3. I was advised that subsequent to Mr Peysack's death, Southern Health Emergency Departments have introduced a compulsory requirement that junior medical staff discuss each patient under their care with a member of the senior medical staff within two hours of the patient being seen, and that such discussion is documented in the medical records. While such a process carries the potential to improved patient safety, it cannot redress any deficiencies in the content of the verbal handover.

4. I was also advised that the introduction of electronic medical records in the Emergency Department has improved the legibility and quality of clinical notes and their ready accessibility to all medical staff, including senior medical staff who may access them to assist their supervision of junior medical staff. Such a use of technology carries the potential to improve patient safety, but necessarily relies on clinical notes being accurate and timely.

RECOMMENDATIONS:

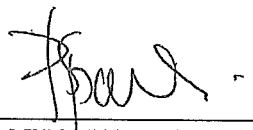
Pursuant to section 72(2) of the **Coroners Act 2008**, I make the following recommendation(s) connected with the death:

1. That Southern Health enhances the electronic medical records in use in the Emergency Department so as to reinforce the "Adult Head Injury Request" protocol by requiring mandatory consideration of the protocol where key factors are present. In the alternative, that the enhancement is premised on the presence of any head strike or injury and anticoagulation therapy.

2. That Southern Health considers expanding the electronic records to all departments so as to facilitate accessibility and encourage treating clinicians to access patients medical records to inform treatment.

3. That Southern Health takes steps to encourage specialist medical staff to make as holistic an assessment of the patient as possible, and at a minimum requires a full re-assessment of the patient upon admission to a specialist unit.

Signature:



PARESA ANTONIADIS SPANOS
CORONER
25th February, 2011

Distribution of finding:

Ms Pauline Hyde
Southern Health
Professor George Braitberg

Professor Gavin Fabinyi
Dr David Eddey

Australasian College for Emergency Medicine (ACEM)
Royal Australasian College of Surgeons
Neurosurgical Society of Australasia College of Surgeons' Gardens
College of Emergency Nursing
Clinical Handover Project VIctorian Quality Council
Centre for Research Excellence in Patient Safety
Australian Commission on Safety and Quality in Health Care
Victorian Department of Health
Quality Directors/Managers Hospitals