IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2019 000142

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	AUDREY JAMIESON, Coroner
Deceased:	Jeffrey Marsden
Date of birth:	09 September 1947
Date of death:	08 January 2019
Cause of death:	1(a) Complications of C1 and C2 cervical vertebral fractures (palliated), sustained in a fall
Place of death:	St Vincent's Hospital, 41 Victoria Parade, Fitzroy, Victoria, 3065
Keywords:	Fall; spinal injury; WorkSafe; hospital; medical

INTRODUCTION

1. On 08 January 2019, Jeffrey Marsden was 71 years old when he died at St Vincent's Hospital in Melbourne. At the time of his death, Mr Marsden lived in Williams Landing with his wife, Azucena Marsden.

2. Mr Marsden had an extensive medical history including multiple myeloma, transurethral resection of prostate with urethral stenosis, hypertension, previous peritonitis, thoracolumbar compression fractures, cardiac arrest from choking, stroke, rectus sheath haematoma, right inguinal hernia repair and peripheral vascular disease.

3. Mr Marsden was also diagnosed with end stage kidney disease. He was reviewed by the renal unit at St Vincent's Hospital Melbourne (**SVHM**) and due to his frailty and ongoing issues with pain was referred to the outpatient renal palliative care clinic for symptom-based management and for review of ongoing haemodialysis, which he received at Werribee Mercy Hospital (**WMH**).

THE CORONIAL INVESTIGATION

Jurisdiction

4. Mr Marsden's death was reported to the Coroner as it fell within the definition of a reportable death in the *Coroners Act 2008* (the Act). Reportable deaths include deaths that are unexpected, unnatural or violent or result from accident or injury.

5. The role of a coroner is to independently investigate reportable deaths to establish, if possible, identity, medical cause of death, and surrounding circumstances. Surrounding circumstances are limited to events which are sufficiently proximate and causally related to the death. The purpose of a coronial investigation is to establish the facts, not to cast blame or determine criminal or civil liability.

6. Under the Act, coroners also have the important functions of helping to prevent deaths and promoting public health and safety and the administration of justice through the making of comments or recommendations in appropriate cases about any matter connected to the death under investigation.

Sources of evidence

7. This Finding is based on the entirety of the investigation material comprising of the coronial Brief of Evidence compiled by then Police Coronial Support Unit **(PCSU**) member, Leading Senior Constable King Taylor ("LSC Taylor") including the statements of Mr Marsden's treating clinicians, and material obtained and submissions provided following the provision of the Brief.

Standard of proof

8. In writing this Finding, I will only refer to that which is directly relevant to my Findings or necessary for narrative clarity. In the coronial jurisdiction, facts must be established on the balance of probabilities.[1]

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

Circumstances in which the death occurred

9. At around 7:30am on 5 January 2019, Mr Marsden attended at Werribee Mercy Hospital for his regular haemodialysis appointment.

10. As he passed through the automatic double sliding doors to the main entrance, using a three wheeled walker for mobility, the sliding doors closed on both of Mr Marsden's shoulders forcing him to fall to the floor, hitting his face on the ground. He sustained injuries to his nose, forehead and both knees.

11. Mr Marsden was approached by a female visitor who then ran to the main corridor and returned with a security guard. A code blue[2] was called and the team attended to Mr Marsden, who complained of a tender cervical spine. A cervical collar was applied to Mr Marsden before he was placed on a trolley and taken to the Emergency Department (**ED**) for assessment.

[1] Subject to the principles enunciated in *Briginshaw v Briginshaw* (1938) 60 CLR 336. The effect of this and similar authorities is that coroners should not make adverse findings against, or comments about, individuals unless the evidence provides a comfortable level of satisfaction as to those matters taking into account the consequences of such findings or comments.

[2] Code blue refers to a medical emergency requiring immediate response.

12. At ED, Mr Marsden was assessed by Dr Heena Choksey ("Dr Choksey"), who noted that Mr Marsden had not lost consciousness following his fall and could recall the whole event. His vital signs were generally unremarkable.

13. Given the nature of Mr Marsden's fall and the potential for head, neck and spinal injuries, Dr Choksey ordered a computed tomography (**CT**) scan of his cervical spine, brain and facial bones. The request for the CT scan included a handwritten note by Dr Choksey stating *"CT cervical spine + CTB + CT facial bones. Fall – tender C5-6 post fall'"*.[3] Mr Marsden was given oxycodone for pain with good effect, and he continued to be monitored in the ED.

14. Between 10:00 am and 11:00 am, Dr Choksey received the results for Mr Marsden's CT scan via a faxed report. The report identified cervical spine fractures to the C1 and C2 vertebrae. After reviewing the report, Dr Choksey mistakenly recorded the result as 'NAD' (no abnormality detected). Mr Marsden's cervical collar was removed, and he was discharged from the ED at around 1:20pm to attend haemodialysis after which he returned home.

15. On the morning of 8 January 2019, Mrs Marsden woke Mr Marsden to attend haemodialysis. He complained of being tired and was unable to move, with numbness down his body. He was confused with slurred speech and had a heavy tongue.

16. Mr Marsden was taken to the WMH ED by Mrs Marsden and their son, Natan. Mr Marsden's family reported to clinicians that he had been complaining of neck pain and had spent most of his time in bed since his discharge from haemodialysis on 5 January 2019. He had not experienced any further falls.

17. Mr Marsden was taken to a resuscitation bay where it was noted his tongue was swollen, partially occluding his airway. Mr Marsden had irregular respirations with oxygen saturation of 80 per cent and a Glasgow Coma Scale[4] of 12/15. Mr Marsden attended for a CT scan.

18. Radiologist Dr Dennis Shandler reviewed the CT scan, which re-affirmed the presence of fractures to the C1 and C2 vertebrae which were missed by Dr Choksey on 5 January 2019. Dr Shandler called the ED at around 8:55am to verbally report his findings, as well as sending a copy of his report.

[3] Coronial Brief (**CB**), Statement of Jacqueline Roarty, Senior Legal Counsel of I-MED Radiology Network, dated 16 March 2020.

[4] The Glasgow Coma Scale (GCS) is a neurological scoring system used to assess conscious level. The GCS is comprised of three categories; best eye response, best vocal response and best motor response. The GCS is scored out of 15, with a score of 15 indicating a normal level of consciousness.

19. A meeting was held between treating doctors and Mr Marsden's family, where it was agreed that Mr Marsden had poor comorbidity status, was not for resuscitation and a conservative management approach would be adopted. He was given intravenous morphine for comfort.

20. Mr Marsden was transferred to St Vincent's Hospital for palliative care under the renal unit, arriving at 12:50pm. He sadly died at 3pm the same day.[5]

Identity of the deceased

21. On 8 January 2019, Jeffrey Marsden, born 09 September 1947, was visually identified by his wife, Azucena Marsden, who completed a Statement of Identification.

22. Identity is not in dispute and requires no further investigation.

Medical cause of death

23. Forensic Pathologist Dr Gregory Ross Young from the Victorian Institute of Forensic Medicine (**VIFM**) conducted an external examination on the body of Jeffrey Marsden on 9 January 2019. Dr Young had regard to the Victoria Police Report of Death (Form 83), post-mortem computed tomography (CT) scan and E-Medical Deposition Form and provided a written report of his findings dated 10 January 2019.

24. The post-mortem examination revealed abrasions on the face, and purple bruising on the backs of the forearms, hands and around the knees, in keeping with the circumstances. No unexpected signs of trauma were noted.

25. The post-mortem CT scan confirmed the presence of fractures to the anterior arch of the C1 cervical vertebra and the dens of the C2 cervical vertebra. No intercranial haemorrhage was identified.

26. Dr Young noted that complications of cervical spine fractures may include spinal cord compression, haemorrhage, chest infection, increased stress on the heart, multi organ system failure, deep vein thrombosis and pulmonary thromboembolism.

27. Dr Young provided an opinion that the medical cause of death was 1 (a) COMPLICATIONS OF C1 AND C2 CERVICAL VERTEBRAL FRACTURES (PALLIATED), SUSTAINED IN A FALL.

[5] Court File (**CF**), E-Medical Deposition Form.

FURTHER INVESTIGATIONS

CPU REVIEW

28. Having considered the circumstances surrounding Mr Marsden's death and the evidence available to me at the early stages of the investigation, I became concerned that Mr Marsden was discharged from WMH soon after his fall with fractures to his cervical spine that did not appear to have been identified by clinicians.

29. I referred the matter to the Health and Medical Investigation Team (**HMIT**) within the Coroners Prevention Unit[6] (**CPU**) for a preliminary clinical review. Having reviewed the available medical records from WMH, the CPU advised that the matter warranted a more extensive review.

30. Consequentially, I asked that the CPU undertake a full case review. As part of their review, the CPU sought statements from Dr Heena Choksey, Associate Professor David Allen, Chief Medical Officer at WMH ("A/Prof Allen") and I-MED Victoria Pty Ltd[7] (**I-MED**).

31. The CPU review identified three issues.

    a) The malfunctioning of the automatic doors which caused Mr Marsden's fall and subsequent injuries;

    b) The lack of verbal communication between radiologist Dr Dulimov and Dr Choksey; and

    c) Dr Choksey's misreading of the CT scan results, resulting in Mr Marsden's discharge from hospital with untreated cervical spine fractures.

32. The CPU did not investigate Mr Marsden's care at St Vincent's Hospital as there were no issues arising out of his admission.

[6] 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.

[7] I-MED Victoria Pty Ltd, a subsidiary of I-MED Radiology Network Limited, was the contracted radiology services provider to WMH.

Malfunctioning of automatic doors

33. According to A/Prof Allen, the Workplace Health and Safety Manager and a representative of the Engineering Department at WMH were notified on 8 January 2019 that the automatic door sensor had malfunctioned and failed to stop the doors from closing on Mr Marsden. They inspected the main entrance doors the same day.

34. On 9 January 2019 Dormakaba Australia Pty Ltd (**Dorma**), a contractor who provided maintenance services on powered doors, attended at WMH to assess the doors. The technician determined that the safety sensors were not sufficient and provided a service report describing the issues found.

    *"*E*xplained to customer that these doors have a large field size and current safety is not sufficient. […] Doors require another safety sensor on external side to give doors more safety range."*

35. The necessary fixes were made the same day.

36. On 17 January 2019 Dorma returned to WMH to conduct an audit of all automatic doors at the facility. Of 81 doors, 12 defects were identified. These defects were repaired between 5-7 February 2019.

37. A/Prof Allen conceded that the doors had not been inspected on a quarterly basis as per Australian standards[8] and there was no inspection or maintenance schedule for the automatic doors.

Lack of verbal communication between Dr Dulimov and Dr Choksey

38. In a statement to the Court, I-MED outlined their involvement in Mr Marsden's care on 5 January 2019.

39. At 8:33am, the Radiology Department received Dr Choksey's request for a CT scan. The scan was then registered in I-MED's information system at 8:55am and performed at 9:14am by technical staff. The scan was made available for reporting at 9:23am.[9]

[8] Section 7.4 of the *Australian Standard AS 2007-5007 Powered doors for pedestrian access and egress* provides that it is a requirement to conduct condition and safety inspections quarterly.
[9] CB, Statement of Jacqueline Roarty, Senior Legal Counsel of I-MED Radiology Network, dated 16 March 2020.

40. Radiologist Dr Alex Dulimov[10] reviewed the CT scan film and dictated his report, which was completed at 9:39am. It was subsequently typed and returned to Dr Dulimov for review, and he signed the report electronically at 10:02am. The report was faxed to the WMH ED at 10:11am, and presumably provided to Dr Choksey shortly thereafter. In addition, the report was emailed to WMH at 10:16am.

41. The report stated, below the heading of 'CT Cervical Spine':

"Alignment is normal. There is a fracture of the anterior arch of atlas with 5mm separation anteriorly. There is also a fracture of the dens 17 15 to 18 mm below its tip the atlantoaxial distance remains normal and there is no posterior displacement of the fractured dense fragment." [11]

42. According to A/Prof Allen, the practice in place at WMH at the time of Mr Marsden's death was that radiological tests that indicated significant clinical findings were to be telephoned through to the treating team, and highlighted in bold text in the report.[12]

43. This practice of telephoning significant findings was confirmed by Mr Simon Cooke, Mercy Health General Counsel,[13] though he later noted that the practice was unwritten.[14] Despite this, Mr Cooke stated that it was the expectation of WMH that the practice would be followed by all radiologists who provided services to WMH. It is unclear whether this expectation was communicated to radiologists.

44. In a statement to the Court, I-MED stated that they were not aware of WMH's practice of calling in significant clinical findings via telephone.[15] However, I-MED had its own policy in place at the time of Mr Marsden's death, which required the reporting radiologist to telephone the referring clinician to advise of any unexpected findings.[16]

45. I-MED's Clinical Reports Procedure: Reporting & Recording of Imaging Findings at Part 4.8 Critical, Urgent & Significant Unexpected Findings states:

[10] Dr Dulimov had extensive radiology experience, having practiced as a radiologist since 1975.
[11] CB, Radiology Report of Dr Alex Dulimov, dated 5 January 2019.
[12] In further correspondence to the Court, A/Prof Allen clarified that further inquiry suggested that the bolding of significant findings may not have been standard practice prior to Mr Marsden's death.
[13] CB, Letter from Simon Cooke, dated 31 August 2020.
[14] CB, Letter from Simon Cooke, dated16 November 2021. Mr Cooke noted that further inquiries had suggested that the bolding of findings may not have been standard practice prior to the incident and appears to be radiologist dependent.
[15] CB, Statement of Sarah Lattimer, General Counsel & Company Secretary of I-MED Radiology Network, dated 29 October 2021.
[16] CB, I-MED Radiology Network, Clinical Reports Procedure Reporting & Recording of Imaging Findings, Version 1 – September 2018.

The results must also be phoned through to the referring doctor and a note made in the Radiologist's report that this was done including the time and date of the call. In a case where the referrer is not available, another doctor at the practice or the admitting doctor in the emergency department must be contacted – whatever is applicable – and their names must be notated in the report. [17]

46. There was no note on Mr Marsden's patient record to suggest that Dr Dulimov called Dr Choksey or another appropriate clinician in accordance with I-MED's policy, or WMH's unwritten practice.

47. In response to a specific question posed by the CPU asking if "unusual findings were routinely highlighted to the treating team", IMED provided the following explanation.

"*As the CT scan requested by the emergency department, Dr Dulimov assumed that the Hospital's Emergency Department was expecting the results of the CT scan within the expected timeframes […] there was no further communication of the findings, other than in the faxed and electronically transmitted copies […]."*[18]

48. I-MED further noted that Dr Dulimov had since retired from practice and as such they could not provide any further detail as to his reasoning for not telephoning Dr Choksey in accordance with their policy.

49. The Royal Australian and New Zealand College of Radiologists (**RANZCR**) Standards of Practice for Clinical Radiology provides minimum standards for the provision of safe radiology services. Section 5.5.2 communication of imaging findings and reports provides an indicator that

"The practice has a protocol for urgent and significant unexpected findings that ensures [...] the reporting radiologist uses all reasonable endeavours to communicate directly with the referrer or an appropriate representative who will be providing clinical follow up."[19]

50. It appears that Dr Dulimov, in failing to telephone Dr Choksey to report his findings of fractures to the C1 and C2 vertebrae, did not act in accordance with either his employer's policy, WMH's unwritten practice or the minimum standards set by RANZCR.

[17] Ibid.
[18] CB, Statement of Jacqueline Roarty, Senior Legal Counsel of I-MED Radiology Network, dated 16 March 2020.
[19] https://www.ranzcr.com/search/standards-of-practice-for-clinical-radiology

51. I do note and acknowledge that Dr Dennis Shandler, the radiologist who reviewed Mr Marsden's CT scan on 8 January 2019, called the WMH ED to report his findings to Mr Marsden's treating clinicians and in doing so acted in accordance with the accepted standards.

Misreading of CT scan results

52. In her statement to the Court, Dr Choksey conceded to misreading the report of Dr Dulimov.

"Regrettably, I misread the results of the CT scan, and recorded these as NAD and removed Mr Marsden's collar. I examined him again and palpated his spine. I do not recall any cervical spine tenderness at this point and coupled with his apparently stable condition and GCS of 15, I was satisfied that he was appropriate for discharge."[20]

53. Dr Choksey did not provide any further explanation as to how or why she came to misread the results, however it can be assumed that this was a case of human error.

WORKSAFE INVESTIGATION

54. On 8 January 2019 the Victorian WorkCover Authority ("WorkSafe") were notified of the incident by Lisa White, Work Health and Safety manager at WMH.

55. WorkSafe's investigation was conducted concurrently with the coronial investigation, though WorkSafe's investigation focussed on the malfunctioning of the automatic doors at the entrance to WMH.

56. On 18 January 2019 WorkSafe Inspector Francis Zawilla attended at WMH. WMH were unable to provide Inspector Zawilla with any evidence that the automatic doors had been inspected and tested on a regular basis and any faults found during these inspections rectified.

57. As a result of his enquiries, Inspector Zawilla formed the belief that the WMH was not providing a safe system of work, in that there was no preventative maintenance program for the automatic doors throughout the facility. Therefore, there was a risk to persons using the automatic doors should they malfunction, and this could result in injuries to persons – as evidenced by the injuries caused to Mr Marsden.

58. Inspector Zawilla issued Mercy Health Victoria Ltd (**MHV**) with an Improvement Notice pursuant to section 111(1) of the *Occupational Health and Safety Act 2004* (Vic) requiring

[20] CB, Statement of Dr Heena Choksey, dated 6 March 2020.

them to provide a safe system of work associated with regular preventative maintenance for the automatic doors.

59. On 8 February 2019 Inspector Zawilla returned to WMH to follow up on the improvement notice. He was advised that a full audit of the automatic doors had been undertaken and twelve defects identified, which had since been rectified. Moreover, a regular inspection and maintenance system had been developed and implemented.

60. As a result of the WorkSafe investigation, MHV was charged pursuant to sections 21(1) and 23(1) of the *Occupational Health and Safety Act 2004* (Vic). The charges were that Mercy Health Victoria Ltd

    a) *failed, so far as was reasonably practicable, to provide and maintain for its employees, a working environment that was safe and without risks to health when it failed to provide or maintain systems of work that were, so far as reasonably practicable, safe and without risks to health; and*

    b) *failed to ensure, so far as was reasonably practicable, that persons other than employees were not exposed to risks to their health or safety, arising from the conduct of the undertaking of Mercy Health Victoria Ltd.*[21]

61. The particulars of the charges were that a patient, being Mr Marsden, who was attending the Werribee Mercy Hospital for dialysis was injured when an automatic door closed on him and caused him to fall, and he passed away on 8 January 2019.

62. MHV instead agreed to accept an Enforceable Undertaking pursuant to section 16 of the *Occupational Health and Safety Act 2004* (Vic). As such, the charges were withdrawn on 31 August 2021 before Magistrate Kimberley Swadesir sitting at the Werribee Magistrates Court.

63. In entering into the Enforceable Undertaking, MHV acknowledged that the incident was such as to justify WorkSafe bringing the charges, the incident giving rise to the alleged contraventions occurred in the manner described in the Enforceable Undertaking, and that MHV regrets the incident.[22]

[21] Part 4, Enforceable Undertaking pursuant to section 16 of the *Occupational Health and Safety Act 2004* (Vic).
[22] Part 9, Enforceable Undertaking pursuant to section 16 of the *Occupational Health and Safety Act 2004* (Vic).

INTERNAL REVIEW

64. An internal review of Mr Marsden's care at WMH on 5 and 8 January 2019 was conducted by the hospital's Serious Incident Review Committee. The case review identified the following[23]

    a) The automatic door sensor malfunctioned and failed to stop the doors from closing. There was no inspection and maintenance schedule for the automatic doors and as such they had not been inspected on a quarterly basis as per Australian Standards; and

    b) the significant finding of a C1 fracture was not highlighted on the radiographer's report or telephoned through to the treating doctor. The finding was misinterpreted and failed to be acknowledged.

65. WMH's internal review of Mr Marsden's death highlighted some areas for improvement including maintenance, improved clinical documentation, patient flow planning and discharge planning, and end of life care procedure for ED clinicians.

66. The incident and the findings of Dorma and WorkSafe were also considered by the Mercy Health Board at its meeting on 5 February 2019.[24] Further, the death of Jeffrey Marsden was reported to Safer Care Victoria as a sentinel event.[25]

67. MHV did not inform I-MED of Mr Marsden's death until around mid-February 2020 when it sought information from I-MED to assist me in my investigation.[26] As such, I-MED did not undertake their own internal review of the incident, nor where they involved in MHV's review.

Family meeting

68. On 25 January 2019 a family meeting was held between Mr Marsden's wife and son and representatives of WMH, Ms Burton (Director, Quality and Innovation), Dr O'Neal (Clinical

[23] CB, Statement of Associate Professor David Allen, dated 5 March 2020.
[24] CB, Statement of Associate Professor David Allen, dated 5 March 2020.
[25] The sentinel event program is a state-wide adverse incident reporting and investigation program run by Safer Care Victoria in both public and private health services. Incidents deemed as sentinel events are investigated by way of a formal process (Root Cause Analysis) with panel member external to the health service recommended by SCV. The report is then submitted to SCV for feedback.
[26] CB, Statement of Sarah Lattimer, General Counsel & Company Secretary of I-MED Radiology Network, dated 29 October 2021.

Services Director Medical, Sub Acute and Palliative Care) and Ms Bean (Quality Coordinator Medical, Sub Acute and Palliative Care).[27]

69. The meeting discussed the events of 5 and 8 January, including the failure of the automatic door sensors and the missed C1 and C2 fractures, as well as the failure to communicate the presence of the fractures to Mr Marsden's family.

70. Further, WMH discussed with Mr Marsden's family how his fractures could have been treated and the likely outcome. Given Mr Marsden's medical history and comorbidities he may not have been an appropriate surgical candidate, and even if surgery was possible, it was impossible to know what the outcome would have been.[28]

71. WMH offered an apology for their failures to Mr Marsden's family, which was accepted.

REMEDIAL ACTIONS

72. Following the death of Mr Marsden MHV has implemented a maintenance plan for all automatic doors at WMH, with doors and sensors inspected, tested and serviced on a quarterly basis.[29]

73. Since the time of Mr Marsden's death in January 2019, I-MED continues to reinforce the requirement to call through unexpected radiology findings and to record this to the patient's report to its radiologists through its National Clinical Management Committee and the business unit specific Clinical Management Committees.[30]

74. MHV considers I-MED to hold primary responsibility for developing policies with regard to the format and communication of radiological findings.[31] According to I-MED, MHV made a recommendation regarding the bolding of significant radiological findings to I-MED following Mr Marsden's death. I note this is at odds with the assertion of MHV that this was standard practice at the time of his death.

75. I-MED advised MHV that they were unable to adopt the recommendation of bolding text on the basis that they provide radiology services nationally, and any changes would need to be made across the entire network. Some services may not be able to receive reports in a bold

[27] CB, Statement of Associate Professor David Allen, dated 5 March 2020.
[28] Ibid.
[29] Ibid.
[30] CB, Statement of Sarah Lattimer, General Counsel & Company Secretary of I-MED Radiology Network, dated 29 October 2021.
[31] CB, Letter from Simon Cooke, dated 16 November 2021.

text format, noting that some end user systems may operate in a basic plain text format. Moreover, I-MED held concerns that bold text may potentially lead to reading bias when the reports were reviewed by clinicians.[32]

76. Dr Choksey advised the Court that as a result of her misreading the CT report on 5 January 2019, she has made changes to her practice. She is now "much more vigilant" in reviewing results of radiological tests for patients she treats, and she now checks radiology scans herself in addition to reviewing the radiologist's report.

"This can be done urgently while awaiting radiology reports, but more importantly, adds an extra layer of checks in place to ensure that crucial results are not missed."

CONCLUDING INVESTIGATION

77. Having reviewed the material obtained during the course of the investigation, I determined that I had sufficient evidence upon which to finalise the matter by way of an in-chambers Finding into Death without Inquest, *Form 38*.

78. In anticipation that I may make adverse comments towards MHV in connection with the death of Mr Marsden, and noting that I had not held a Mention Hearing allowing parties to make oral submissions, I directed that my Solicitor write to Mr Simon Cooke, General Counsel of Mercy Health inviting Mercy Health to make any further submissions in mitigation.[33]

79. By letter of reply dated 28 February 2022, Mr Cooke outlined the material Mercy Health had provided the Court during the course of the investigation. He further noted that it would be of assistance if the proposed wording of my Finding insofar as it relates to adverse comments made against Mercy Health be provided in order to determine whether formal submissions would be necessary.[34]

80. Noting the time that had passed since Mr Marsden's death and trusting that the content of correspondence and requests made by the Court to Mercy Health during the course of the investigation would allow them to anticipate the substance of any adverse comments, I did not deem it necessary to provide Mercy Health, or any other party with the proposed wording of my Finding and communicated as such to Mercy Health.

[32] CB, Statement of Sarah Lattimer, General Counsel & Company Secretary of I-MED Radiology Network, dated 29 October 2021.
[33] CF, Letter to Simon Cooke, dated 18 February 2022.
[34] CF, Letter from Simon Cooke dated 28 February 2022.

COMMENTS

Pursuant to section 67(3) of the Act, I make the following comments connected with the death.

1. Patients attending Victorian hospitals do so with the expectation of receiving a high standard of appropriate care, and those who attend for other reasons do so with the expectation that they will not be placed in harm's way while at the facility.

2. Mr Marsden's death was preceded by a series of failures in adhering to accepted standards. Had the automatic doors at the entrance to Werribee Mercy Health not malfunctioned and caused Mr Marsden to fall, he would have, in all likelihood, attended his scheduled haemodialysis appointment without issue. However, he sustained a serious injury which was further compounded by the substandard treatment he received whilst a patient in the Emergency Department.

3. Mr Marsden's death highlights the importance of thorough communication within our hospitals, particularly in such a busy environment as an emergency department. Whilst I accept Dr Choksey's concession that she misread the results of Mr Marsden's CT scan, this would likely have been prevented had Dr Dulimov telephoned to advise her of his findings.

4. Whilst it is to be expected that each clinician would thoroughly review the materials that come before them, human error does occur and as such clinicians rely on a system of checks and balances such as WMH's 'unwritten' policy of having significant radiological findings telephoned through to the referring clinician, or indeed the same practice which is written in RANZCR's Standards of Practice for Clinical Radiology. With the view to providing hospital clinicians with the appropriate support and preventing like situations from occurring, I will make a pertinent recommendation.

5. In her statement to the Court, Dr Choksey outlined the process she would have followed had she identified the fractures, stating *"the best practice would be to provide cervical spine protection by applying or maintaining a cervical collar, and refering [sic] the patient to a neurosurgical unit."*[35]

6. Whilst I appreciate that Mr Marsden may not have been a good surgical candidate due to his medical history, the fact remains that by not identifying the fractures to C1 and C2 vertebrae, an opportunity was lost to provide Mr Marsden with appropriate medical care.

[35] CB, Statement of Dr Heena Choksey, dated 6 March 2020.

7. I remain concerned that Mercy Health Victoria Ltd did not advise I-MED of the death of Mr Marsden, despite I-MED evidently falling short of WMH's expected practice at the time of his death. By failing to advise I-MED, their ability to conduct a thorough review, scrutinise their own systems of work and implement appropriate restorative and preventative measures in a timely manner was hampered. This matter has highlighted what appears to be a worrying gap in communications between MHV and its service providers and I will make a recommendation on this issue.

8. I am also concerned that Mercy Health Victoria Ltd relied on an unwritten practice in their provision of patient care. Unwritten practices within organisations, particularly those responsible for the delivery of healthcare, are clearly fraught. They provide no flexibility for the many complexities within these organisations, such as staff numbers and changes and the use of contracted services, and barely convey a level of confidence in the delivery of services. Policies and practices need to be written, communicated and enforced or they are likely to lead to patient care errors.

9. I consider that Mercy Health Victoria Ltd's agreement to enter into an Enforceable Undertaking with WorkSafe Victoria represents a concession of their failure to appropriately maintain the automatic doors at Werribee Mercy Hospital which caused serious injury and resulting death to Mr Marsden.

10. Although I-MED have not made any concessions as to their involvement in this matter, in the circumstances where they were put at a distinct disadvantage by not being informed of Mr Marsden's death in a timely manner, I do not intend to make further adverse comments about I-MED or any clinicians employed by them.

11. I acknowledge the restorative and preventative measures taken by Dr Choksey and Mercy Health Victoria, and I further acknowledge the apologies they have provided to the family of Mr Marsden.

RECOMMENDATIONS

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

1. With the aim of preventing like deaths and promoting public health and safety, I recommend that the Royal Australian and New Zealand College of Radiologists consider using the death of Jeffrey Marsden as a case study in educational campaigns or materials highlighting the

importance of communicating urgent and significant unexpected radiological findings directly to the referrer, in keeping with their Standards of Practice for Clinical Radiology.

2. With the aim of preventing like deaths and promoting public health and safety, I recommend that Mercy Hospitals Victoria Ltd develop a system, if they have not already done so, by which they communicate deaths and other serious events to contracted service providers involved in the provision of clinical care to those patients. Such a system would ensure each entity is able to undertake a thorough review of their involvement and implement any necessary restorative and preventative measures in a timely manner.

FINDINGS AND CONCLUSION

1. The standard of proof for coronial findings of fact is the civil standard of proof on the balance of probabilities, with the *Briginshaw* gloss or explications.[36] Adverse findings or comments against individuals in their professional capacity, or against institutions, are not to be made with the benefit of hindsight but only on the basis of what was known or should reasonably have been known or done at the time, and only where the evidence supports a finding that they departed materially from the standards of their profession and, in so doing, caused or contributed to the death under investigation.

2. Pursuant to section 67(1) of the *Coroners Act 2008* I make the following findings:

   a) the identity of the deceased was Jeffrey Marsden, born 09 September 1947;

   b) the death occurred on 08 January 2019 at St Vincents Hospital, 41 Victoria Parade, Fitzroy, Victoria, 3065;

   c) I accept and adopt the medical cause as ascribed by Dr Gregory Ross Young and find that Jeffrey Marsden died whilst palliated, from complications of C1 and C2 cervical vertebral fractures sustained in a fall;

3. AND, I find that Jeffrey Marsden died due to a series of failures within the Werribee Mercy Health system, including the malfunctioning of the automatic doors, the lack of communication by Dr Alex Dulimov regarding his radiological findings, and Dr Choksey's

[36] *Briginshaw v Briginshaw* (1938) 60 CLR 336 at 362-363: 'The seriousness of an allegation made, the inherent unlikelihood of an occurrence of a given description, or the gravity of the consequences flowing from a particular finding, are considerations which must affect the answer to the question whether the issues had been proved to the reasonable satisfaction of the tribunal. In such matters "reasonable satisfaction" should not be produced by inexact proofs, indefinite testimony, or indirect inferences…'.

misreading of the CT scan report. I find in all the circumstances that Jeffrey Marsden's death was preventable.

4. AND FURTHER, given the sequence of events preceding Jeffrey Marsden's death involved a series of failures to adhere to accepted standards, I am unable to find with any certainty which event or decision in isolation caused Jeffrey Marsden's death, and as such I am unable to find that any one person or entity was responsible for this tragic outcome.

I convey my sincere condolences to Mr Marsden's family for their loss.

Pursuant to section 73(1B) of the Act, I order that this finding be published on the Coroners Court of Victoria website in accordance with the rules.

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

Azucena Marsden, Senior Next of Kin

Slater and Gordon, on behalf of Natan Marsden

Mr Simon Cooke, Mercy Hospitals Victoria Ltd

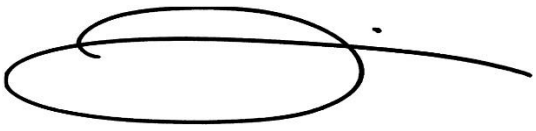
Avant Law, on behalf of Dr Heena Choksey

St Vincent's Hospital Melbourne

WorkSafe Victoria

Police Coronial Support Unit

Signature:



AUDREY JAMIESON

CORONER

Date: 4 July 2023

NOTE: Under section 83 of the ***Coroners Act 2008*** ('the Act'), a person with sufficient interest in an investigation may appeal to the Trial Division of the Supreme Court against the findings of a coroner in respect of a death after an investigation. An appeal must be made within 6 months after the day on which the determination is made, unless the Supreme Court grants leave to appeal out of time under section 86 of the Act.