
FINDINGS and RECOMMENDATIONS of Coroner Rod Chandler following the holding of an inquest under the *Coroners Act* 1995 into the death of Neita Jean Little.

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Record of Investigation into Death (With Inquest)

Coroners Act 1995
Coroners Rules 2006
Rule 11

Hearing Dates

3, 4 and 5 July 2017; 31 July 2017

Representation

Counsel Assisting the Coroner	Mr Jody Dennison
Counsel for Dr Jensen	Mr Phillip Harris
Counsel for Dr Stolk	Mr Aled Vince
Counsel for North West Private Hospital	Mr Paul Lamb
Counsel for Mr Albert Little	Mr Rod Glover

Introduction

1. On 28 June 2014 Mrs Neita Jean Little died at the North West Regional Hospital (NWRH) in Burnie following surgery carried out four days previously at the nearby North West Private Hospital (the Private). An inquest has been held concerning the death and these are the resultant findings.

Background

2. Mrs Little was born on 25 November 1934 and was aged 79 years. In 1956 she married Albert Algernon Little and for the duration of their marriage resided at 32 Franklin Street, Brooklyn in Burnie. They had three children.
3. Mrs Little's past medical history included atrial fibrillation, hypertension and morbid obesity. At post-mortem her weight was recorded at 116.4 kg and her body mass index was calculated at 43 kg/m². Previous surgery included a laparotomy and gall bladder removal.

4. In May 2014 Mrs Little consulted general practitioner, Dr Lyn Armitage, because of gynaecological difficulties and she was referred to obstetrician/gynaecologist, Dr Raymond Jensen. On 26 May Mrs Little saw Dr Jensen. It was apparent that she was suffering from severe genital collapse and that she required surgery in the form of a vaginal hysterectomy with anterior and posterior vaginal repair. Arrangements were made for this procedure to be undertaken by Dr Jensen at the Private.

Circumstances Surrounding the Death

5. I am satisfied upon the evidence that Mrs Little's death occurred in the circumstances which follow.
6. In the morning of 24 June 2014, Mrs Little was admitted to the Private as a patient of Dr Jensen. That afternoon he carried out a total hysterectomy with anterior and posterior vaginal repair as planned. The anaesthetist was Dr Boudewijn Stolk. The surgery was uneventful and Mrs Little was returned to the ward at 4.45pm after an unremarkable stay in the recovery room. Her vital signs during the night were satisfactory. The next morning she was reviewed by Dr Jensen and shortly afterwards by Dr Stolk. The latter directed that she not have her usual antihypertensive medication. Later that morning Mrs Little became hypotensive but a haemoglobin measurement ordered by Dr Stolk showed her haemoglobin level to be within the expected post-operative range. She was given an intravenous fluid bolus. An hour later Dr Stolk reviewed Mrs Little again and he then arranged for her to be transferred to the High Dependency Unit (HDU) for closer monitoring of her vital signs and fluid balance.
7. In the HDU Mrs Little was noted to be confused at times but afebrile and stable. At this time Mr Little expressed to nursing staff his concerns for his wife's possible deteriorating mental state. This entry was made in the nursing notes: *"Staff have been concerned re patient's mental state as well. Writer reassured husband that we will organise post-acute program for personal care and domestic assistance when patient is discharged. Also send referral to Older Person's Mental Health assessment team and discharge summary to Dr Reynold's (Mrs Little's G/P) highlighting our and husband's concerns."*
8. Dr Stolk reviewed Mrs Little in the morning of 26 June. She was passing adequate amounts of urine and her vital signs were within normal limits. He was satisfied with

Mrs Little's progress and was content for her to be transferred back to the ward. He informed Dr Jensen that he was handing Mrs Little's care back to him. The balance of the day was uneventful. It was noted at 4.00pm that she was *"drinking well"* and at 7.30pm that she was *"Tolerating diet and fluids."*

9. Dr Jensen saw Mrs Little at 8.45am on 27 June. At this time it was recorded by nursing staff that he was happy with her progress and that she was to be discharged on the upcoming Monday, being 30 June. Clinical observations taken that day indicated that Mrs Little was afebrile, normotensive, with a heart rate of 83-84bpm, a respiratory rate of ~ 18 breaths per minute and a saturation rate of 98%.
10. In the late afternoon Mr Little visited his wife in the hospital. He had with him a land transfer document which required her signature. He later left the hospital and returned the transfer form to the lawyers. He then had some time at his bowls club before returning to the hospital. Together, Mr and Mrs Little then watched an AFL football game on television. Mr Little said that at the game's end he left the hospital and went home. He said that the time was then around 11.20pm. However, there has been put into evidence a copy of a report upon the game which records the final result and is shown to have been published that night at 10.20pm. This leads me to conclude that Mr Little is incorrect in his estimate of the time he left the hospital and that he more probably departed around one hour earlier or a little more. It was Mr Little's further evidence that during that evening his wife was her *"happy self"* and she *"certainly never indicated to me that she felt unwell."*
11. The Private records show that at 6.30pm Mrs Little had an episode of vomiting. (This must have taken place before Mr Little's return to the hospital). Specifically the records state; *"Tolerated small meal. Vomited x 1 @ dinner time. Pt stated, 'It's just sudden.' Nil dizziness and nausea – complained. Pt vomited gastric content approx. – 200mls. Settled after that."* At 8.00pm Mrs Little was given a 4mg dose of the anti-emetic drug Ondansetron which was recorded to have had *"good effect."* At 9.55pm there was a nursing shift handover and Registered Nurse Paula Smith assumed Mrs Little's nursing care.
12. At about 10.50pm Mrs Little rang the nurse call bell. Nurse Smith responded. Mrs Little reported that she had experienced the sudden onset of nausea and vomiting. The vomit comprised approximately 200mls of undigested food. Mrs Little's clothing and linen were changed and she was administered a further 4mg dose of

Ondansetron. At around midnight Mrs Little vomited again. It is recorded as being approximately 50-100mls in volume, brown in colour and non-offensive. Nurse Smith attended. Mrs Little was assisted to sit in a recliner chair whilst her bed linen was changed. She was noted to be alert, co-operative and able to converse with staff. She was assisted to the bathroom and voided in the toilet. It was noted that she also passed flatus.

13. At approximately 1.25am on 28 June, Mrs Little vomited for the fourth time. Again it was about 50-100ml in volume. Following this episode Nurse Smith telephoned Dr Jensen. She explained that Mrs Little was experiencing ongoing nausea and vomiting despite the two doses of Ondansetron. He provided a telephone order for the alternative anti-emetic, Metoclopramide, and Nurse Smith administered a 10mg dose at 1.30am by intramuscular injection.
14. Mrs Little next vomited at around 3.00am. She used the nurse call bell and Nurse Smith again responded. Mrs Little needed to use the toilet and she was accompanied to the bathroom. She was then assisted back to bed. In her affidavit Nurse Smith describes events at this point in these terms:

“Mrs Little was able to lift her legs back into bed with relative ease, with minimal assistance required. Mrs Little denied any pain or discomfort. I attended Mrs Little’s vital signs observations: Blood pressure normotensive. Afebrile. Heart rate initially elevated on oxygen monitor post exertion, poor wave form noted. Radial pulse palpated with heart rate settling at rest. Strong, irregular pulse 95-100 beats per minute. Peripherally warm and well perfused. Oxygen saturation was 88% on room air. In response I applied oxygen via nasal prongs at 2-3L per minute. I encouraged Mrs Little to perform deep breathing exercises. Mrs Little’s oxygen saturation level increased to >95% and the dyspnoea resolved.”

15. At about 6.55am Mrs Little was heard calling out. She was attended by Nurse Smith and was found sitting on the edge of the bed. She appeared confused. Further brown fluid emesis was noted on her gown. It was changed. She was re-oriented and re-positioned in her bed. Her oxygen therapy remained in situ with *“nil dyspnoea noted.”*
16. The morning shift for the nursing staff commenced at 7.00am and Registered Nurse Jennifer Cantley took over Mrs Little’s care. Also on the morning shift was Enrolled

Nurse, Ms Elizabeth van der Linde-Keep. At about 7.30am Mrs Little called from her room. She was confused about her whereabouts and the location of her clothes and toiletries. Enrolled Nurse van der Linde-Keep went to her room and re-assured her. At 8.00am Nurse Cantley gave Mrs Little her medication. At about 8.30am she next attended Mrs Little to check if she had eaten any breakfast. Some spilt milk was seen on the breakfast tray and floor. Mrs Little said she *“wasn't hungry anyway.”* Approximately 45 minutes later she again attended Mrs Little. She was detached from the supplemental oxygen. There was evidence of coffee-ground vomit on her gown. Nurse Cantley assisted her to have a shower. Mrs Little then cleaned her teeth, applied some makeup and was then assisted back to her bed.

17. Dr Jensen visited Mrs Little that morning, sometime between 9.45am and 10.00am. He had not had any communication concerning Mrs Little since his phone conversation with Nurse Smith at around 1.25am. Nurse Cantley was with Dr Jensen and advised him that Mrs Little had been vomiting and had required oxygen overnight. She obtained a monitor and undertook a set of observations. Of these she only recorded the temperature, being 36.5C and the oxygen saturation level of 91%. She considered the latter to be a little lower than ideal so she *“put oxygen back on her at that stage”* via nasal prongs. At the same time Dr Jensen carried out his examination. There is conflicting evidence between Dr Jensen and Nurse Cantley concerning the thoroughness and duration of the medical examination. Their evidence conflicts too upon the discharge plan set for Mrs Little. These are matters which I will address in more detail later. At this time it's sufficient for me to record that following his examination Dr Jensen left the ward and then made this entry in the records:

“Afebrile. Looks well.

Pulse ✓ BP ✓

Voiding well.”

18. At about 10.25am Mrs Little called out from her room. Nurse Cantley responded. She noted that she had vomited some coffee-ground vomit and mucous. Nurse Cantley changed Mrs Little's gown and placed some towels on her chest. She then rang a nearby ward and asked that Dr Jensen be requested to return to attend Mrs Little. By this time Mrs Little had noisy, wet respirations. Nurse Cantley pressed the Emergency Assist bell and nursing staff along with Obstetrician/Gynaecologist, Dr

Tania Hingston, attended. It was her impression that Mrs Little was experiencing acute pulmonary oedema. Despite being a hospital the Private did not have the resources to deal with an emergency of this nature. Accordingly, a call was made to Ambulance Tasmania (AT) and its records show that an ambulance was dispatched at 10.29am and arrived at the Private 6 minutes later. Mrs Little was then transported by Ambulance to the NWRH arriving at 10.55am.

19. In the NWRH's Emergency Department Mrs Little was unresponsive. She was intubated and a naso gastric tube inserted. Coffee-ground vomit was suctioned from the tube. A mobile chest x-ray showed widespread pulmonary oedema. A CT scan of the brain did not show an acute event or infarct. A CT pulmonary angiogram did not show a pulmonary embolus but did show extensive basal consolidation along with bilateral pleural effusions. A CT scan of the abdomen demonstrated a large pelvic haematoma.
20. Mrs Little was transferred to the Intensive Care Unit. Her admission diagnosis was stated to be aspiration pneumonitis. During the afternoon and early evening Mrs Little's condition gradually deteriorated despite maximal medical support. At around 5.30pm she experienced a cardiac arrest. She could not be resuscitated and was declared deceased at 5.37pm on 28 June 2014.

Post-Mortem Examination

21. This was carried out by forensic pathologist, Dr Donald Ritchey. His autopsy revealed: *".....heavy congested lungs that microscopically had aspiration pneumonia. There were large distended loops of small bowel and marked peritoneal adhesions supporting the clinical suspicion of small bowel obstruction. In addition there was a large volume haematoma within the surgical site above the vaginal cuff in the region of the resected uterus. The surgical site was without evidence of localised infection and the sutures appeared intact."*
22. In the opinion of Dr Ritchey the cause of Mrs Little's death was *"aspiration pneumonia that was caused by aspiration of emesis that developed because of an evolving small bowel obstruction that in turn was caused by the combined effects of longstanding peritoneal adhesions (the result of remote surgery to remove the gall bladder) in addition to a large volume haematoma (blood clot) that developed at the site of the resected uterus."* Other significant factors which contributed to the death

were Mrs Little's atherosclerotic and hypertensive cardiovascular disease and her morbid obesity.

The Issues for Consideration

23. The facts surrounding Mrs Little's death give rise to the following issues, each of which I will consider in turn:

- 1) The cause of death.
- 2) Mrs Little's nursing and medical care, particularly with reference to:
 - i. The involvement of Dr Stolk.
 - ii. The response to Mrs Little's presentation at 1.25am on 28 June.
 - iii. The response to Mrs Little's presentation at 3.00am on 28 June.
 - iv. Dr Jensen's attendance upon Mrs Little on 28 June.
 - v. The ambulance transfer system.
- 3) The Private's response to the death.

24. My consideration of these matters was assisted by the evidence of Dr A J Bell in his capacity as medical adviser to the coroner and by consulting intensivist, Dr David Cooper, who was retained by Dr Jensen.

The Cause of Death

25. I accept the cause of Mrs Little's death to be aspiration pneumonia, this being the unanimous opinion of Drs Ritchey, Bell and Cooper. I accept too that the pneumonia was attributable to an aspiration of emesis or vomit, that event occurring at around 10.20am on 28 June 2014. In turn I am satisfied, accepting the evidence of Dr Ritchey, that the emesis was a consequence of an evolving bowel obstruction which was attributable to two factors. The first was longstanding peritoneal adhesions which had resulted from Mrs Little's previous gall bladder surgery. The second was a haematoma or collection of blood which was a complication arising from the surgery undertaken by Dr Jensen.

The Involvement of Dr Stolk

26. As already recorded, Dr Stolk was Mrs Little's anaesthetist for the purposes of her gynaecological surgery. I am satisfied that the care he provided to Mrs Little was

appropriate and did not in any way contribute to her death. In particular, I make these specific findings:

- That Rivaroxaban, the blood thinning medication being taken by Mrs Little as a thrombosis prophylaxis, was ceased at an appropriate time, pre-surgery.
- That Mrs Little's anaesthesia management during the course of her surgery and immediately post-surgery was unremarkable and appropriate. This includes the treatment of her hypotension which presented in the morning of 25 June.
- I have noted that at autopsy Dr Ritchey found a large volume haematoma within the surgical site. This raises the question whether this should have been detected by Dr Stolk before he handed over Mrs Little's care to Dr Jensen on the morning of 26 June. It seems clear on review that Mrs Little suffered a post-operative haemorrhage and this was the likely cause of her hypotension presenting on 25 June. The hypotension was successfully managed by Dr Stolk and I am satisfied that when she was transferred back to a ward on 26 June her signs and symptoms evident at that time did not suggest ongoing bleeding or the presence of a significant haematoma. There was therefore not in my view any reason for further diagnostic steps to be taken at that time. For these reasons I do not believe any criticism should be made of Dr Stolk for the non-detection of the haematoma whilst he was responsible for Mrs Little's care.
- For the reasons stated earlier, Mrs Little suffered from a bowel obstruction attributable to adhesions which were a result of her earlier gall bladder surgery. Dr Stolk's non-identification of this complication does not, in my view, merit any criticism. First, I note the evidence that a bowel obstruction following a vaginal hysterectomy is a rare complication. Second, I am satisfied that Mrs Little did not present with any symptoms which should have alerted Dr Stolk to the possibility of this condition whilst she was in his care. Finally, I note and accept the opinion of Dr Bell that Dr Stolk should "*absolutely not*" have appreciated a bowel obstruction to be a possible diagnosis.

The Response to Mrs Little's Presentation at 1.25am on 28 June

27. When Nurse Smith telephoned Dr Jensen in the early hours of 28 June, Mrs Little had over the previous seven hours vomited on 4 separate occasions notwithstanding

that she had been administered an anti-emetic. Dr Jensen's response was to authorise an alternative anti-emetic and nothing more. This circumstance gives rise to the question whether Dr Jensen's response was sufficient and represented good practice.

28. It was the opinion of Dr Bell that a patient who continues to vomit and does not respond to an anti-emetic is a cause for concern. Nevertheless, it was his view, in the circumstances of this matter, that Dr Jensen's response to Nurse Smith's early morning call was reasonable. Dr Cooper expressed a similar opinion. This uncontradicted opinion evidence leads me to find that Dr Jensen did respond appropriately when phoned by Nurse Smith.

The Response to Mrs Little's Presentation at 3.00am on 28 June

29. I have set out earlier in these findings Nurse Smith's response following Mrs Little's fifth episode of vomiting occurring at around 3.00am, along with her episode of desaturation. It did not include making further contact with Dr Jensen or seeking emergency medical help. The question arises whether this response was adequate in the circumstances.
30. It was the opinion of Dr Bell that the episode of desaturation, particularly in the context of repeated vomiting should have been a matter of concern. It required investigation, initially by imaging and the making of a diagnosis. Dr Cooper accepted that the events occurring around 3.00am were "*significant*" and represented a "*clear change in her condition.*" This exchange took place between him and counsel for Mrs Little's family:

Question: "Is it fair to say then that the significant event that gave rise to the change in circumstances was the 3 00am event where there was a change in the sense that the oxygen saturation level dropped?"

Answer: "This-I believe so. This was the first sign that there was a potential or respiratory compromise as a result of something that was-something going on. She'd had an operation on her abdomen, the expectation at this stage is not that she is going to have-develop chest problems, so at 3 o'clock in the morning that is the time at which I would have expected that Dr Jensen should have been notified

that there would have been-that there has been some sort of change in her condition.

Question: *“So Dr Jensen should have been notified and investigations done at that time?”*

Answer: *“At that time, I believe so. I believe it would have been prudent for her to have been reviewed by a medical officer and on the basis of that review a chest x-ray would almost certainly have been organised at that time.”*

31. Relevant to this issue, Dr Jensen said that had he been informed of Mrs Little’s condition at around 3.00am including her desaturation that he would not have been “*over alarmed*” and that it would not have caused him to change her management.
32. I accept the clear opinion evidence of both Drs Bell and Cooper and find that those events occurring at around 3.00am, most particularly the episode of desaturation, were significant and required Nurse Smith to report them to Dr Jensen. Further, I find that those events were sufficiently significant to require a medical review which should have included imaging. As Dr Cooper said, there was a need for an x-ray; *“to look at what was going on within the chest, whether or not there was any sign of aspiration or of basal atelectasis or of pulmonary oedema or of any one of a number of possibilities that could cause a night time desaturation in an elderly patient with multiple comorbidities.....”*
33. As events evolved, Mrs Little was not medically reviewed nor x-rayed in the early hours of 28 June and hence it is not known what these steps may have revealed. On the one hand they may have revealed nothing. On the other they may have enabled a diagnosis of her condition and led to an appropriate treatment response. In these circumstances all that the evidence permits me to do is find that Mrs Little’s presentation at around 3.00am on 28 June should have served as a red flag to her carers which prompted a medical review along with imaging and the failure to take these steps denied her the possibility of a diagnosis and the initiation of treatment at a time which may, if successful, have avoided her death.

Dr Jensen’s Attendance Upon Mrs Little on 28 June

34. As I have stated earlier there is a conflict in the evidence concerning Dr Jensen’s examination of Mrs Little and the plan for her discharge.

35. It was the evidence of Nurse Cantley that she was present when Dr Jensen examined Mrs Little. She says that Dr Jensen was in Mrs Little's room for a total of about 15 minutes but only a portion of that time involved the physical examination. During the balance he conversed with Mrs Little including a discussion about the health and capacity of his own mother. She said the physical examination was brief and comprised listening to Mrs Little's lungs with a stethoscope and prodding her in the abdomen whilst Nurse Cantley assisted her to sit forward. She said that Mrs Little was unable to sit forward by herself and was breathless when she did so. She did not have any recollection of Dr Jensen inspecting her vaginal area. For his part Dr Jensen says that he spent 20 to 25 minutes with Mrs Little and that his examination was thorough, more so because he was aware of her presentation during the early morning. Following his examination he concluded that Mrs Little was recovering well and that there were not any issues of concern. Notably he considered her oxygen saturation to be normal and unlike Nurse Cantley did not detect any breathlessness.
36. Whether Dr Jensen's examination took 25 minutes or a lesser time is not particularly material. What is more important are the events that followed. In my view Nurse Cantley was a most credible witness. It was her evidence, which I accept, that following his examination Dr Jensen indicated that Mrs Little was fit to be discharged home that day. Too, it was Nurse Cantley's evidence, again which I accept, that she challenged the notion that Mrs Little was fit for discharge. She reminded Dr Jensen of her ongoing vomiting and the oxygen saturation issue but felt that he was "*not processing the information that (she was) trying to impart.*" Further I accept that she informed him that an assessment had been arranged for the Monday for a post-acute care package and this assessment could only occur if Mrs Little was an in-patient.
37. I am satisfied that Dr Jensen did form the view that Mrs Little was fit for immediate discharge. This is consistent with the outcome of his examination and his assessment of her state of health. It is also consistent with the absence of any plan put in place for her ongoing care. Too, it is consistent with the corroborative testimony of Enrolled Nurse van der Linde-Keep who said that Nurse Cantley informed her, following the examination of Mrs Little, that Dr Jensen believed that she was fit to go home. Enrolled Nurse van der Linde-Keep's response was: "*What, are you kidding me?*"

38. Although I am satisfied that Dr Jensen considered Mrs Little fit for discharge, it is clear that he nevertheless permitted her to remain in hospital. I deduce that the sole reason for this was in recognition that Mrs Little was required to remain an inpatient until the acute-care assessment could take place on the upcoming Monday. This is consistent with the evidence of Mr Little who testified that he spoke to his wife by telephone shortly after Dr Jensen's visit and *"She sounded bright and well. She told me that she was up, the nurse had showered her, she had her hair set and that the Dr had seen her. She said that Dr Jensen told her that she should be able to go home on Monday after they had a nurse come to see her about showering and being able to get around at home."*
39. This brings me to the question whether Dr Jensen's decision that Mrs Little was fit for discharge was reasonable and represented appropriate medical care. Mrs Little was four days post-surgery. In the 15 hours prior to her examination by Dr Jensen she had vomited on seven occasions (although she was taking an anti-emetic), the last of these just 30 minutes before his attendance. Because of nausea she did not have an appetite and the evidence suggests that she had not opened her bowels since the surgery. Further, there was the issue of her oxygen saturation level. I have referred to the episode at around 3.00am when it fell to 88% but was restored to 95% with oxygen. When it was next checked by Nurse Cantley at the time of Dr Jensen's attendance, the level was 91% prompting her to maintain oxygen support. There was evidence that an oxygen saturation level of 91% was within the normal range, albeit at the lower end. However, an examination of Mrs Little's observation charts over the duration of her hospital stay indicates that in the main her oxygen saturation level was recorded in the high 90's and never, prior to 28 June, fell below 93%. For her a level of 91% was below the norm. To my mind the foregoing paints a picture of a patient who was not fit to be discharged on 28 June and I find accordingly. This conclusion coincides with the opinions of Drs Cooper and Bell. How then should Mrs Little have been managed?
40. It was the evidence of Dr Cooper that Mrs Little's proper management required her to be monitored over the upcoming two days. Whilst Dr Bell agreed that the 'wait and see' approach was an option, he felt that a more prudent approach would be to initiate investigations. A first step was to have Mrs Little x-rayed. In the circumstances I favour Dr Bell's opinion. However, it has to be acknowledged that even if Dr Jensen had taken this approach and ordered an x-ray following his examination that morning

such x-ray could not have been done and acted upon prior to that fateful event which led to Mrs Little's transfer to the NWRH.

The Ambulance Transfer System

41. An issue considered by this inquest was whether transferring a patient such as Mrs Little by ambulance from the Private to the NWRH rather than by alternate means was in the best interests of the patient. The evidence on this subject establishes that:

- 1) In the early 1990's the Private was built at Brickport Road in Burnie. At this time the NWRH was located at Edwards Street in Burnie. The two hospitals were approximately 3kms apart.
- 2) After the Private was established an arrangement was put in place for AT to respond to a patient emergency at the Private on a needs basis. Often it was necessary for the patient to be transported to the NWRH for emergency treatment.
- 3) The NWRH re-located to Brickport Road in the late 1990's. A medical centre separated it and the Private. The two hospitals were linked by a covered walkway.
- 4) Shortly after the NWRH's re-location a protocol was settled whereby patients of the Private requiring emergency treatment were conveyed by gurney via the walkway to the NWRH. This arrangement made AT's involvement in the patient transfer unnecessary.
- 5) Sometime in 2010 the NWRH notified the Private that the protocol was at an end. AT was informed and advised that henceforth it was required to respond to emergency calls from the Private and when necessary to convey, via ambulance, any patient of the Private requiring emergency attention at the NWRH. This arrangement was in place on 28 June 2014 and explains the involvement of AT in Mrs Little's transfer.
- 6) The Private recognised that the transfer of its emergency patients by ambulance, given the close proximity of the two hospitals, was less than ideal and over the following years participated in negotiations with the NWRH to settle on an alternative system.

- 7) By 2016 the NWRH had put in place a Medical Emergency Team (MET) protocol which provided that the NWRH would provide a MET service to manage patients of the Private requiring emergency attention. Any such patients requiring transfer to the NWRH would ordinarily be conveyed via the walkway as previously. This made AT's involvement redundant.
 - 8) Although the new MET protocol came into effect on 23 February 2016 AT was unaware of its existence until May 2017 when informed by investigators preparing for this inquest.
42. It is self-evident that the patient transfer system in place at the time of Mrs Little's hospitalisation was cumbersome and potentially exposed patients to a delay in receiving urgent medical treatment. Its replacement by the current protocol is a significant improvement.
43. I need to record that although Mrs Little was transferred by the 'ambulance system' to the NWRH such transfer did not in any way contribute to her death.

The Private's Response to Mrs Little's Death

44. The Private commissioned a Root Cause Analysis of the circumstances surrounding Mrs Little's death. It led to several recommendations being made, namely:
- 1) That an SBAR (Situation, Background, Assessment, Recommendation) tool be introduced as a guide concerning the communication of relevant clinical information to medical staff. Such a tool serves to alert staff to a patient's deteriorating condition and for the need for relevant intervention.
 - 2) That a staff training package for the SBAR tool be developed and implemented.
 - 3) That a Medical Emergency Team (MET) response system be established and implemented with staff being required to participate in an appropriate training and awareness programme.
 - 4) That an external peer review be undertaken by a specialist obstetrician/gynaecologist.
45. I am advised by the Private that it has acted upon and implemented each of these recommendations. Such a response is, in my opinion, most commendable.

Findings Required by s28(1) of the Coroners Act 1995

46. The evidence enables me to make these findings:

- a) The identity of the deceased is Neita Jean Little.
- b) Death occurred in the circumstances set out in these findings.
- c) I have set out above my findings upon the cause of death, same largely based upon the opinions of Dr Ritchey.
- d) Mrs Little died at the NWRH on 28 June 2014.

47. Further, to enable the death to be registered under the *Births, Deaths and Marriages Registration Act 1999*, I find that Mrs Little was aged 79 years, having been born on 25 November 1934. Also, I find that she was not of Aboriginal or Torres Strait Islander origin.

In Closing

48. I convey to Mrs Little's family and loved ones my sincere condolences. It is my hope that this inquest has assisted them in understanding the circumstances of Mrs Little's death and will be of some help in dealing with it.

49. I thank counsel assisting and those counsel representing the various interested parties for their assistance and their professionalism both during the conduct of the inquest and via their written submissions.

Dated: 14th day of March at Burnie in the State of Tasmania

Rod Chandler

Coroner