Anaesthetic and post-Anaesthetic Nursing– from Induction to Emergence and beyond.

Lessons to be learnt from the Coronal Jurisdiction

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“We speak for the dead to protect the living”
Overview of Coronal System

• Inquisitorial rather than adversarial
• Judicial model not medical examiner model
• May identify system failures or inadequacies
• May make recommendations
• Prevention focussed
NOT A CORONER
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The role of the Coroner

• Investigate reportable deaths
• Make findings as to
  • Identity
  • Cause of death
  • Circumstances of death
Reportable Deaths

Death is connected with Victoria and
Death is:
– unexpected
– accident or injury
– violent or unnatural manner
– during or following a medical procedure
– death occurred in ‘care or custody’
– under control or custody of the Secretary of the Dept of Justice or Victoria Police
– death of a patient within the *Mental Health Act 2014* (Vic)
– identity is unknown
– medical practitioner not signed a death certificate
Reportable deaths – Medical Procedures

- A death is reportable if the death occurs during a medical procedure or following a medical procedure (where the death is or may be causally related to the medical procedure), and where a registered medical practitioner would not have reasonably expected the death.

- The term ‘medical procedure’ is defined as being a procedure performed by, or under the general supervision of, a registered medical practitioner and includes imaging, internal examination and surgical procedures.

- Note: the new definition of a reportable death replaces the former references to ‘during’ or ‘as a result of an anaesthetic’ (as contained in the Coroners Act 1985).
Duty to report deaths

- Coroners wait for a death to be reported to them.
- Whilst doctors must report reportable & reviewable deaths, any person (including nurses) who has reasonable grounds to believe that a reportable death has not been reported must report it to a Coroner or the Police.
- 20 penalty units (each unit $151.67) for failure to report
Coronial Investigation
Distinguishing features in medical matters:

- family concerns/complaints
- clinical course and medical management unclear from medical records
- poor and/or inadequate documentation
Inquests
Recurring themes in medical matters

- **poor flow of information:**
  - within hospitals
  - between hospitals and other institutions

- **poor communication:**
  - between healthcare workers
  - with families

- **failure to recognise & treat departures from a “normal” clinical course**

- **failure to escalate**
Recurring themes in medical matters

- delayed/incorrect diagnosis (importance of vital signs observations)
- failure to act when a patient is not responding to treatment
- discharge plan and communication to families
- high risk medications and
- documentation
Coroner’s findings may go to...

- the Attorney-General
- the Ministers of Government
- any relevant organisation or government body
- Australian Health Practitioner Regulation Agency
- hospital/aged care/mental health facility in question
Professional accountability in the Coronial System

- Coroners do **not** determine guilt or apportion blame
- Aim of investigation is generally to ascertain whether **adequate systems** were in place
- Even if system not sufficient/fails, there must be a causal link between insufficiency/failure and cause of death
  - any problems in patient management & emergency protocol
  - safety procedures & information provision
  - staff training & communication
- Was the death **preventable**?
Professional accountability

- Adverse Finding
  - Matter referred to professional organisation/OPP by Coroner
  - Matter referred to professional organisation by another party
Recommendations
CASE 1

- Ms K gave birth on 26 December 2004 at 20.37hrs
- third stage of labour incomplete
- to theatre for MRP
- arrested at 10.27hrs – resuscitated ~ 40 mins
- spontaneous return of circulation – large bleed noticed
- hysterectomy & t/f to ICU
- irreversible brain injury – Rx withdrawn, Ms K died shortly after
CASE 1 (con’d)

- Cause of death (COD) - hypoxic brain injury complicating cardio-respiratory arrest during manual removal of placenta (under spinal anaesthetic) following postpartum haemorrhage

- Issues at Inquest included
  - observations in birthing suites prior to t/f to theatre for MRP
  - amount of blood lost and how is was measured
  - whether fluid resuscitation was appropriately tempered
CASE 1 (con’d)

Complicated by:

- lack of documentation of blood loss
- lack of certainty re blood loss (estimates)
- lack of documentation regarding fluid resuscitation
- Inquest years after event – clinicians unable to recall

Especially important as the deceased’s family submitted that Ms K died as a result of unrecognised post partum haemorrhage

COD amended to include ‘in the presence of a patent foramen ovale’
Case 2

- Ms P for elective termination of pregnancy at 21 weeks at day procedure clinic (no emergency/ICU facilities)
- two Physicians involved in procedure
- from the outset of the investigation, there appeared to have been an issue with the function of the patient monitoring equipment in theatre
- surgery proceeded with the patient apparently being in part manually observed
CASE 2 (con’d)

- Ms P arrested intraoperatively, medical staff commenced resuscitation
- return of circulation with inotropes (?down time), t/f to Hospital ED, t/f ICU, CTB – extensive cerebral oedema consistent with hypoxic brain injury
- Ms P died 4 days later
- COD: unascertained, although anatomical finding of global cerebral ischaemia noted
- Issues explored at Inquest:
  - appropriateness of continuing with the procedure in the absence of a workable pulse oximeter
  - adequacy of the documentation during the procedure
  - qualifications of the medical and nursing staff
Case 3

- Mrs M was a 69 year old woman with a hx of Crohn’s disease, recurrent rectal bleeding, total colectomy and ileostomy with a remaining 6cm rectal stump.
- Presented to GP with recurrent rectal bleeding → gastroenterologist for colonoscopy.
- Gastroenterologist booked Mrs M in for gastroscopy and a flexible sigmoidoscopy at an Endoscopy centre.
Case 3 (con’d)

• On day of procedure Mrs M was admitted for preoperative assessment.
• Bowel preparation involved the administration of a fleet enema → abandoned
• Surgery (gastroscopy, colonoscopy with flexi sigmoidoscopy to examine the 6cm rectal stump) proceeded without incident. Biopsies taken.
Case 3 (con’d)

- Anaesthetic:
  - Initially a “small amount of sedation”
  - Early in the procedure another 100 micrograms of Rapifen and 20-30 milligrams of Propofol

- Post operatively
  - Transferred to recovery ward for observation
  - 45 minutes later Mrs M was still unrousable
Case 3 (con’d)

Transfer to hospital

- Approximately 2 hours after reporting that Mrs M was unrousable she was transferred to the RMH. GCS3 recorded by paramedics.

- CTB = diffuse watershed and cortical infarction with increased mass effect and evidence of increased intracranial pressure with uncal herniation.

- Mrs M died 2 days later
Case 3 (con’d)

Coronial Investigation

- Medical cause of death = “Hypoxic brain injury in the setting of general anaesthetic and sigmoidoscopy for investigation of gastrointestinal haemorrhage.”
- Letter of concern from Mrs M’s daughter
- A number of issues about Mrs M’s anaesthetic and post operative management identified.
- Assisted by the HMIT (now CPU)
Common themes...

- Poor documentation
- Inadequate handover
- Communication lacking
- Inadequate risk assessments
Documentation is your best defence

- Critical evidence
- Legal document
- *Aide memoir*
- Means of communication between clinicians
- Getting questioned about your notes years down the track.
- Addendums – write notes at home if need be and add as retrospective note next shift
- Don’t change dates
- Won’t be criticised for retrospective notes
- Document that have spoken with other clinicians
- Poor documentation can lead to inquests
Some tips.....

• Aim for best practice
• Maintain accurate documentation
  – clear notes
  – write notes immediately after an incident to refresh your memory
  – be truthful
• Be aware of applicable policies and procedures
• Risk assessments
• Handover
• If in doubt, speak to your employer and request legal advice
• Don’t embellish or over exaggerate your recollection
• You will be assessed/questioned and asked to explain
• Deaths – affect clinicians too!
Any questions?