CITATION: *Inquest into the death of Henry George Wilson aka Albert George Wilson* [2018] NTLC 022

TITLE OF COURT:	Coroners Court
JURISDICTION:	Darwin
FILE NO(s):	D0077/2017
DELIVERED ON:	21 September 2018
DELIVERED AT:	Darwin
HEARING DATE:	22 August 2018
FINDING OF:	Judge Greg Cavanagh
CATCHWORDS:	**Unexpected death in Hospital caused by injury during procedure, not reported to coroner, failure to treat elderly man dying in pain, failure to communicate appropriately with family during treatment and after death**

REPRESENTATION:

Counsel Assisting:	Kelvin Currie
Counsel for Top End Health Service:	Stephanie Williams

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IN THE CORONERS COURT
AT DARWIN IN THE NORTHERN
TERRITORY OF AUSTRALIA

No. D0077/2017

In the matter of an Inquest into the death of

HENRY GEORGE WILSON aka ALBERT GEORGE WILSON

ON 19 SEPTEMBER 2016
AT ROYAL DARWIN HOSPITAL

FINDINGS

Judge Greg Cavanagh

Introduction

1. Mr Wilson was born 20 September 1938 in York, Western Australia. He was one of six children to Agnes and Alfred Wilson. He was named Henry George Wilson. However at some stage he changed his name to Albert George Wilson.
2. He was Aboriginal and a member of the Stolen Generation. At the age of five years he along with his brother and sisters were removed from his parents and grew up in Sister Kate's Cottage Home in Perth.
3. He had four children between 1960 and 1966: Rosemary, Graham, Christine and Annette. He married three times. The last time was at 68 years of age when in 2007 he married Prime Rapada.
4. He worked as a heavy machinery operator. He worked until the time he was admitted to hospital on 29 August 2016. He was 77 years, 11 months and 9 days old. By that time he was finding it more difficult to manage the more complex of his daily affairs. He relied on his daughter Annette to assist him.
5. On 29 August 2016 he went to his GP. He said he had epigastric pain and had been feeling tired lately. He had lost weight. Blood was taken at 9.35am. The results were available in the early afternoon. His liver function tests were highly deranged. His

GP referred him to the Emergency Department at Royal Darwin Hospital to exclude pancreatitis and hepatitis.

6. He was found to have stage 4 colorectal cancer. He had a cancerous growth obstructing his colon, metastatic cancer in his liver and obstruction of the common bile duct due to portal lymphadenopathy. He was admitted to the care of the GS3 team, led by the General Surgeon, Dr Philip Toonson. The team consisted of Dr Toonson leading two Registrars and an Intern.
7. The following day Mr Wilson was struggling with the diagnosis. It was noted in the medical notes that he seemed to be in denial about his prognosis.
8. He had the obstruction removed from his colon on 1 September 2016 in an open right hemicolectomy with primary anastomosis. The operation was successful. However, the common bile duct remained obstructed and Mr Wilson remained jaundiced. The plan was to rectify the obstruction and then have Mr Wilson assessed for palliative chemotherapy.
9. On 6 September 2016 an Endoscopic Retrograde Cholangiopancreatography (ERCP) procedure was carried out by Dr John Treacy. The procedure was to insert a stent into the common bile duct. However the procedure was unsuccessful as the duct was unable to be cannulated. Following that attempt Mr Wilson developed mild pancreatitis.
10. From 2.00am on 8 September 2016 he began to feel nauseous. By 8.20am he was noted to be "very nauseated", vomiting and complaining of moderate abdominal pain. The family had a meeting with one of the GS3 team Registrars on 9 September 2016. They asked and were assured that no further procedures would be carried out without the family being informed. The family were advised that on Thursday 16 September 2016 the multi-disciplinary team would meet and the family would be informed.
11. By 12 September 2016 Mr Wilson appeared much improved. He was tolerating a soft diet, fluids and was mobilising. Two days later his pain was noted to be 4/10 but the pain subsided after being given analgesia.
12. By the morning of 15 September 2016 he was mobilising up and down the stairs and he denied having pain. The plan that day was to undergo a Percutaneous

Transhepatic Cholangiography (PTC) performed by an Interventional Radiologist. The family were not informed of those plans.

13. At 2.00pm Mr Wilson underwent the PTC procedure. A permanent biliary wall stent was positioned under general anaesthetic by a visiting interventional radiologist. It was thought the stent was successfully positioned.
14. The following morning, Friday 16 September 2016, on the ward round (conducted by the Registrar) at 7.45am, it was noted that Mr Wilson's blood pressure was high and he complained of pain to the stent insertion site. The plan at that stage was to aim for discharge on the following Tuesday, the 20th September 2016. That happened to be Mr Wilson's 78th birthday.
15. However by midday his heart rate was 130 bpm and he was looking generally unwell. He was seen by the team Intern. His haemoglobin was dropping and his white cell count was markedly elevated. He was unable to sit up because he felt too nauseous and was in too much pain. It was reported that he was vomiting. A discussion was had with one of the team Registrars and a diagnosis of sepsis post biliary stent insertion was made. He was resuscitated on fluids and commenced on the antibiotic, Tazocin.
16. A CT scan was not ordered nor was there consultation with the Interventional Radiologist. Dr Toonson said he thought Mr Wilson was suffering from pancreatitis.[1] The following day (Saturday), Mr Wilson appeared to have improved and was mobilising again. He went outside with his family.
17. At 1.30pm on Sunday, 18 September 2016 he told the doctor that the pain in his abdomen had increased. He said it was sharp and constant. He said he also had left-shoulder pain. He refused food and his abdomen was noted to be distended and tight. He said he could feel his body shutting down. His haemoglobin was at 62g/l. He was diagnosed as suffering from peritonitis. His daughter demanded the doctors do something. An x-ray did not reveal any gas indicative of bowel perforation. A CT was organised.

[1] Transcript page 90

18. At 7.00pm that evening the Radiologist called to say that it was suspected that the biliary stent had damaged the duodenal wall. There was a large gas filled collection in the right anterior pararenal space. There was infected necrotising peripancreatic inflammatory change but no sign of pancreatic parenchymal necrosis. Urgent assessment and management by a surgeon was recommended. A CT tubogram was also recommended. The plan by the Surgical Cover was to continue IV antibiotics and "nil by mouth" from midnight.
19. The next morning (19 September 2016) on the ward round by the GS3 Registrar the CT tubogram was ordered. The result was provided at 1.00pm:

> "Contrast is filling the biliary stent and proximal small bowel and stomach. There is also contrast seen in the retroperitoneum and right paracolic gutter, this finding is consistent with a bowel perforation which is favoured to be within the second or third part of the duodenum".

20. At 2.15pm at a surgical review the images were reviewed by the radiologist and Dr Toonson. It was noted that the right retroperitoneal collection was amendable to percutaneous drainage.
21. The Registrar discussed the findings and plan to drain the collection with Mr Wilson. His family was not there at the time. The following note then appears:

> Patient initially reluctant to undergo procedure. He said, 'I just want to die'. However agreeable to procedure as may improve clinical condition – decrease pain.
>
> Limits of care discussed with patient. He does not want:
>
> - Further surgery
> - ICU care including intubation and ventilation
> - Resuscitation in the event of a cardiac event
>
> He will accept:
>
> - Intravenous fentanyl
> - Intravenous antibiotics
> - Comfort measures

A “not for resuscitation” form was completed. The plan included percutaneously draining the collection and discussion with the family. However, at no stage before his death was there any discussion with the family about the severity of his condition or the limits of care.

22. At 4.25pm Mr Wilson went to radiology to have the collection drained. However he did not have the procedure. The Registrar indicated that the Radiologist said they did not have the time to undertake the procedure. The procedure was rebooked for the following day.
23. By 5.30pm Mr Wilson was returned to the ward. He was in severe pain. He complained of not being able to breathe. He was given Endone and Fentanyl. A nasal gastric tube was inserted and immediately drained 500ml. He was provided oxygen via nasal prongs. His observations were said to be stable. Due to his deterioration the General Surgical Registrar was called at 6.00pm. At 6.15pm Mr Wilson stopped breathing. The Registrar arrived at 6.20pm. Mr Wilson was surrounded by his family. The Registrar found no signs of life. Dr Toonson was notified of his death by telephone.
24. The most junior doctor on the team, the Intern, was left to attempt to explain the sudden deterioration and death to the family. The following was written in the medical notes:

> family upset as death has happened suddenly feeling they were not told adequately how advanced disease was. Questions answered. Family will advise if they need further meeting.

25. At 10.55am on 20 September 2016. The Intern rang the wife and daughter to say that Dr Toonson could meet with them at 4.00pm to discuss events. That apparently took place although there is no mention of it in the medical notes.
26. After his death the Surgical Cover wrote a retrospective entry in the notes. It spoke of a deterioration in the clinical state at 3.50pm. He then wrote:

> “Family is around, aware patient is not well, hasn’t been expecting this much of sudden deterioration.

> Discussion with on call surgical registrar, advised that deterioration can be expected, can upgrade antibiotics as team planned, patient is Not For Resuscitation, we are not going to do any active management.
> Explained to family that patient is deteriorating and as we discussed before it is comfort care at the moment.
> …
> non-coroner's case. Family doesn't want a post-mortem."

27. Despite that notation the Intern expressed the view to the Registrar that the death was a reportable death and should be reported to the Coroner. The Registrar agreed. The next day the family said they would like a post-mortem.
28. Two days later, on 22 September 2016 at 1.39pm the Registrar sent a text to the Intern stating:

> Spoke to Coroner – not reportable death. Called mortuary they will do autopsy once a family member signs a form for permission ...

29. There is no evidence that the Coroner's Office was contacted. The Registrar cannot now remember making the call and an examination of all incoming phone calls to the Coroners Constables from 19 to 22 September 2016 indicated that there were no calls from the Royal Darwin Hospital or relayed through the towers picking up calls in the area of the Royal Darwin Hospital.
30. On 26 September 2016 an autopsy was carried out by the Forensic Pathologist, Dr John Rutherford. He understood the purpose was, "to elucidate the pathological findings so that the understanding of clinical staff might be enhanced in order to allow informed discussions with family members".
31. On 27 September 2016 a doctor at the hospital signed a Medical Certificate of Cause of Death. The cause was noted as, "sepsis due to retroperitoneal collection after biliary stent insertion".
32. On 18 October 2016 the family sent a list of 42 questions to the Hospital relating to the care and treatment of Mr Wilson. The Hospital logged the questions into *RiskMan,* the software the Hospital uses to record adverse events and near misses.

That was the first entry in *RiskMan* relating to the death of Mr Wilson. His death and the circumstances of his death had not and still have not been entered.

33. An appointment was made for the family to come to the Hospital on 11 November 2016 to discuss their concerns with Dr Toonson, Dr Treacy and Dr Mahiban Thomas, the Head of Surgery. The meeting was held at lunchtime. Four members of the family attended and another was connected by phone.
34. Dr Treacy attended for about 15 minutes. Dr Toonson did not attend at all, despite attempted telephone calls and messages to him. It was left to Dr Thomas to talk to the family. He understood from conversations with Dr Toonson that the main communication issue had been a desire by Mr Wilson that the family not be informed about his malignancy and the terminal nature of his illness. He said that was the reason the doctors were forced to remain silent.
35. However that was not the desire of Mr Wilson. His family were well aware of those aspects. In evidence Dr Toonson said he was told that was Mr Wilson's wish, but cannot recall who told him. He concedes it was not Mr Wilson. The Registrar who consented Mr Wilson to the procedures stated that she could not remember Mr Wilson saying he did not want information told to his family.[2]
36. Dr Thomas thought the meeting on 11 November 2016 went well although he thought it was hampered by a "lack of detail", which he said, "was probably not the best representation". Dr Toonson told him later that he had been scrubbed. It was on his "operating day". He operates every Friday. He stated at the inquest that he saw no reason to change the time of the meeting by reason of him operating that day and said that if he had time he would have attended.[3]
37. On 29 November 2016 the case of Mr Wilson was presented at the Surgical Mortality and Morbidity (M&M) meeting. Dr Toonson said he would have been at that meeting but has no recollection of the determination at that meeting. It was in part, in the following terms:

> "There was a delay in the percutaneous drainage being undertaken by the Radiologist (should have been done the day/evening of the

[2] Transcript page 66
[3] Transcript page 102-103

> diagnosis of the retroperitoneal collection, but not done until the next day). There was no discussion between the Radiologist and the Surgical Consultant which impeded the best outcome for the patient."[4]

38. The *RiskMan* entry was closed on 27 February 2017 on the basis of the meeting on 11 November 2016. No written response was made to the 42 questions. Top End Health Service seems not to have had any issue with the failure of the *RiskMan* system to capture the complications from the PTC, the failure to drain the collection identified at the M&M meeting and the unexpected death of Mr Wilson.

39. The family remained confused about what had happened and on 28 April 2017 one of his daughters made a complaint to the *Health and Community Services Complaints Commission*. She wrote, "over a period of 96 hours, in insurmountable pain, my father died of sepsis". Part of that complaint was in the following terms:

> "My sister had constantly asked to meet the doctors for an update on our father's condition. Left phone messages but had no responses. My sisters then started to go to the hospital early in the morning to talk to the doctors during their rounds, then they went later because the doctors would come later, but this was to no avail. We eventually asked the social worker and the Aboriginal Liaison Officer to make a meeting for us as the doctors were not responding. A meeting was arranged for 9 September 2016, with the Registrar. We were advised by the doctor that tests were going to be run and that no procedures would occur until they spoke with the multi-disciplinary team and we were assured that they would contact us after this meeting. After a few days we asked the nurses whether they were aware of when the multidisciplinary team would meet. They didn't know. Without any contact prior, we find out our father had had a procedure. The doctors deliberately ignored our requests and shut us out of being part of the consultation process with regards our father's treatment. Our father had to come to terms with being told he had advanced cancer in a very short time frame. Our father usually relies on my youngest sister to explain more complex daily things to him and whilst he kept us informed to the best he could, of what the doctors did and were going to do, my sister should have been part of his decision making as he would not have been making an "informed decision".

[4] Annexure 5 to the statement of Dr Charles Pain dated 16 August 2018.

> It was suggested by Dr Toonson that possibly our father wasn't telling us how serious his condition was. Is this a common response from doctors when the patient dies?"

40. On 9 May 2017 the *Health and Community Services Complaints Commission* contacted the Coroner and the following day the Coroner's Office commenced an investigation.
41. The family also complained to AHPRA (Australian Health Practitioner Agency). They posed 33 questions that for them remained unanswered. Dr Toonson provided a response to those questions. However the response was certainly not as helpful as the family might have hoped. For instance, the following question was posed:

> "Our father still had jaundice. His pain was beyond unbearable, he was still having nausea and we are unaware of any clinical indications. This is all happening within hours of the procedure and does not settle in the slightest, after 24 hours, 36 hours, 48 hours and 72 hours. With all these presenting symptoms at each of these hours, when should these doctors have come to the realisation that these symptoms were a complication of the PTC?"

42. The response from Dr Toonson was:

> "A complication was suspected over time as the patient's blood tests and observations changed".

43. On 6 February 2018 the Coroner's Office obtained an expert medical report from Consultant Physician, Dr John Sampson. He outlined the treatment and care provided to Mr Wilson and then provided (in part) the following conclusions:

> "I regard the clinical management to be appropriate and of a satisfactory standard apart from the management subsequent to the diagnosis of peritonitis at 1.20pm on 18 September 2016 and confirmation of a likely perforated duodenum later that day. Institution of appropriate management appears delayed. However it seems unlikely that this would have influenced the ultimate outcome."

44. Under the heading "Limits of Care", Dr Sampson stated:

> "Detail discussion of this is appropriate in a 78 year old man who despite good functional status had stage 4 colorectal cancer. His prognosis is less than 10% five year survival and a median survival

> in this situation of less than twelve months. Discussion regarding limits of care is first documented as occurring at 2.15pm on the day of death … I would comment that this is very late in the course of his illness for the limits of care first to be discussed. As well at the time of discussion he was in a precarious clinical state with sepsis and duodenal perforation and that it would have been appropriate for an urgent discussion with the family who had been present often during his admission."

45. Under the heading "Documentation", Dr Sampson stated:

> "This has generally been to a satisfactory standard. However, at times a clear picture of events cannot be formed.
>
> Documentation of family discussions in particular, if they occurred, is lacking at times.
>
> The documentation is difficult to follow on the day of his death.
>
> For example, the reason for return from x-ray without having the drainage procedure to attempt to control his sepsis on 19 September 2016 is not clear.
>
> As well the documentation of the events following his return to the ward on 19 September 2016 do not give a clear picture of the reason for his rapid decline. The retrospective note does not make this clear.
>
> The family indicate in discussions after his death that they were upset because the death happened suddenly and they were not aware how sick he was. Throughout his admission there is documentation that discussion (details were not included) has occurred with family.
>
> There is however, no documentation that this has occurred in the two days prior to his death when the complications of his illness and treatment have become critical and urgent discussion with the family who appear to be interested and concerned would be indicated."

46. On 14 February 2018 a copy of Dr Sampson's report was sent to the Top End Health Service. On 10 April 2018 Dr Charles Pain provided the response of the Top End Health Service. His comments included:

    - "His family (particularly his children) felt his death was sudden and unexpected;

- From a clinical perspective his death was not unexpected, certainly once his condition began to deteriorate;
- It was Mr Wilson's wish that he not have further treatment, once he began to deteriorate;
- A complicating factor in this misunderstanding between the family and the clinicians was that Mr Wilson had insisted that his family not be told of the severity of his condition;
- It is acknowledged that there was some delay in instituting appropriate management of his perforated duodenum.
- There are lessons to be learned from this case relating to communication, particularly regarding the limits of care. In our meeting, we discussed with the Head of Surgery that consultants should try to help patients to consider the possible implications of withholding information from their families in such circumstances. The complicated bereavement reaction that this family is undergoing is likely to be in part due to the fact that his death was unexpected and they felt they were not fully involved in decision making. Indeed they were not, at the request of the patient. This placed the clinicians in a difficult position."

47. As noted above the suggestion that it was Mr Wilson's wish that the family not be involved in decision making has no foundation whatsoever. The only difficult position for the clinicians was explaining their poor communication with the family. By the time of the inquest it was accepted by Top End Health Service that Mr Wilson's did not request that his family be excluded. It was troubling that with no evidence whatsoever Top End Health Service persisted in blaming Mr Wilson for the poor communication with his family.
48. The other aspect of particular note in the Top End Health Service response was the suggestion that the death was an expected death (or "not unexpected") from a clinical perspective. The suggestion being that even after review it was considered that Mr Wilson's death may not have been a reportable death. On 14 May 2018 I listed the death of Mr Wilson for inquest.

49. Just prior to the inquest the family provided a statement they wished to read out at the inquest. It was obviously well thought out and insightful. I set it out in full:

> We were informed by Mr Kelvin Currie that if we wanted to say anything or ask any questions at the inquest, that we would have the opportunity to do so. I am Peter Brown, the grandson of Alby Wilson and I am speaking on behalf of our family. We want to speak first about our father and grandfather, so he is not just known for his medical history over that 3 week period. He was much more.
>
> Then in the 2nd part we want to put forward, respectfully, suggestions how the hospital could learn from our experience, in the hope that other families don't endure what our father and pop went through. We accept and appreciate that each of the doctors who undertook those procedures, did try their best to bring about the best possible outcome that they could, given our dad and pop's circumstances.
>
> We have this deep sadness that our dad and pop had to endure immense pain and suffering in the last few days of his life.
>
> **ALBY WILSON**
>
> Pop was born in the wheat belt town of York, in Western Australia. Sadly, at the age of 5 years old, along with his brother and three sisters he was taken away from his parents and placed into Sister Kates Children's Cottage Home in Perth. He recalled that his youngest sister, Trudy as being a baby in arms when this happened. He wouldn't see his parents again. We now know this was part of the Stolen Generation.
>
> Whilst at the home, Pop had a bike and all the kids from the home would ride down to the river. At the time Pop had a dog called Toby and he didn't want Toby to walk as it was too far, so he built a cart on the back of his bicycle to put Toby in.
>
> The army would regularly take the kids from Sister Kate's for activities and picnics and we believe that's probably why Pop had a respect for the military. Throughout his life he attended ANZAC Day marches and liked visiting military events in Darwin.
>
> Pop grew up poor and was always cold at the home and he disliked the cold, so he eventually moved up to the Territory where he would stay for the rest of his life.

Pop taught himself how to weld and built a boat, trailers, bull bars and tow bars. For someone who had a limited education he had the ability to read plans and develop designs. All self-taught.

Pop was a part of the road gangs that built roads throughout the Northern Territory including a section of the McArthur Highway to Borroloola.

Pop was a beautiful father and grandfather. He made sure his kids wanted for nothing and taught them to appreciate the simple things in life.

Even if Pop was struggling he would put other peoples' needs above his own.

On 18 [was the 19th] September 2016 our father expressed that he was still in pain and he could feel his body shutting down and he wanted to die. This came after three days of excruciating pain. It appears he had temporary relief, but this was short lived given the sepsis and then the peritonitis was present throughout that period. Our father did not want to die. He was agreeing to intervention, however, by Sunday 18 September 2016 there is no doubt in our mind our father knew that further treatment was pointless.

To summarise, Pop triumphed over adversity. He was strong, resilient, a hard worker, generous, caring, intelligent, great father and provider for his family.

Pops death has had a profound impact on his family which is still very raw today. He took a part of us when he left, and he is still deeply missed.

Improving care

1. When a patient or family member expresses that they are in pain, listen to them. Talk to them. Show them understanding. Believe them. When they tell you they can feel their body shutting down, show compassion and respect. Don't dismiss how they are feeling.

2. After a procedure, if a patient is expressing concern about the amount of pain they are experiencing, don't dismiss. Even if the specialist said it was successful. Reassessing or obtaining imaging should be the first option to identify the source.

3. A family member should not have to tell a doctor that their patient's situation is dire. As a doctor, you should be aware their situation has elevated in seriousness.

4. It should be mandatory that permission be obtained early in the treatment of the patients desire to have family involved or not. Thereafter, family should be involved at every stage of decision making in the presence of the patient to assist and support the patient.

5. Include family in discussions about treatment. The patient is trying to come to terms that they have a serious illness and they may not survive. If the patient is responding to your questions or agreeing to the treatment, don't assume that they have the required mindset to make decisions. In these circumstances people need to have that family support.

6. Talk to family and the patient together about how serious their situation is. Not all family live in Darwin, and arrangements need to be made for those interstate family members to get to Darwin for their final goodbyes.

7. Talk to family and the patient together about the seriousness of their situation. Don't hold back from family any details. Be open. This can lead to the family distrusting doctors and the health system and taking matters further. There should be no surprises for family and family should not have to find out other significant details in reports and other documents after the family member has passed away.

8. Don't downplay the patient's pain and only record what appears favourable to the hospital. Be honest. Be open.

9. A lack of communication between senior and junior doctors can and at times does result in fatal outcomes. Better communication should be addressed as a priority.

10. When a patient has sepsis, treatment and finding the source should be carried out simultaneously and immediately upon diagnosis and intravenously as the first option or dependent upon the patient's medical history. Don't choose one over the other. To ignore one over the other raises the question, what did you think was going to happen? It was going to cure itself?

11. If no policy exists, one be developed addressing the identification, treatment and management of sepsis. It is to include educational material to be distributed throughout the NT Hospitals and be given to patients as part of the Informed Consent process. Proper data be

developed to accurately reflect sepsis as a cause of death as noted in Insight of the Medical Journal of Australia.

12. Medical staff should be aware of their body language and tone when communicating with family members about the death of their loved one. These can be misinterpreted as arrogant or give the perception that you would rather be elsewhere. This is a basis of respectful communication.

13. Junior doctors should be tactful at all times. This is about the patient and their family, not the doctor's feelings. If they are going to feel intimidated addressing a number of family members, assign this task to someone else more experienced.

14. If you are going to tell family that you will involve them in discussions about treatment, do it. You don't tell them one thing, then do another.

15. Medical staff need to be cautious, when informing a patient and their family that due to limited resources other patients are of higher priority. That patient may well be a high priority had doctors not made an incorrect assessment and not given him the priority he deserved.

16. After a high risk procedure and the patient's history of unsuccessful procedures, complexity and/or the presence of sepsis, the patient should be immediately sent to ICU for close observation.

17. Family should be made aware that their family member is dying, not have the family attend the hospital only to ask questions about what is happening when they see their family member in a catatonic state.

50. The institutional response from Top End Health Service in relation to the inquest was received on the evening of 16 August 2018. That response conceded that Mr Wilson's death was reportable and should have been reported to the Coroner. Top End Health Service accepted that Mr Wilson was not expected to die suddenly by his family or his treating clinicians.

51. However, the Top End Health Service continued to persist with the version that Mr Wilson had communicated an express wish that his family not be told of his cancer diagnosis. That only changed on the day of the inquest during the course of the evidence.

ISSUES

Deterioration and delay in treatment

52. The day following the PTC procedure, Mr Wilson was diagnosed with sepsis. Dr Toonson said he thought it was probably a case of pancreatitis. There is, however, no evidence that he saw Mr Wilson after the PTC procedure. Dr Toonson indicated that with the benefit of hindsight it would have been appropriate to order a CT scan on that day.
53. Not doing so however did not draw adverse comment from Dr John Sampson. His criticism was reserved for the time after 1.20pm on 18 September 2016. He wrote:

> "Peritonitis was diagnosed clinically at 1.20pm on 18 September 2016 and duodenal perforation is considered likely at 7.00pm following a CT scan on the same day. Conservative therapy for likely duodenal perforation is appropriate particularly given the patient's wishes not to have further surgery [although it was not until the following day that the patient indicated he did not want further surgery].
>
> Conservative therapy (nasogastric tube and suction, nil by mouth, intravenous proton pump inhibitor) would be indicated. There appears to have been significant delay in institution of this management (nil by mouth and nasogastric insertion) and I am not certain whether medication has been given. Drainage of the associated collection is appropriate to help control ongoing sepsis, but this is postponed for uncertain reasons on the day of his death.
>
> In summary, I regard his clinical management to be appropriate and of a satisfactory standard apart from the management subsequent to the diagnosis of peritonitis at 1.20pm on 18 September 2016 and confirmation of a likely perforated duodenum later that day. Institution of appropriate management appears delayed. However, it seems unlikely that this would have influenced the ultimate outcome."

54. The criticism from Dr Sampson related to the delay in instituting treatment on the afternoon of 18 September 2016. Mr Wilson waited in pain and feeling that his body was shutting down another 24 hours until the conversation was had with him about further procedures. That is when he commented he wanted to die.
55. There seemed however to be a lack of urgency in making a diagnosis. It took Mr Wilson's daughter demanding something be done before scans were ordered.

Thereafter there was no attempt to drain the collection until late the following afternoon.

56. Dr Toonson was asked the following question:

Counsel:	Do you think that's an appropriate level of care and treatment for a person such as Mr Wilson: to allow them to have the sepsis operate for another 24 hours or thereabouts?
Dr Toonson:	My expectation was with or without the drain his sepsis would persist for much longer than one or two days. It would take weeks for the sepsis to resolve with or without a drain and antibiotics. I am disturbed that he had that much pain which we did not manage. For me, it really is symptom management whether it's nausea, vomiting, pain. That's where we failed."

Communication with Mr Wilson and his family

57. There was a failure to communicate appropriately with Mr Wilson and his family. That heightened the family's concerns during the time of his care. In particular, there was no discussion with Mr Wilson about limits of care until a few hours before he died and there was no discussion about the limits of care with his family until after his death. The family felt, for very good reasons, ignored and excluded.

58. The important discussions about diagnosis and treatment were not had in the presence of, or with his family. He was 77 years of age. He relied on and needed the support and assistance of his family. That was not recognised by the clinicians and their failure to include the family in the crucial stages toward the end of Mr Wilson's life appears to have added to the frustration of Mr Wilson and his family and undoubtedly to the grief of his family.

59. It appears that Mr Wilson was not aware he was to have the ERCP procedure until the day of the procedure. The consent for the procedure had been obtained by a Registrar on the same day as the procedure was carried out. None of the family were there during the explanation of the risks and benefits of the procedure. There was no chance for the family and Mr Wilson to discuss those aspects with him or the doctors before he was taken to theatre.

60. It was after that the family sought to discuss their concerns with the treating team. Eventually they went to the Social Worker who organised a meeting with one of the Team Registrars on 9 September 2016. The family were assured that any further procedures would be discussed with them. They weren't.
61. On 15 September 2015 the visiting specialist spoke with Mr Wilson about the PTC procedure. Again he had the procedure the same day before being able to discuss it with family. The family were not advised. The risks outlined to Mr Wilson were listed as, bleeding, infection, mobility of stent and stent misplacement.
62. Those certainly did not reflect the risk of perforation and death. A later review by an expert Radiologist found no issue with the procedure itself. However, if the risks are not understood by the family prior to the procedure being undertaken, suspicion, angst and grief is an understandable reaction.
63. Thereafter, the family did not get a satisfactory explanation. Having being excluded prior to Mr Wilson's death it was obviously going to take a great deal more time and effort on the part of clinicians to bridge the knowledge and trust gap that had emerged. That time and effort was not invested.
64. Firstly, the Consultant left the first explanation to be undertaken by the Intern. Then the 42 questions posed were not answered in writing. The Consultant failed to attend the meeting ostensibly to answer the questions. The Director of Surgery found that situation far from ideal.
65. There appears to have been a lack of respect in the way the family were treated. That clearly can have consequences. It did in this case. It is the primary cause of the continuing angst and grief felt by the family, the complaints to the various regulatory bodies and the holding of this inquest. A great deal of time has now been spent by doctors and the Top End Health Service following the death of Mr Wilson that might have been avoided by appropriate communication at the time.
66. Clearly the doctors did not see good communication with Mr Wilson and his family as an important part of their care and treatment. However if they had, the terribly sad situation of Mr Wilson, alone and in severe pain, telling the Registrar he just wanted to die may have been avoided.

Communication between doctors

67. The lack of communication between the doctors troubled the family. The assurances of the Registrar on 9 September 2016 that they would be included in the plans appeared not to have been communicated to others.
68. Similarly, they were later troubled after the PTC procedure, when it was clear that Mr Wilson was suffering a complication, that the Consultant did not liaise with the Specialist Interventional Radiologist. That lack of communication also concerned the doctors at the M&M meeting.
69. However one of the continuing issues is that there appears to have been no learning or improvement following the matter being raised in the M&M meeting. The following evidence was given:[5]

> Counsel: Do you remember this M&M where it seems that one of the outcomes or learnings was that there was no discussion between the Radiologist and the Surgical Consultant which impeded the best outcome for the patient?
>
> Dr Toonson: No.
>
> Coroner: Was that brought to your attention?
>
> Dr Toonson: I can’t remember.
>
> Coroner: You’d expect it to be brought to your attention, if the Hospital is to learn from a death like this?
>
> Dr Toonson: Absolutely, in a room full of colleagues, exactly.
>
> Counsel: Thinking about it now, would that be your conclusion: that the best outcome for the patient was impeded because you didn’t talk to the Radiologist?
>
> Dr Toonson: Quite possibly.

[5] Transcript page 99

Failure of systems to ensure improvement

70. The M&M meeting was not the only system to have little impact on learning and improvement. The *RiskMan* system used by the Top End Health Service to track incidents in the Hospital did not function.
71. Dr Toonson gave evidence that it wasn't his practice to enter incidents into *RiskMan* when he expected those incidents to be discussed in forums like the M&M meetings or when his expectation was that it would be reported to the Coroner.
72. Top End Health Service must have been aware by 18 October 2016 that there was no entry in *RiskMan* in relation to the death of Mr Wilson. They thought the 42 questions were sufficient reason to put them into *RiskMan*. However, the Service never sought that the incidents leading to those questions be put into the system.
73. The complaints to AHPRA appear not to have motivated Top End Health Service to examine the circumstances of Mr Wilson's death. The Coronial investigation also doesn't appear to have stimulated Top End Health Service to a proper analysis of his treatment and the circumstances of his death.

Failure to report to the Coroner

74. The *Coroner's Act* provides that **reportable deaths** must be reported to the Coroner at section 12:

> *(2) A person who has reasonable grounds to believe that a reportable death has not been reported must report the death as soon as possible to a coroner or police officer.*
>
> *Maximum penalty: 40 penalty units.*
>
> *(3) A medical practitioner who is present at or after the death of a person must report the death as soon as possible to a coroner if:*
>
> *(a) the death is a reportable death; or*
>
> …
>
> *(c) the medical practitioner is unable to determine the cause of death.*
>
> *Maximum penalty: 40 penalty units.*

75. Reportable deaths are in part defined as:

> ***reportable death*** *means:*
>
> *being a death:*
>
> *(iv) that appears to have been unexpected, unnatural or violent or to have resulted, directly or indirectly, from an accident or injury;*

76. In this case the death was clearly unexpected **and** from an injury from a procedure four days earlier. That resulted in a perforation of the duodenum and led to the sepsis from which Mr Wilson died.
77. There were at least five doctors present or involved at the time of Mr Wilson's death or shortly thereafter. None reported the death. It seems that the prevailing view was that from the point of diagnosis of peritonitis on 18 September 2016 his death was expected. Obviously, that logic is flawed. However, it was perpetuated in the response from Top End Health Service 18 months after his death.

The Institutional Response

78. The inquest into Mr Wilson's death was a "discretionary" inquest. That is, the *Coroners Act* did not require that the investigation into his death result in an inquest. It was listed for inquest after the poor response from the Top End Health Service to the expert report of Dr Sampson. This inquest was also listed at the same time as another discretionary inquest into a similar death, that of David Fensom.
79. The formal institutional response was not received until two business days before the commencement of the inquest, on the evening of 16 August 2018. The late provision of such responses so close to an inquest has been the subject of comment more often than not in recent times. In this case the statement had 23 attachments. The institutional response did at least concede that the death was unexpected and should have been reported to the Coroner.
80. On 20 August 2018 Top End Health Service provided another statement. In that statement it was said (amongst other things) that the *Occurrence of Death/Consent to Autopsy* form would be changed. In its current form Part B of the form requires that

if the death is reported to the Coroner, the reason for so doing is provided. That is to be changed to require the Consultant to provide the reason as to why the death is not being reported to the Coroner.

81. It was indicated by Dr Mahiban Thomas that from January 2019 he will institute an hour's "pause" the day after a death. All clinical activity will be shut down for the team involved to allow for debriefing and "completion of all paperwork and to ensure communication with the family at the appropriate level".[6]

82. The information provided also included implementation of the R.E.A.C.T. (Recognise, Engage, Ask, Call, Talk) system. That it was said is already in service and provides a system that enables patients and their families to escalate concerns about care or lack thereof. They can make a call and a Top End Health Service employee will come and talk to them and assess their concerns.

Formal Findings

83. Pursuant to section 34 of the *Coroner's Act*, I find as follows:

(i) The identity of the deceased is Henry George Wilson also known as Albert George Wilson, born on 28 September 1938 in York, Western Australia.

(ii) The time of death was 6.15pm on 19 September 2016. The place of death was Royal Darwin Hospital in the Northern Territory.

(iii) The cause of death was sepsis due to retroperitoneal collection after biliary stent insertion on a background of colorectal carcinoma with liver metastases causing biliary obstruction.

(iv) The particulars required to register the death:

1. The deceased was Henry George Wilson also known as Albert George Wilson.
2. The deceased was Aboriginal.
3. The deceased was a Plant Operator working for Alan Birch Transport at the time of his death.
4. The death was not reported to the Coroner.

[6] Statement dated 17 August 2018 paragraph 9

5. The cause of death was confirmed by Dr John Rutherford.
6. The deceased's mother was Agnes Wilson (nee Bryant) and his father was Alfred John Wilson.

Comment

84. The circumstances of the death of Mr Wilson illuminates a number of issues. Those include poor communication with the family, poor communication between doctors, poor note taking (at least in-so-far as recording communication with the family), failure of the *RiskMan* system, inadequate care and treatment of a dying man and failure to report the death to the Coroner.
85. Sometimes systems fail or don't work as intended. In a busy hospital there are bound to be issues from time to time. However, there are a number of features of this case that cause continuing concern:
    a. The story is essentially about an elderly gentleman that was left untreated to die in pain;
    b. There was a failure to communicate appropriately with the family;
    c. The communication issues were denied by the institution and in effect the deceased was blamed. That was an insult to the deceased and his family;
    d. The Top End Health Service seemed more intent on defending its actions than critically analysing the facts. It is difficult to see how systems are going to improve if the Top End Health Service is unwilling to start by analysing the facts;
    e. In this case Top End Health Service had not sought to learn from the death of Mr Wilson by time of the inquest.
86. One would hope that such issues are isolated. However, the issues in this case were similar to the other case set for the same day (that of David Fensom) as was the response of the Top End Health Service.

Recommendations

87. I **recommend** that Top End Health Service require the consultants providing care and treatment to the patients of the Top End Health Service to fulfil their obligations in leading teams, communicating with other treating professionals, communicating

with families, and ensuring that any adverse events are appropriately recorded and reported.

88. I **recommend** that Top End Health Service ensure that medical staff have all necessary training and induction in relation to communicating appropriately with patients and families about symptoms, pain, prognosis, risk of procedures and limits of care.
89. I **recommend** that Top End Health Service speak to families after the death of a loved one and ensure that the family have been afforded proper communication, open disclosure and their reasonable needs are being met.
90. I **recommend** that Top End Health Service ensure sufficient governance and audit in relation to *RiskMan* and M&M meetings to ensure they are operating as intended.
91. I **recommend** that Top End Health Service ensure that all deaths of patients reportable pursuant to the Coroners Act are reported in accordance with the law.

Dated this 21st day of September 2018.

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GREG CAVANAGH
TERRITORY CORONER