MAGISTRATES COURT *of* TASMANIA

CORONIAL DIVISION

Record of Investigation into Death (Without Inquest)

Coroners Act 1995
Coroners Rules 2006
Rule 11

I, Rod Chandler, Coroner, having investigated the death of Tristan Adam Jones

Find, pursuant to Section 28(1) of the *Coroners Act* 1995, that

a) The identity of the deceased is Tristan Adam Jones;
b) Mr Jones was born in Launceston on 27 May 1976 and was aged 40 years;
c) Mr Jones died at the Royal Melbourne Hospital (RMH) on 8 January 2017; and
d) The cause of Mr Jones' death was a subarachnoid haemorrhage due to a middle cerebral artery rupture.

Background

Mr Jones was married to Catherine Elizabeth Jones. They had two children, Lochie and Gracie. Mr Jones was a self-employed business owner. He enjoyed good health.

Circumstances Surrounding the Death

At about 6.00pm on Saturday 7 January 2017 Mr Jones complained to his wife of a *"terrible headache."* She noted that his speech *"was starting to become a bit slurred."* He took some Panadol and rested for about 30 minutes. He then reported feeling better. Mr and Mrs Jones then drove to Invermay to buy a takeaway meal. On the way home Mr Jones again complained of a severe headache. He vomited. Mrs Jones then drove him to the Launceston General Hospital (LGH). They presented in the Emergency Department (ED) at around 7.30pm.

In the ED Mr Jones was triaged as a category three patient (to be seen within 30 minutes). His presentation was recorded as: *"Sudden onset of headache around 17:00 hours. Felt lightheaded, almost passed out. Has vomited twice since. Walked into Department. Had a couple of Panadol at time of headache but thinks he may have vomited them up. Alert and oriented at triage. Has been out in the sun today."*

Mrs Jones reports that she and her husband had been waiting about 15-20 minutes when *"Tristan stood up suddenly and started walking towards the doors through to the emergency ward. I don't think he was aware of what he was doing as he was staggering. He nearly got to the wall next to the doors through to the ward and he just collapsed. After he had collapsed he was taken through to the Emergency Ward and placed on a respirator. He was then surrounded by medical staff and I waited in a nearby room."*

At 8.42pm Mr Jones had a CT scan of his brain. The report has this conclusion: *"Large right subarachnoid haemorrhage and right temporal haematoma secondary to ruptured right middle cerebral artery aneurysm. Imaging findings have been discussed at the time of reporting."*

Mr Jones was then transferred back to the ED after which steps were initiated for his transfer to a specialist neurosurgical facility for urgent treatment. I will detail these steps later in these findings. At this point it is sufficient to say that Mr Jones was transferred by air to the RMH after an unsuccessful attempt to have him transferred to the Royal Hobart Hospital (RHH). Records show that he left the LGH at 10.18pm and arrived at the RMH at 1.45am on the next morning. He was promptly assessed by a neurosurgical registrar who noted: *"…dilated, unreactive pupils since 21:30"* and *"No corneal reflex, no gag reflex. Patient is not on any muscle relaxants (only propofol). Clearly unsurvivable cerebral insult→not for surgery. Palliation."* Brain death testing carried out later that day confirmed Mr Jones to be deceased.

Report of Death

Clinicians at the RMH did not report Mr Jones' death to the coroner, either in Victoria or Tasmania. However, Associate Professor Andrew Turner, the director of the Department of Critical Care Medicine at the RHH, in an email dated 12 January 2017, advised the coroner in Tasmania of the death and requested its investigation.

Investigation

This has been informed by:

1. An email from Dr Adam Deane, Deputy Director, Intensive Care Unit at the RMH to Associate Professor Turner.
2. The email from Associate Professor Turner to the Office of the Coroner in Hobart.
3. An affidavit from Mrs Jones.
4. A review of Mr Jones' records at the LGH carried out by clinical nurse, Ms L K Newman.
5. A Final Root Cause Analysis (RCA) report of Tasmanian Health Service (THS).
6. Consideration of Mr Jones' record at the RMH.
7. A report from Dr A J Bell as medical advisor to the coroner.

In his helpful report Dr Bell includes these comments:

i. Subarachnoid haemorrhage is often a devastating event. About 25% of patients die within 24 hours of onset. There is therefore a need for EDs to quickly recognise and treat the condition.
ii. At the LGH Mr Jones was quickly and accurately diagnosed. Thereafter there were some aspects of his management which indicated a lack of experience in the care of a patient with a subarachnoid haemorrhage and raised intracranial pressure. However, any shortcomings in his care at this time did not contribute to the eventual outcome.
iii. That the RCA, including its report upon the transfer issue, was of a high standard.

As I have noted, the THS produced a report following its own RCA of the circumstances of Mr Jones' death. A focus of the analysis was a consideration of the events which led to Mr Jones' transfer to Melbourne rather than Hobart. This is an issue which is important to my investigation and it is helpful to my consideration of it for me to set out the timeline detailed in the Final RCA report on 7 January 2017:

> 7.49pm Mr Jones presented to the ED of the LGH accompanied by his wife.
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> 7.49 to 8.37pm Mr Jones was sitting in the waiting room. He stood up and collapsed. He was attended by ED clinicians. An ED consultant commenced airway management and intubated Mr Jones.
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> 8.37pm Mr Jones was transferred to the CT room.
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> 8.57pm Final CT scan was completed.
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> 9.00pm (approx.) Director of Surgery called ICU consultant to identify the retrievalist on call.
>
> 9.00pm ICU consultant made call to identify the retrievalist on call. ICU consultant then called the retrievalist on call at home and requested them to attend at the ED.
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> 9.07pm Ambulance Tasmania specialist clinical consultant received a direct call from ICU consultant at LGH informing him of time-critical transfer of Mr Jones from LGH and stated that the patient had been accepted by the neurosurgeons at our RHH stop
>
> 9.00 to 9.10pm Director of surgery at LGH phoned neurosurgery registrar at RHH who agreed to the time-critical transfer of Mr Jones to the RHH but advised that he had to first speak with the consultant. RHH neurosurgery registrar then phoned the consultant and advised him that there were no ICU beds available. There was a discussion re Mr Jones' poor prognosis based upon the CT scans viewed remotely. It was then determined that if there were no RHH ICU beds available that RHH was unable to accept the patient and the recommendation would be that Mr Jones be transferred to a Melbourne facility. (The decision regarding ICU bed availability was not discussed by the ICU registrar with the RHH ICU consultant.) The RHH neurosurgery registrar then rang the director of surgery at the LGH to report that there were no beds available in ICU at RHH and that Mr Jones could not be transferred to RHH.
>
> 9.10pm Arrival of retrieval team at LGH.
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> 9.10 to 9.16pm LGH Director of Surgery makes calls to Melbourne hospitals seeking an available surgeon.
>
> 9.12pm RHH ICU reiterates that RHH cannot accept Mr Jones for the safety of department and patients.
>
> 9.16pm Bed located at RMH for Mr Jones. Director of Surgery at LGH made calls to RMH to arrange transfer.

9.20 to 9.25pm (approx.) LGH Department of Radiology head provides an opinion upon CT images.

9.25pm Discussion between RMH neurosurgery registrar and clinical consultant retrieval re Mr Jones' condition. It is noted that neurosurgeon unable to operate for another 2 hours because of another urgent surgery.

9.25pm Advice noted that ICU at LGH had available beds for a two way swap with RHH ICU and that LGH had capacity to take RHH ICU patients.

9.25 to 10.18pm Ongoing clinical care, monitoring and stabilization of Mr Jones continued.

10.18pm Transfer of Mr Jones to RMH commenced.

As I have noted earlier Mr Jones arrived at the RMH at 1.45am the next morning, that is about 4 ¾ hours after steps began to have him transferred to a suitably resourced hospital.

The RCA analysis led to these findings:

1. There was not a current time-critical transfer document in place, meaning that the final decision-making was dependent on a series of individual clinicians making decisions based on their own local circumstances.
2. There was a lack of coordinated, simultaneous, clear communication between key medical consultants involved in the care of Mr Jones in this time-critical process, meaning that the opportunity to influence the decision-making to transfer him to RHH was lost.
3. There was a lack of understanding of the usual process for acceptance of time-critical transfers at RHH meaning that the ICU believed that they had the autonomy to decide whether or not to accept a patient based on bed availability without reference to the ICU consultant on call.
4. There was a lack of understanding of the team resources available (i.e. there was a fixed wing asset only) and transfer times which contributed to the decision to transfer Mr Jones to the RMH in the belief that there would be little delay in the patient receiving timely and appropriate care.
5. There was a lack of process to enable the transfer/swap of ICU patients between ICU at RHH and ICU at LGH which contributed to the perception that the RHH ICU was unable to accept care of Mr Jones.

It needs also to be noted that since the incident involving Mr Jones the THS has adopted an interim protocol for time-critical patients. It incorporates these two principles:

- The retrieval destination is to be based purely on clinical need and the nearest required clinical service. ICU bed availability will <u>not</u> be taken into consideration, as this will be dealt with after the patient's immediate clinical needs are attended to.
- Time-critical patients are not to be transferred interstate for level 6 hospital care; they will be transported to the RHH. The only exceptions to this rule are:
    - Patients covered by approved protocols (e.g. State wide burns policy).
    - Paediatric patients with special needs.

- In the event of a crisis (major incident, system overload) by approval of the Emergency Operations Centre of Ambulance Tasmania.
- In an unforeseen, extraordinary circumstance; only by approval of the rostered Ambulance Tasmania Clinical Consultant, after conferring with the Director, Aeromedical Retrieval if possible.

Findings, Comments and Recommendations

When Mr Jones presented at the LGH his subarachnoid haemorrhage was promptly diagnosed. This is a very serious and life-threatening condition, which requires urgent management in a neurosurgical facility to maximise the patient's chances of survival. The LGH does not have such a facility and its clinicians rightly made the decision to arrange Mr Jones' transfer to a suitably resourced hospital. The most obvious destination was the RHH.

I have set out details of a report made by THS following its investigation of the circumstances surrounding Mr Jones' transfer. It shows that multiple systemic failures led to Mr Jones being rejected by the RHH on the basis that an ICU bed was not available. This was a regrettable outcome which then compelled the LGH clinicians to seek a suitable interstate hospital. In the end Mr Jones was transferred to the RMH.

The need to transfer Mr Jones interstate gives rise to the question whether this was a factor which played a role in Mr Jones' death.

The evidence shows that Mr Jones' subarachnoid haemorrhage was diagnosed at around 9.00pm on 7 January and that steps for his transfer were promptly initiated. Within minutes the RHH had indicated that Mr Jones' admission would be accepted subject to consultant input. On the assumption that Mr Jones' transfer had been confirmed, it is, in my view, reasonable to conclude that his transport to the RHH by a combination of ambulance and fixed-wing plane or helicopter could have been achieved by around 11.30pm. That is more than two hours faster than the time taken to transfer Mr Jones to the RMH. Would the outcome for Mr Jones have been different if he had been transferred to the RHH?

The Hunt and Hess grading scale is an accepted means of assessing mortality for patients with subarachnoid haemorrhage. I am advised by Dr Bell that the observations taken at the LGH indicate that at around 9.30pm on 7 January Mr Jones' condition warranted a grade 5 rating. For such a patient the scale prescribes a greater than 65% likelihood of death with an approximate 10% prospect of a functional recovery. Dr Bell further advises that as time passed Mr Jones' condition would, in all likelihood, have continued to deteriorate with it being almost certain that by around 11.30pm his condition had become unsurvivable. I accept this advice. It leads me to find that even if the RHH had agreed to accept Mr Jones as a patient when first approached it is most unlikely that its neurosurgical team could have implemented treatment in time to save his life. It follows that the regrettable decision taken by the RHH to refuse his admission which then compelled his transfer to the RMH was not a factor which caused or contributed to Mr Jones' most unfortunate death.

I need to acknowledge that the THS's investigation of this matter has been thorough and it is gratifying that it has led to the adoption of a retrieval policy which specifically provides that a patient's clinical needs will be the basis for determining a transfer destination. Specifically, the policy rejects ICU bed availability as a factor to be taken into consideration. This policy, if abided by, will avoid a repeat of the unfortunate transfer decision which occurred in this case.

I note that the THS report lists several recommendations designed to address those shortcomings identified by the RCA. I support each of those recommendations.

I have decided not to hold a public inquest into this death because my investigation has sufficiently disclosed the identity of the deceased, the date, place, and cause of death, relevant circumstances concerning how his death occurred and the particulars needed to register his death under the *Births, Deaths and Marriages Registration Act 1999*. I do not consider that the holding of a public inquest would elicit any significant information further to that disclosed by the investigation conducted by me. The circumstances of the death do not require me to make any further comment.

I convey my sincere condolences to Mr Jones' family and loved ones.

Dated: 17 October 2018 at Hobart in the State of Tasmania.

Rod Chandler
Coroner