CITATION: *Inquest into the death of Robert Douglas Dalgleish* [2004] NTMC 015.

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JURISDICTION:	Darwin
FILE NO(s):	D0121/2002
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HEARING DATE(s):	17, 18, 19, 20 November 2003
FINDINGS OF:	Mr V Luppino SM

CATCHWORDS:

Coronial – Inquest – Death in Hospital – Death in consequence of complications of gastric band surgery – Failure of Accident & Emergency Department to provide appropriate treatment.

REPRESENTATION:

Counsel:

Counsel Assisting:	Mr R Bruxner
Dr Treacy, Dr Goodhand and Dr Moore:	Mr C McDonald QC
Department of Health & Community Services:	Ms S Seivers

Solicitors:

Dr Treacy, Dr Goodhand and Dr Moore:	Paul Maher
Department of Health & Community Services:	Cridlands

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

No. D0121/2002

In the matter of an Inquest into the death of

ROBERT DOUGLAS DALGLEISH
ON 22 JULY 2002
AT ROYAL DARWIN HOSPITAL

FINDINGS

(Delivered 11 February 2004)

Mr V LUPPINO SM:

1. Robert Douglas Dalgleish ("Mr Dalgleish") died in the Intensive Care Unit of the Royal Darwin Hospital ("RDH") at 7.45am on 22 July 2002.

2. Section 12(1) of the Coroners Act ("*the Act*") defines a "reportable death" to mean a death that

   > "appears to have been unexpected, unnatural or violent, or to have resulted directly or indirectly from an accident or injury".

3. For reasons that appear in the body of these Findings, the death fell within the ambit of that definition and this Inquest is held as a matter of discretion pursuant to section 15(2) of *the Act*.

4. Section 34(1) of *the Act* details the matters that an investigating Coroner is required to find during the course of an Inquest into a death. That section provides:

   (1) A coroner investigating -

   (a) a death shall, if possible, find -

   (i) the identity of the deceased person;

(ii) the time and place of death;

(iii) the cause of death;

(iv) the particulars needed to register the death under the Births, Deaths and Marriages Registration Act;

(v) any relevant circumstances concerning the death.

5. The Inquest in this matter was heard at the Darwin Magistrates Court between 17 and 20 November 2003. Counsel assisting me was Mr Bruxner. Mr McDonald QC, instructed by Paul Maher, sought leave to appear on behalf of Dr John Treacy, Dr Elizabeth Moore and Dr Gerald Goodhand. Ms Sievers sought leave to appear on behalf of the Department of Health & Community Services. I granted both leave pursuant to section 40(3) of *the Act*. The Inquest heard evidence from eight witnesses namely:-

1. Senior Constable Anne Lade, Coroners Constable in charge of the investigation;
2. Dr John Treacy, General Surgeon;
3. Dr Edith Bodnar, junior Surgical Registrar at RDH at the relevant time;
4. Dr Richard Gilhome, Consultant;
5. Dr Terence Sinton, Forensic Pathologist;
6. Dr Jason Boldery, Surgical Registrar at RDH at the relevant time;
7. Mr Patrick Bade, Consultant Surgeon;
8. Dr David Read, senior Surgical Registrar at RDH at the relevant time.

6. In addition a full brief of documentary evidence was tendered through Senior Constable Lade.

FORMAL FINDINGS

7. The evidence enables me to make the following formal findings as required by *the Act*:

   (a) The deceased was Robert Douglas Dalgleish, born 3 January 1945.

   (b) The deceased died on 22 July 2002 at the Intensive Care Unit, Royal Darwin Hospital, Tiwi, Northern Territory.

   (c) The deceased died as a result of multiple organ failure in consequence of peritonitis resulting from complications from gastric banding surgery.

   (d) The particulars required to register the death are:

      1. The deceased was a male.

      2. The deceased was of Caucasian Australian origin.

      3. The death was reported to the Coroner.

      4. The cause of death was confirmed by post-mortem examination.

      5. The death was caused in the manner described in sub-paragraph (c) above.

      6. The pathologist viewed the body after death.

      7. The pathologist was Dr Terence Sinton.

      8. The usual address of the deceased was Lot 1, Virginia Road, Virginia in the Northern Territory of Australia.

RELEVANT CIRCUMSTANCES CONCERNING THE DEATH

8. By way of general background, Mr Dalgleish had a number of serious health problems apart from his obesity. These were diabetes, asthma, hypertension,

colitis, hypercholesterolemia and valvular heart disease. He was an ex-smoker and had also been fitted with a pacemaker. He was referred to Dr Treacy by his general practitioner to investigate surgical options for treatment of his obesity. Dr Treacy was then and remains the only surgeon in the Northern Territory performing gastric banding surgery. Dr Treacy is very experienced in the performance of that procedure. Mr Dalgleish saw Dr Treacy on 22 December 2000. His weight at the time was 155kgs. The procedure was performed on 21 March 2001 at Darwin Private Hospital.

9. The outcome of the surgery appeared to be successful. Mr Dalgleish saw Dr Treacy for adjustments of the band on a number of occasions until 25 February 2002, which was the date he last saw Dr Treacy. At that time his weight was down to 112 kilograms. The target weight was 105 kilograms.

10. Most of the relevant events relating to the matter up to 14 July 2002 were uncontroversial and not in dispute. I summarise these at this point for convenience and elaborate below where required. The uncontroversial matters were as follows:

    (1) Postoperatively Mr Dalgleish was seen by Dr Treacy on 27 April 2001 when his weight was recorded as 141 kilograms. On 22 June 2001 his weight was recorded as 135.5 kilograms.

    (2) When seen by Dr Treacy on 18 August 2001 his weight was 128 kilograms. However the reservoir port had apparently shifted and Dr Treacy was unable to needle the reservoir. As a result the reservoir was surgically re-positioned on 19 September 2001 and at that time four millilitres of fluid were added to the band.

    (3) Dr Treacy reviewed Mr Dalgleish on 20 October 2001. His weight was then noted at 132 kilograms. At that time a further two millilitres were added to the band.

(4) On 19 January 2002 Dr Treacy noted Mr Dalgleish's weight at 119 kilograms. The weight was the same during a further consultation on 2 February 2002 at which time a further one millilitre of fluid was added taking the total to seven millilitres.

(5) On 9 February 2002 Mr Dalgleish saw Dr Treacy and complained that the band was too tight. As a result Dr Treacy extracted half a millilitre of fluid.

(6) On review on 25 February 2002 Mr Dalgleish informed Dr Treacy of minor vomiting and accordingly Dr Treacy removed another quarter of a millilitre of fluid. The weight was then noted to be 112 kilograms.

(7) On 14 July 2002 Mr Dalgleish saw Dr Moore complaining of severe abdominal pain from the previous day and having vomited in the previous week. Dr Moore arranged for Mr Dalgleish to return the following day so that a barium swallow test could be conducted.

(8) The barium swallow test was conducted on 15 July 2002 and a number of x-rays were taken during the test. The test showed a narrowing of the stomach at the level of the gastric band and the presence of a sliding hiatus hernia. The constriction did not result in a total blockage as an amount of barium had passed through the band.

(9) Later on 15 July 2002, Mr Dalgleish saw Dr Goodhand. Dr Treacy had an arrangement with Dr Goodhand whereby Dr Goodhand would see his private patients during periods of his absence from Darwin. Dr Goodhand considered the x-ray report and was of the view that the report findings were consistent with a tight gastric band. He proceeded to remove two and a half millilitres of fluid. He observed

a significant and immediate improvement in Mr Dalgleish's symptoms.

(10) Despite that noted improvement, Mr Dalgleish's symptoms returned. On 17 July 2002 Mr Dalgleish saw Dr Forrest, a colleague of Dr Moore, when it was noted that he still had symptoms of obstruction. It was arranged that he would see Dr Goodhand the following day.

(11) On 18 July 2002, and before he could see Dr Goodhand, Mr Dalgleish was in such pain that he called an ambulance and was conveyed to RDH at 4.15am. He was seen by Dr MacNair, the Emergency Department Resident, who diagnosed complications due to the gastric banding surgery.

(12) At 9.15am on the same day Mr Dalgleish was seen by Dr Shand. He gave consideration to insertion of a nasogastric tube but decided to await the Surgical Registrar’s consultation due later that morning.

(13) At 1.00pm on that same day Mr Dalgleish was seen by Dr Bodnar and then again at 3.00pm. Dr Bodnar’s evidence and her diagnosis and treatment plan are discussed in more detail below.

(14) On 19 July 2002 the surgical team of Mr Bates, a Consultant at RDH, saw Mr Dalgleish during a ward round. Mr Bates then tasked Dr Boldery to attend to the aspiration of the band and to contact Dr Treacy.

(15) On the same day Dr Boldery attempted to contact Dr Treacy on his mobile phone on three occasions without success and without leaving a message. At 4.09pm that same day, Dr Boldery again called Dr Treacy’s mobile number and this time he left a detailed message of two minutes and 25 seconds duration. Regrettably Dr Treacy had retrieved his messages at 3.40pm that day.

(16) At 11.30pm that same day, Mr Dalgleish is seen by Dr Smyth, another Emergency Department Resident, who reported no signs of obstruction. He saw him again at 3.00am and at 6.20am on the 20 July 2002.

(17) He was seen by a Surgical Registrar (Dr Gett) at 7.50am on the same day and he inserted a nasogastric tube at that time.

(18) At 8.15am on the same day he was seen by the Intensive Care Unit Registrar (Dr Potter) who noted amongst other things "…picture seems septic to me…"

(19) At approximately 10.00am on that day Mr Dalgleish was seen by Dr Treacy. He removed all fluid from the band. He later performed a laparotomy and a gastrectomy during that surgery which took in excess of six hours and concluded at approximately 1.00am on the following morning.

(20) Mr Dalgleish remained in the Intensive Care Unit of RDH until 22 July 2002 at 7.45am when support was terminated and Mr Dalgleish died.

11. As is stated above, Mr Dalgleish's last consultation with Dr Treacy before the admission to RDH preceding his death was on 25 February 2002. The events immediately leading up to the death occurred from approximately 14 July 2002. Dr Treacy was on leave at the time and outside the mobile phone coverage area. From that date and until 17 July 2002, the events summarised in sub-paragraphs (7) to (10) of the preceding paragraph occurred.

12. On 18 July 2002, when Mr Dalgleish was conveyed to RDH by ambulance, he was initially assessed by Dr McNair who recorded a two day history of complaints of abdominal pain. Mr Dalgleish had not been able to eat or drink since Dr Goodhand had removed the two and a half millilitres of fluid from the band (see subparagraph 10(9) above). Mr Dalgleish brought the x-

rays and report of the barium swallow test with him. Initial abdominal examination revealed a soft obese abdomen which was not tender at all and no masses were then detected. The assessment by Dr McNair was that the pain was most likely due to a complication of the gastric banding surgery. As the evidence would show, that diagnosis was to be essentially correct.

13. Mr Dalgleish was then assessed at 1.00pm on 18 July 2002 by Dr Edith Bodnar who was a junior Surgical Registrar at RDH at the time. She took a detailed history. She said that it was her impression following the examination that the symptoms were consistent with a tight gastric band. She confirmed that her plan of treatment at the time included consideration of aspirating the gastric band and the insertion of a nasogastric tube. She said that the latter was important to decompress the stomach. She said that she recommended this to Mr Dalgleish but he declined. She said she gave him a full explanation of the procedure, the likely benefits, the importance of decompression of the stomach and the likely consequences if it was not inserted. She said that Mr Dalgleish was an intelligent, articulate and well informed patient and she respected his decision to decline that. She did not record this in the case notes, nor the agreement she negotiated with Mr Dalgleish regarding the insertion of the nasogastric tube the next day in the event that his vomiting continued.

14. She said that she consulted the senior Surgical Registrar in relation to her proposed plan. She could not remember who this was although it was later confirmed that this was Dr Read. She confirmed however that the senior Surgical Registrar decided to defer consideration of aspirating the band until the following morning. Apart from her presence at the ward round the following day, that concluded her involvement in the treatment of Mr Dalgleish.

15. I thought that Dr Bodnar was an excellent witness and I accept her evidence. Her notes were very thorough and of high standard. I was very impressed

with the level and quality of her notes notwithstanding the absence of the note regarding the refusal of the tube by Mr Dalgleish. I accept however that that discussion occurred as she recited. I was impressed by her correct assessment of Mr Dalgleish's condition. The evidence was to subsequently show that the treatment plan she proposed was correct on all counts. Had she been able to implement her treatment plan on 18 July 2002, the death of Mr Dalgleish would likely have been avoided.

16. Dr David Read also gave evidence at the Inquest. He is presently practising as a Consultant Surgeon. In July of 2002 he was a senior Surgical Registrar at the RDH. His statutory declaration of 12 November 2003 formed Folio 9 in Exhibit 1. He confirmed that he was the senior Surgical Registrar with whom Dr Bodnar conferred after her examination of Mr Dalgleish on 18 July 2002. He also confirmed that he was a member of the team during the ward round of 19 July 2002.

17. He confirmed that on the occasion that Dr Bodnar consulted him on 18 July 2002 it was his decision to await until the next morning to consider aspiration of the band. He said that he came to this based a number of factors. Firstly he said that the complaints of Mr Dalgleish had been relatively unchanged for a period of seven days. Secondly he said that although there was some pain and tenderness evident in Mr Dalgleish's presentation, he was not in acute distress. Lastly he said that there were not any signs to indicate the likelihood of occurrence of any catastrophic events. He elaborated that the white cell count was normal, there was no fever, the pain was being well controlled with analgesia, there was nothing unfavourable in the abdominal x-ray and, significantly, the patient was not hiccoughing. Accordingly he said that he did not expect any deterioration overnight and therefore decided to defer consideration of aspiration of the band until the following day, no doubt in part due to the fact that he would then have the benefit of the views of the Consultant leading the surgical team. This explanation is quite plausible and his decision was based on his

professional opinion according to his level of knowledge. It is plain that he made an informed assessment based upon the thorough information provided by Dr Bodnar and in the knowledge that a Consultant would review Mr Dalgleish the following morning. It is reasonably clear also, from Mr Dalgleish's observed condition at the ward round attendance the following morning, that he was not yet gravely ill.

18. However his considered decision was clearly wrong. This is quite apparent from the evidence of both Dr Gilhome and Dr Treacy. They have an abundance of experience and specialist knowledge between the two of them. It is regrettable that Dr Read was not experienced in the gastric banding procedure and/or the possible complications. Although there is no basis for criticising his decision to defer the aspiration of the band, essentially however this only serves to render acceptable the reason why he made the entirely wrong decision. I have no doubt that if he had more than a rudimentary knowledge of the procedure and the treatment of its complications he would no doubt have immediately directed the total deflation of the band.

19. As regards the ward round on 19 July 2002, Dr Read confirmed that Mr Bade was the leader of the team and that he, as the senior Surgical Registrar, was second in authority. He confirmed that Dr Bodnar and Dr Boldery were present as well as an intern. He said that Mr Dalgleish had remained relatively well. There had been no vomiting or hiccoughing overnight and there were no contra-indicating outward signs. He said there were no outward signs to indicate an impeding abdominal catastrophe.

20. He said that the decision was made that the gastric band had to be aspirated. He could not recall any discussion as to the amount to be aspirated. He said it would be usual for the deflation to occur by increments. He said most of the discussion was in relation to where the special needle required could be

obtained. He confirmed that Dr Boldery was directed to find the correct needle and to attend to the aspiration of the band.

21. Mr Patrick Bade was the Consultant at the RDH who was the leader of the surgical team charged with the care of Mr Dalgleish. He gave evidence and also provided a report dated 23 May 2003 which was included in Exhibit 1 at Folio 8. His further statutory declaration made on 17 November 2003 was tendered as Exhibit 5.

22. He confirmed that he first saw Mr Dalgleish during the ward round conducted on the 19 July 2002. He had been aware of the partial aspiration of the band by Dr Goodhand. He formed the view that there was slippage of the band. He referred to the slippage as "displacement". He also said that Mr Dalgleish did not look unwell when he assessed him on the morning of the 19 July 2002 and his observations were acceptable. Particularly, he said there were no severe abdominal signs and he had not vomited overnight.

23. He said that the treatment plan devised at that ward round was to completely empty the band and then reassess the position. He gave instructions to Dr Boldery to attend to the aspiration of the band and to contact Dr Treacy for his input.

24. Mr Bade said that he next saw Mr Dalgleish on the ward round on 20 July 2002 with Dr Treacy and that was either contemporaneous with or just after Dr Treacy had fully aspirated the band. He noted that in the interim Mr Dalgleish's condition had deteriorated from approximately 1.45pm on 19 July 2002 with the most significant deterioration occurring later that evening involving abdominal tenderness and signs of blood in his vomit.

25. He said that Dr Boldery did not contact him after the ward round on 19 July 2002 to advise that he had not been able to aspirate the band or contact Dr Treacy. He said that he had told Dr Boldery that the aspiration of the band was a priority. He said that on previous occasions where Dr Boldery had

any difficulty complying with an instruction that Dr Boldery referred back to him. Hence he did not feel the need to qualify his instruction with that proviso when tasking Dr Boldery on this occasion. I think that was quite reasonable. In consequence, he said he had no cause for concern when he had not heard back from Dr Boldery following the ward round.

26. He said that he first learnt of Dr Boldery's failure to aspirate the band on the morning of 20 July 2002. Although he said that he expected he would have been advised sooner of that failure, he qualified his answer by relying on the level of Mr Dalgleish's positive signs at the time. He said that Dr Boldery might not have been concerned enough to contact him given the then favourable state of the symptoms.

27. All that of course belies the fact that, as Dr Gilhome pointed out, the favourable position in relation to Mr Dalgleish's symptoms was largely due to the level of analgesia and intravenous fluids. Mr Bade's qualification of his answer is even more curious when it is noted that he was aware of the tenderness in the abdomen and still came to the conclusion that he did. Dr Gilhome thought this abdominal pain was by then a very significant factor. I have difficulty accepting Mr Bade's qualification in light of that.

28. Moreover, although both Dr Treacy and Dr Gilhome considered both the aspiration of the band and the insertion of a nasogastric tube to be important from the outset on 18 July 2002, Mr Bade was apparently not so convinced of the latter. This may well have been influenced by knowledge of Mr Dalgleish's refusal to accept the tube on 18 July 2002. Given the agreement which Dr Bodnar negotiated with Mr Dalgleish the previous day i.e., to reconsider the nasogastric tube if further vomiting occurred, given also that further vomiting had occurred, it is likely that Mr Dalgleish would then have agreed to that especially if the recommendation came from a Consultant and in strong terms.

29. Although Mr Bade acknowledged that the insertion of such a tube is standard and accepted treatment in the case of gastro intestinal obstruction, he rationalised his view by saying that in this case the cause of the obstruction was known i.e., the band, and as the purpose of the tube is to allow for decompression, its insertion was not as critical given that Mr Dalgleish's vomiting did provide some decompression. This I think is circular. Although Mr Dalgleish was vomiting earlier, the history shows that there was no vomiting overnight between 18 and 19 July 2002. It was in fact this which was taken into account in deciding on how to proceed. Therefore the conclusion that it was the vomiting which was providing some decompression is untenable. This is more so given that he agreed with the view of Dr Treacy and Dr Gilhome that the aspiration of the band and the insertion of the nasogastric tube were, in that order, the two most important steps to have taken at that time.

30. He agreed also that although some steps were taken to call a Surgical Registrar overnight on the 19 July 2002 when Mr Dalgleish's condition deteriorated, more concerted efforts should have been made and a Consultant should have been arranged. This I think would more likely have occurred if the notes had properly recorded the instructions to Dr Boldery and Dr Boldery's failure to comply with those instructions.

31. Dr Jason Boldery gave evidence by video link. He had provided a report dated 23 August 2003 which was included in Exhibit 1 as Folio 10A. Apart from uncontroversial matters already covered in other evidence, in that report Dr Boldery states that following the ward round on 19 July 2002 that Mr Bade <u>suggested</u> that he contact Mr Treacy and that he <u>try</u> to deflate the band. He repeated this in his evidence. This contradicts the evidence of Mr Bade who said that he emphasised the importance of the aspiration of the band and that the band was to be fully aspirated. I prefer Mr Bade's evidence on this point. It fits in clinically on the evidence that I have heard. On the other hand, Dr Boldery was vague as to the amount. He had no

expertise in the area as far as it is apparent on the evidence and it is extremely unlikely that Mr Bade, who had some experience with the procedures and the complications, would have used the word "some" without being more specific as to the quantity.

32. Notwithstanding my preference for the evidence of Mr Bade on this issue, I have no reason to suspect that Dr Boldery gave anything but an honest account of his recollection, unreliable as it may be. Mr Bruxner submitted that the divergence in the respective recalls of Dr Boldery and Dr Read highlighted a rather critical breakdown in communication on 19 July 2002. Ms Sievers submitted that it was only indicative of recall problem. Mr Bruxner's submission might explain Dr Boldery's apparent lack of diligence in the implementation Mr Bade's instructions. It is difficult to explain his actions absent such a misunderstanding as I remind myself that Mr Bade said that he stressed that the deflation of the band was a priority.

33. I think that in terms of this Inquest the most relevant matter highlighted by the divergence is the absence of proper recording of the instructions in the casenotes. There could be little scope for divergence had Mr Bade's instruction been noted, assuming of course that Dr Boldery would have referred to the notes. There must be some doubt about that given his failure to enter details of his own involvement in the treatment of Mr Dalgleish later that day. It also highlights the shortcoming in the notes of the ward round attendance as a contributing factor to the death, albeit in combination with Dr Boldery's failure to note his own inability to comply with Mr Bade's instructions. Ms Sievers attempted to rationalise Dr Boldery's failures (as did Mr Bade, see paragraphs 28 and 29 above) based on his assessment of Mr Dalgleish's apparent condition. However, that was based on outdated information which Dr Boldery would have known had he troubled to review the notes. Moreover had he bothered to note his own inability to comply with Mr Bade's instruction (even as he understood it), he would have had occasion to see the note made at 1.45pm on 19 July 2002.

He can hardly be excused for a faulty assessment he has made in such circumstances.

34. Dr Boldery said that he made attempts to deflate the band using a port-a-cath needle but was unsuccessful. Although the port-a-cath had a bevelled tip, the needle part itself has a 90° angle. It was not the precise bevelled needle that was required. His problem therefore was that he could not insert the needle far enough to access the port. He said he took two hours to achieve that limited success. He confirmed that he had tried to contact Mr Treacy via his mobile phone several times that afternoon but was also unsuccessful. This is discussed in sub paragraph 10(15) above. The matter was also complicated by Mr Dalgleish's unwavering insistence that the correct needle be sourced before he would allow any attempt to deflate the band.

35. In his statement Dr Boldery goes on to say that "...It was decided to continue to observe the patient as his condition had not worsened during the day...". Notwithstanding the curious wording of that phrase which suggests otherwise, he confirmed that the decision referred to was made by him alone and without consultation with any other person. He confirmed that the decision was made after his attempt to aspirate the band and to contact Dr Treacy. He confirmed that it was made on the basis that there was no deterioration in the patient's condition since the ward round. The case note entry at 1.45pm on 19 July 2002 was then put to him. That note indicated that the patient was still in pain, he had vomited several times and a temperature spike had occurred. Dr Boldery agreed that these factors were not consistent with his claim that Mr Dalgleish's condition had not deteriorated. He then attempted to defend the comment made in his report by claiming that the reference to the condition not having deteriorated was in comparison to his condition as at the admission time as opposed to the time of the ward round. This was most unconvincing and I do not accept this claim. There is no reason for him to make the comment that he did in

comparison to the admission time as opposed to in comparison to the time of his ward round. That is more reason to doubt the veracity of his answer given that the note at 1.45pm on 19 July 2002 records that Mr Dalgleish had vomited further. I was very unimpressed by his obviously defensive and untenable qualification. In addition, the claim made by Dr Boldery does not seem to have regard to the effects of the treatment with intravenous fluids and the ongoing analgesia.

36. Dr Boldery confirmed that by the time he had left work on 19 July 2002 he had been unsuccessful in complying with the two instructions given to him by Mr Bade. He also confirmed that he did not note this failure in the case notes, nor did he did tell anyone of those failures or arrange for anyone to take over those attempts.

37. Although he confirmed that his attempt to aspirate the band occurred after the time of the note made at 1.45pm on 19 July 2002, he said that he had not seen the note at that time. His omission therefore to note his own failed attempt to aspirate the band and to contact Dr Treacy becomes more significant as obviously had he contemporaneously proceeded to note his failure, he would have then had an opportunity to view the note made at 1.45pm that day. In my view I think it is likely that as a result he would have become aware that a deterioration in Mr Dalgleish's condition had occurred.

38. Although Dr Boldery might not be criticised for the failure of his attempt to aspirate the band, criticism is appropriate for his omission to refer this failure to Mr Bade or to record it in the notes. The absence of such a note to the doctors who attended to Mr Dalgleish overnight on the 19-20 July 2002 probably denied Mr Dalgleish the last opportunity he had of survival. In saying this, I bear in mind Dr Gilhome's evidence that although by 3.00am on 20 July 2002 the necrosis of the stomach was irreversible, it appears that this was the approximate time when the process of septic shock

commenced. Although a gastrectomy would then still have been inevitable, the patient had some chance of survival at that point.

39. When Dr Treacy gave his evidence he confirmed that he fist spoke to Dr Boldery at approximately 9.00am on 20 July 2002 when Dr Boldery rang him at his home to advise of Mr Dalgleish's condition. He then attended at RDH arriving at approximately 10.00am and he immediately saw Mr Dalgleish, apparently in company with Dr Boldery and perhaps also Mr Bade. He immediately removed all the fluid from the band using an ordinary needle. He said he did so because of the history given by Mr Dalgleish that he had vomited and had had abdominal pain over the preceding five or six days. Dr Treacy said in his evidence that this indicated the possibility of a blockage at the site of the gastric band.

40. Dr Treacy reviewed all the case notes and formed the view that Mr Dalgleish was in a life threatening situation. He took immediate steps to arrange for resuscitation procedures to be put in place. He reviewed Mr Dalgleish later that morning. He was already mindful of the possible need for emergency surgery and this was confirmed by 3:00pm that day.

41. He said that he suspected necrosis of the upper portion of the stomach. He performed a laparotomy which confirmed this. Necrosis is a restriction of the blood supply to organs and tissues resulting in the death of those tissues. On confirming that this occurred he decided to perform a full gastrectomy. This involve d removal of the stomach and reconstruction of the gastro intestinal tract. The surgery took over six hours and concluded at approximately 1.00am. Dr Treacy's involvement in the care of Mr Dalgleish had commenced at 10.00am that day and I take this opportunity to commend Dr Treacy for his dedication to his patient. His response was most impressive.

42. Dr Treacy said that he noted the position of the gastric band during that surgery and particularly that it was still in the horizontal position. He said

this indicated that there was no slippage. He viewed the seven x-rays taken during the barium swallow test. He said that these also indicated that the band was horizontal and therefore indicated no slippage. He also said that the x-rays indicated a certain symmetry of the upper and the lower portion of the stomach which he again said was indicative of a lack of slippage. He said that the radiologist who reported on the x-rays did not comment on slippage on his report. He said that had he seen these x-rays on 15 July 2002 he would not have concluded a need for surgery to correct possible slippage.

43. In cross examination by Ms Sievers, he was asked whether the hiatus hernia referred to in the barium swallow x-ray report was consistent with slippage. He said that a hiatus hernia can occur independently of slippage and was not necessarily indicative of slippage. In turn he conceded it was possible that the band could have caused the hiatus hernia. He did say that if there had been a slippage, certain other clinical signs would have evident specifically a reported increase in pain of increasing intensity over a short period of time.

44. Dr Treacy was not certain as to the cause of the blockage but in his opinion there were two options namely, that the band was too tight or that there was a food bolus causing the obstruction. He did not rule out slippage as a possible cause of the blockage. Indeed the information provided by him (Exhibit 1 Folio 16) acknowledged slippage as a possible cause of obstruction.

45. He said that at the time that he fully deflated the band, he suspected serious internal damage had occurred. He said that he partly withdrew the nasogastric tube which had been inserted on 20 July 2002 at 7.50am to the "level of the upper stomach". This was largely experimental and he was hopeful that may have relieved some pressure. He confirmed that if there was a blockage that it would have been difficult for the tube to pass the band

into the lower stomach. I note that the tube did pass. This is evident from Dr Treacy's evidence that he initially extracted the tube to the level of the upper pouch. There was no evidence of any difficulty experienced in inserting the tube.

46. He said that a full blockage at the band site would be necessary for necrosis to develop. Dr Gilhome largely agreed as he said that although a partial blockage could achieve the same result, it would need to very close to a total blockage in any event. He was therefore of the view that at least at the time that the barium test was taken that there was no total obstruction and consequently no necrosis as some of the barium had passed through.

47. Dr Treacy said that he agreed that Mr Dalgleish's condition would have been readily recognisable and treatable by someone with specific knowledge in the field. He agreed also that an obstruction is a straightforward complication of the surgery albeit that it can have lethal consequences if not addressed. Lastly he said that he did not think that the treatment of Mr Dalgleish on admission was satisfactory. He said that the key thing would have been the immediate insertion of a nasogastric tube. He said that this is standard treatment in the case of obstruction.

48. Dr Richard Gilhome, an expert in gastric banding surgery, had been engaged by the Coroners office to independently report on surgical aspects of this matter. He gave evidence via video conference link. He had provided an undated report which was included in Exhibit 1 as Folio No. 10.

49. In summary form his report states:

    (1) He considered that the report of the barium swallow test indicated blockage by a slippage of the band resulting in a large dilated upper pouch. He noted that some barium passed through into the lower stomach indicating that the blockage was not total.

(2) Noting the attendance of Mr Dalgleish at RDH Emergency Department in the early hours of 18 July 2002 complaining of "severe" abdominal pain, noting further that the symptoms did not abate by the time that Dr Bodnar assessed Mr Dalgleish, he said that at this point the band should have been totally aspirated and a nasogastric tube should have been inserted. He suspected that the increase in pain was due to the impending ischaemia and necrosis of the upper pouch. He estimated that necrosis started sometime between 3.00pm on 18 July 2002 and 3.00am on 19 July 2002.

(3) As at 3.00am on 20 July 2002, he suspected that the events of the preceding four to five hours were increasing the ischaemia of the stomach and that Mr Dalgleish had entered the final phase of septic shock. He considered that at this point the patient was suffering from a gangrenous stomach and had showed signs of peritonitis and ensuing septic shock.

(4) He noted that Dr Treacy first saw Mr Dalgleish at 10.00am on 20 July 2002 and he approved of Dr Treacy's action of removing all the fluid in the band and of the operative steps subsequently taken by Dr Treacy namely an initial laparotomy followed by a total gastrectomy. He was of the view that Dr Treacy then had no other option available to him.

(5) He disagreed with the conclusions of the Forensic Pathologist made in the autopsy report. Those conclusions are discussed in more detail below. Specifically he said that there was no evidence of thrombus in the cardio vascular system. He said that the micro infarctions of the liver, spleen and adrenals were consistent with a toxic septic episode which was in turn caused by the obstruction of the band. In his view, the obstruction was

due to slippage of the stomach through the band and not a food bolus as Dr Treacy thought.

(6) He concluded that the patient was not treated appropriately with regard to the obstruction. He concluded that if all the fluid had been removed on admission the patient may not have gone on to a necrotic stomach.

(7) He said that the aspiration of the band, nasogastric aspiration and subsequent observations were the required management as it was then only possible to determine whether surgical intervention was required.

(8) He also said that Dr Treacy should have been contacted at the time of the patient's admission to hospital.

50. In his evidence he impressed that the treatment plan first devised by Dr Bodnar was appropriate except that he said that a nasogastric tube should then also have been inserted. This omission however has to be looked at in light of Mr Dalgleish's informed decision to decline it after he had been fully advised of the need at the time.

51. At the time of preparation of his report he had only viewed the report of the barium swallow test and not the actual films. By the time he gave evidence he had actually viewed the x-rays. He said that although there was no evidence of slippage per se on the x-ray, he maintained his view that slippage had in fact occurred because the upper pouch is much larger (of the order of ten times) than the usual size. The herniation he said was also an indication. He said slippage occurs because the stomach, being a living muscle, can contract and wiggle its way through the band resulting in an increased size of the upper pouch. On the basis of this explanation, it occurs to me that it is possible that slippage might occur yet the band remains in a horizontal position. He said that optimally the upper pouch

should be of the order of 15 to 20 millilitres in size. He explained that as it becomes larger through the action of slippage, it can flop over the band and cause a blockage or simply the slippage itself can cause swelling leading to obstruction. He said that the key indicator in his view was the size of the pouch above the band which was much greater than normal.

52. Dr Treacy's view that there was no slippage was based on the horizontal alignment of the band (both on x-rays and as observed during the laparotomy) as well as the symmetrical shape of the upper pouch. Although Dr Gilhome agreed that these observations were relevant, he disagreed with Dr Treacy's conclusion. He said the important difference was the size of the upper pouch. Although Dr Treacy commented on the shape of the pouch, he made no mention of the significance of the size of the upper pouch. It was put to Dr Gilhome that another relevant factor which supported Dr Treacy's view was the sudden onset of pain as opposed to a gradual increase in the intensity of the pain. Again Dr Gilhome agreed that this was relevant but said that this did not change his view. Ultimately there is no need for a firm finding as to what precisely caused the obstruction. What is important is that there was a time at which Mr Dalgleish's gastrointestinal tract became sufficiently blocked at the location of his gastric band to cause increased pressure on the stomach which compromised the supply of blood to tissue at and above the band. According to Dr Treacy, tissue death is likely to have occurred soon afterwards. Dr Gilhome similarly gave evidence that there is only a very small window of opportunity once obstruction occurs.

53. Dr Gilhome confirmed that a point would have been reached when Mr Dalgleish's condition would have become irreversible. He estimated that the likely maximum available time from blockage occurring to corrective surgery is of the order of six to eight hours. He said that although it was difficult to determine precisely when Mr Dalgleish's stomach became necrotic, he would say that it was in the 24 to 36 hours preceding the time when the signs of septic shock became evident. According to the hospital

notes, he determined that septic shock was evident at 3.00am on 20 July 2002, hence on his reckoning, necrosis would have started sometime between 3.00pm on 18 July 2002 and 3.00am on 19 July 2002.

54. He said that the relevance of the insertion of the nasogastric tube is that it reduces gas in the stomach and any distention caused by that. The consequent reduction of volume of the pouch thereby reduces the pressure in the pouch. He said that by far the most important step would be the timely deflation of the band.

55. In cross-examination by Ms Sievers, although he noted the apparent signs of improvement in Mr Dalgleish's condition during the ward round conducted on 19 July 2002, he did not retreat from his views that the band should have been fully aspirated and a nasogastric tube inserted on the previous day. Moreover it was noted that following that ward round further observations recorded as occurring at 1.45pm on 19 July 2002 indicated to him that there was tenderness in the left upper quadrant of the abdomen. He said that the fact that there was tenderness despite the administration of analgesia was extremely significant.

56. Dr Terence Sinton was the Forensic Pathologist who performed the autopsy. His autopsy report was in evidence as part of Exhibit 1 (Folio 4). A pathology report in relation to the stomach had been separately tendered as Exhibit 4.

57. The autopsy report was largely uncontroversial but for one of the conclusions reached by Dr Sinton. He concluded that Mr Dalgleish died from peritonitis arising from acute gastric infarction of the stomach. His view was that the infarction was caused by a thromboembolism. Dr Gilhome, with whom Dr Treacy agreed, however concluded that the infarction of the stomach followed septic shock consequent upon the blockage and not a thromboembolism.

58. In his evidence however, although Dr Sinton maintained his view that the infarction of the liver, spleen and adrenal glands resulted from a thromboembolism, in relation to the infarction of the stomach he was prepared to agree that Dr Gilhome's view was more likely based on the additional information available. Dr Sinton had been disadvantaged by the absence of the gastric band at the time of the autopsy. All he saw at the time was a plainly gangrenous stomach and he attempted to postulate a cause of death based on the information he had available at the time. He now accepted that the problem derived from the gastric banding complication. In my view that must logically be so given that all seemed to agree that the death started with a sequence of events commencing with the necrosis of the stomach and that the infarction of the other organs appeared to be secondary to that.

59. In any event the difference between the views of Dr Sinton and Dr Gilhome is only in relation to the end result and precise mechanism of the cause of the blockage. Both agreed in any event that the blockage of the vessels caused by the increased pressure on the stomach ultimately lead to the infarction of the organs downstream. Either way, the apparent controversy which existed on the papers as to the mechanism of the cause of death is resolved.

60. It is apparent from all of the evidence placed before the Inquest that the death in this case arises because of a series of events involving a number of persons, with each contributing to a certain extent to the death. These events are:

(1) The failure to aspirate fluid from the band and to insert a nasogastric tube on 18 July 2002 (this would likely have prevented necrosis of the stomach occurring);

(2) The failure to aspirate any fluid from the band on 19 July 2002 (this may not have prevented necrosis of the stomach but would

likely have prevented the shutdown of the other organs which led to the death);

(3) The failure to note the instruction given during the ward round of 18 July 2002 to aspirate the band and to contact Dr Treacy.

(4) The failure of Dr Boldery to note his unsuccessful attempt to aspirate the band and to contact Dr Treacy.

(5) The failure by Dr Boldery to advise anyone of his failed attempts to aspirate the band or to contact Mr Treacy.

61. The events contributing to the death of Mr Dalgleish and occurring in consequence of the respective roles of the persons involved in his treatment, although not necessarily indicating fault on their part, are as follows:-

(1) Dr Bodnar:

Her failure to arrange aspiration of the gastric band and to insert a nasogastric tube following her consultation on 18 July 2002;

(2) Dr Read:

His failure to instruct Dr Bodnar to fully aspirate the gastric band and to insert a nasogastric tube at the time she conferred with him on 18 July 2002;

(3) Dr Navaratna:

His failure to adequately note the treatment plan decided upon by the surgical team during the ward round on 19 July 2002.

(4) Mr Bade:

(a) His failure to pursue the insertion of a nasogastric tube at the time of the ward round on 19 July 2002;

(b) His failure to ensure compliance by Dr Boldery of the instructions given him at the time of that ward round.

(5) Dr Boldery:

(a) His failure to comply with the instruction given by Mr Bade regarding aspiration of the band;

(b) His failure to contact Dr Treacy;

(c) His failure to advise Mr Bade of his unsuccessful attempt to aspirate the band and of his inability to contact Dr Treacy;

(d) His failure to advise any other person of his inability to aspirate the band and his inability to contact Dr Treacy;

(e) His failure to arrange for any other person to aspirate the band and to contact Dr Treacy in his stead;

(f) His failure to record in the hospital notes, details of his attempts to aspirate the band, that his attempts were unsuccessful and that he had been unsuccessful in contacting Dr Treacy.

62. Dr Bodnar's actions really cannot be faulted. Clearly she thoroughly examined Mr Dalgleish and her noting was close to exemplary. She cannot be faulted in relation to the failure to then insert the nasogastric tube given her evidence, which I accept, that she fully explained the importance, the likely benefits and consequences to Mr Dalgleish and that he made an informed choice to decline it at that point. Moreover as a junior Surgical Registrar she was not permitted to implement any treatment options without first referring the matter to the senior Surgical Registrar. This she did, namely to Dr Read. Dr Read confirmed that it was his decision to defer consideration of aspiration of the band until the following morning.

63. In relation to Dr Read, he cannot realistically be faulted in relation to the decision he made on 18 July 2002 to defer consideration of the aspiration of the band until the following morning, albeit that that decision was entirely wrong. I thought that his explanation to justify that deferral was plausible and reasonable. His error arose out of lack of knowledge of the treatment of complications of a specialist surgical procedure.

64. In relation to Dr Navaratna, the deficiencies in critical respects in his recording of the treatment plan decided upon at the ward round are inexcusable and are inexplicable except for his very junior status. In addition to the notes being deficient in minor respects, i.e., that it is misdated and does not indicate the time of the attendance, more importantly, it fails to record key instructions given by Mr Bade to Dr Boldery. The note records the relatively less important aspects of the treatment plan i.e., the continuation of intravenous fluids, the administration of a phosphate enema and the order for further abdominal x-rays. However the note omits any reference to the instructions for the removal of fluid from the band or for Mr Treacy to be contacted. That instructions along those lines were given is beyond doubt on the available evidence. Dr Gilhome gave evidence that in the circumstances it would have been 'routine' for the Consultant's instructions to be recorded by a Registrar or Resident. The significance of these deficiencies and the causal connection with the death are clear from the matters discussed above. The relevance of this is that those notes may have been significant to the Registrar and Resident who attended Mr Dalgleish overnight on 19 and 20 July 2002. They may have been alerted to further attempt the aspiration of the band. It may also perhaps have focussed their thoughts on the possibility of necrosis of the stomach and the need to perform a gastrectomy at that point. At the very least they may have called in a Consultant who may have considered those steps. Mr Bade said that calling a Consultant was something which should have occurred on that occasion. They may have thought to do so if armed with all that information.

Given that septic shock had not then commenced, although the stomach might not have been saved, the death could still have been avoided.

65. In relation to Mr Bade, noting that he first became involved in Mr Dalgleish's treatment during the ward round of 19 July 2002 and bearing in mind his role as the Consultant and leader of the surgical team, his decision to then aspirate the band was obviously the correct one. That has been clearly established and the evidence goes as far as to show that that should have occurred earlier. Mr Bade however is not responsible for that not having occurred earlier. He should also have directed the insertion of a nasogastric tube at that time. I do not however consider that the failure to insert a nasogastric tube at that time, or at any other time for that matter, was causative of the death based on Dr Gilhome's evidence that the insertion of the nasogastric tube is largely for the relief of symptoms.

66. I do not accept Mr Treacy's evidence that the blockage resulted from a possible food bolus. In my view the explanation given by Dr Gilhome, i.e., of slippage of the band, is more persuasive and is to be preferred. I note that Mr Bade shared Dr Gilhome's view. Although Dr Gilhome accepted the basis upon which Dr Treacy expressed his view (i.e., the horizontal finding of the band operatively, the lack of requisite clinical signs in the lead up and the symmetrical shape of the upper and lower pouch) the important consideration appears to be that the size of the upper pouch was significantly greater than the 15-20 millilitres which was the optimum. This was evident to Dr Gilhome on the x-rays. I note Dr Treacy made no comment at all about this. Moreover the explanation given by Dr Gilhome of the significance of the inflated size of the upper pouch is very convincing. In light of this it is my view that although the insertion of a nasogastric tube may have relieved symptoms, it could not have relieved the obstruction. For that reason I conclude that the failure to insert a nasogastric tube did not contribute to the death.

67. That therefore leaves only Mr Bade's reliance on Dr Boldery to comply with his instruction as the only possible basis to be critical of Mr Bade. Mr Bade said that he expected that Dr Boldery would have referred the matter back to him if he had difficulty in complying with the instructions he was given. He said he had this expectation as Dr Boldery had, in the past, referred back to him when he had difficulty in complying with instructions. This is all quite a reasonable expectation in my view and I therefore do not criticise Mr Bade on that account.

68. I cannot lay any blame on Mr Bade for the deficiency in the notes. It appears to be normal and accepted practice that a Registrar or a Resident makes notes at ward rounds. In the same way as Mr Bade was entitled to expect Dr Boldery would have complied with the instruction he gave, it is not unreasonable for Mr Bade to have expected Dr Navaratna to have competently completed those notes. In any event there is no certainty that Dr Boldery would have referred to the notes.

69. In relation to Dr Boldery, I consider that each of the faults that I have identified above were a significant contributor to the death of Mr Dalgleish. Although his inability to aspirate the band and to contact Dr Treacy may be excusable, his failure to put alternatives into place, to delegate completion of that instruction and most importantly to refer back to Mr Bade are all inexcusable. Moreover had those failures been recorded in the notes then that may have been of significant assistance to the staff that treated Mr Dalgleish when his condition deteriorated overnight on 19 and 20 July 2002. Dr Boldery's failure to check the case notes at the time that he attempted to aspirate the band is also significant. He was of the view, inappropriately on my findings, that until that time that the condition of Mr Dalgleish had not deteriorated and that supposedly gave him some comfort concerning his apparent failures. I doubt that he had proper basis to be of that view but in any event, had he seen the entry made at 1.45pm on 19 July 2002, he would have known that deterioration had commenced and I suspect that that would

have impressed upon him a greater urgency and a greater realisation of the need to ensure compliance with Mr Bade's instructions or to put alternatives in place.

70. It is significant that even if the band had been aspirated at the time when Dr Boldery left work on 19 July 2002, although the necrosis of the stomach would not likely have been prevented, there were still realistic prospects that the death would have been avoided. In my view on the evidence presented there were prospects that the death could have been avoided with appropriate treatment up to approximately 3.00am on 20 July 2002. The prospects were diminishing up to that time but nonetheless the prospects were real. Death however was inevitable when septic shock occurred at approximately 3.00am 20 July 2002.

71. In relation to Dr Treacy, he also cannot be criticised in relation to his involvement in Mr Dalgleish's treatment. There is no evidence to suggest that Mr Treacy's surgical procedure was flawed. Indeed the evidence is to the contrary as the complication developed a considerable time after the surgery and a considerable time after Mr Dalgleish last saw Dr Treacy. Nor can he can be criticised for his management of Mr Dalgleish while under his care and until the time of his death. Moreover the lengths he went to from the time that he was actually contacted by Dr Boldery at approximately 9.00am on 20 July 2002 until approximately 1.00am the following morning when he completed the gastrectomy were impressive and indicate a high level of dedication to his patient's care.

72. Likewise no fault can be attributed to Dr Goodhand, Dr Moore and Dr Forrest. Their treatment of Mr Dalgleish was entirely appropriate on his presentation to them at the various times.

CONCLUSIONS, COMMENTS AND RECOMMENDATIONS

73. Section 34(2) of *the Act* operates to extend my function as follows:

> "A coroner may comment on a matter, including public health or safety or the administration of justice, connected with the death or disaster being investigated."

74. Notwithstanding that I do not fault the actions of Dr Bodnar, Dr Read, Dr Treacy and Mr Bade, the simple fact of the matter here is that as a result of the interplay of a number of factors, Mr Dalgleish did not receive the appropriate and timely treatment for his surgical complication. The death flowed from that failure. By far the most significant of the factors was the lack of knowledge in relation to the specialist procedure of gastric banding on the part of the majority of RDH staff involved. To that extent it is excusable. Faults with the proper recording of matters in the RDH case notes and indirectly the supervision of junior medical staff also contributed to the death to a lesser extent. The fact remains that an avoidable death occurred as a result. The RDH remains responsible to the extent that its systems have failed and an avoidable death has resulted. It is therefore incumbent upon the RDH to take steps to redress the faults that I have highlighted above and to prevent recurrences.

75. Recognising that the complication experienced with the gastric banding procedure in this case was a straightforward one, recognising also the severe repercussions of not addressing that complication in a timely fashion leads me to conclude that further education of staff is required in relation to specialist procedures such as the gastric banding procedure. The significance of the complication and the severe consequences absent proper treatment was not known to most, if not all, of the RDH staff then involved. That the specific surgical procedure in this case is not performed at RDH is not the point. The important point is that patients presenting in an emergency situation suffering from complications such as in this case will, as occurred here, in all likelihood present to RDH. It is therefore consistent with sound medical practice and hospital management that staff are adequately trained in relation to procedures, and the complications of

procedures, where it is likely that a patient may present at the Emergency Department.

76. I appreciate that it may not be possible to cover all situations. Indeed, it would place too much of a burden on the RDH resources to expect that the guidelines that I recommend hereunder be prepared for all specialist procedures. However I think that it is appropriate that the various Consultants at RDH have input into the preparation of a set of guidelines in relation to at least those specialist procedures where, as in this case, there are known to be severe consequences absent appropriate and timely treatment of complications. Those guidelines should identify those complications and spell out the appropriate treatment and the relative importance or urgency of dealing with the symptoms in each case.

77. If such a guideline relating to the adjustable gastric banding procedure had been in existence before Mr Dalgleish's admission, then I expect that the death would have been avoided. Dr Treacy said the complication was a routine one and easily recognisable by someone experienced in the field. He described it as straightforward complication of that procedure. He also said that the consequences of not addressing it would be lethal. Sadly, he was proven to be correct in this case. Both Dr Treacy and Dr Gilhome said that the treatment of aspiration of the band and insertion of the nasogastric tube was fundamental. From that I conclude that had such a guideline existed then the aspiration of the band would then have occurred at the least would have occurred at the latest on 18 July 2002 when Dr Bodnar conferred with Dr Read. Conceivably it might even have occurred following the assessment of Mr Dalgleish by Dr MacNair earlier that morning. Anticipating that the guideline would also specify further action required following that step, I expect that the appropriate surgical intervention would have then occurred in a timely manner. I am of the view that as a result a death would have been avoided. Therefore I think that it is appropriate that the necessary resources be directed to preparation of such guidelines or some suitable alternative.

78. Another contributing factor related to the case notes. This has two aspects. Firstly, the quality of the note recording by Dr Navaratna, a then newly appointed junior staff member. Secondly, the failure to record important matters by Dr Boldery. I am not convinced that a requirement such as that a more senior medical officer to the Resident check the accuracy and adequacy of the notes is appropriate. It will intrude on the time and resources of more senior medical personnel and would be unreasonable to that extent. Some better education of junior staff members in relation to the requirements and importance of proper and thorough noting should suffice. That should routinely occur as part of the normal induction training.

79. Dr Boldery however was far from being a newly appointed junior member of staff. I expect that he knew better and that he must appreciate the serious deficiency in his noting. If so then the RDH has done all that can reasonably be expected in that regard. The avoidable death in this case may well be the occasion for a reminder to all medical staff of the requirement for, and the importance of, proper and thorough noting.

Dated this 11th day of February 2004

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V M LUPPINO
CORONER