Act 1996
(Section 26(1))

RECORD OF INVESTIGATION INTO DEATH

I, Barry Paul King, Deputy State Coroner, having investigated the death of ***Susan Jessica Elsie Windie*** *with an inquest held at Carnarvon Courthouse on 23 October 2019, find that the identity of the deceased person was* ***Susan Jessica Elsie Windie*** *and that death occurred on 29 October 2016 at Carnarvon Hospital from bowel obstruction due to faecal impaction in the following circumstances:*

Counsel Appearing:

Ms M F Allen assisted the Coroner.
Ms H C Richardson (State Solicitor's Office) appeared for the WA Country Health Service and the North Metropolitan Health Service
Ms C V J Wood (Aboriginal Legal Service of WA) appeared for the Windie family

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INTRODUCTION

1. Ms Windie lived in Gascoyne Junction with her father. She was born with genetic abnormalities which predisposed her to recurrent constipation, for which she was treated at Carnarvon Hospital and at tertiary hospitals in the Perth metropolitan area.

2. At 3.00 am on 27 October 2016, Ms Windie was admitted to Carnarvon Hospital with severe constipation after receiving treatment from the emergency department during the previous afternoon. The doctors were unable to remove the blockage manually or with laxatives, so they contacted Sir Charles Gairdner Hospital (SCGH) to seek advice and to arrange for Ms Windie to be transferred there.

3. Following a telephone discussion on the morning of 28 October 2016 between Dr Geert Dijkwel from Carnarvon Hospital and a gastroenterology registrar at SCGH, Ms Windie was treated with further laxatives with an expectation that, if the blockage did not clear, she could be transferred on 29 October 2016.

4. By the evening of 28 October 2016, Ms Windie was experiencing increasing pain. At 8.00 pm, her father stated that he wanted something done about her pain. The after-hours manager attended and spoke with the doctor on duty, Dr James Read, who requested that Ms Windie be transferred to the emergency department.

5. Dr Read ordered a CT scan and contacted the emergency department at SCGH, where Ms Windie's transfer was accepted. Dr Read then contacted the Royal Flying Doctor Service (RFDS) and arranged for the transfer.

6. Over the next few hours, Ms Windie's condition deteriorated sharply. Dr Read obtained ongoing advice from the SCGH intensive care unit and emergency department. He managed her care until the RFDS team arrived and took over, but by then her condition was incompatible with survival.

7. Ms Windie died at 5.49 am on 29 October 2016. She was 22 years old.

8. Dr Read issued a certificate of cause of death in which he identified the cause of death as ischaemic necrosis of bowel/colon in association with megacolon, obstructive faecal obstruction and sacral aplasia and

imperforate anus.[1] Ms Windie's father did not accept the certificate because of his belief that the doctors in Carnarvon Hospital failed to manage Ms Windie properly by failing to send her to Perth as had been done previously, so he requested a coronial inquiry.[2]

9. Following an investigation, I held an inquest in Carnarvon on 23 October 2019. The focus at the inquest was on the care provided to Ms Windie, especially the circumstances surrounding the possible failure to transfer her to SCGH.

10. The documentary evidence adduced at the inquest consisted primarily of a brief of evidence, comprising a report by Senior Constable Lee with attached documents and reports from medical practitioners who had taken part in Ms Windie's care.[3] Also included in the brief was the report of an independent expert, colorectal surgeon Professor Cameron Platell.[4] Further documents accepted into evidence were the Carnarvon Hospital records for Ms Windie,[5] the 'SCGH Admission and Bed Allocation Policy'[6] and the WA Country Health Service (WACHS) document entitled 'Unplanned Adult Inter-hospital Patient Transfers'.[7]

11. The following witnesses provided oral evidence at the inquest:

    a. Professor Platell;[8]

    b. Dr Read;[9]

    c. Dr Jason Armstrong, emergency physician at SCGH;[10]

    d. Dr Dijkwel;[11] and

    e. Dr Allan Pelkowitz, the regional medical director of WACHS Midwest.[12]

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[1] Exhibit 1.1.3
[2] Exhibit 1.1.5
[3] Exhibit 1.1
[4] Exhibit 1.1
[5] Exhibit 1.2
[6] Exhibit 2
[7] Exhibit 3
[8] ts 4 – 26 Platell, C
[9] ts 27 – 45 Read, J
[10] ts 56 – 70 Armstrong, J
[11] ts 71 – 83 Dijkwel, G A
[12] ts 83 – 98 Pelkowitz, A R

12. Following the evidence, Ms Wood made submissions on behalf of Ms Windie's family.

SUSAN WINDIE AND HER MEDICAL HISTORY

13. Ms Windie was born on 15 December 1993 at King Edward Memorial Hospital with an imperforate anus, ectopic urethra, partial sacral agenesis, neurogenic bladder and a rectovaginal fistula. These congenital abnormalities were extremely rare.[13] She required surgery at two days of age and again at nine months of age.[14]

14. Ms Windie's family was small but they were incredibly close. Because she was unwell as a child, she became the boss of the family, and they would have done anything for her.[15]

15. Ms Windie experienced recurrent constipation and leakage of faeces. She underwent an elective procedure called an antegrade polymic enema, or ACE, whereby a small port was created in her lower abdomen in order to allow her bowel to be flushed with saline solution to produce a bowel movement. Despite that procedure, she continued to experience episodes of severe constipation.

16. On 19 March 2011, Ms Windie was admitted to Carnarvon Hospital with bowel obstruction from constipation that did not respond to laxatives. She required transfer to Princess Margaret Hospital, where she had manual dis-impaction under general anaesthesia and an ACE washout.[16]

17. On 24 May 2011, she was admitted to Carnarvon Hospital again with the same problem, but she was treated with laxatives through the ACE tube as advised by a paediatric surgeon and she responded well. She was discharged home in three days.[17]

18. On 25 August 2011, Ms Windie was admitted to Carnarvon Hospital with the same problem, as well as the ACE tube being blocked for three days. In addition to the laxatives used previously, she required manual dis-

[13] ts 29 Read, J; Exhibit 1.1.18
[14] Exhibit 1.1.9
[15] ts 99 Wood, C
[16] Exhibits 1.1.9 and 1.1.10
[17] Exhibits 1.1.10 and 1.2 2nd Admission

impaction. Despite a set-back on the fourth day which required re-starting the ACE laxatives, she was fit for discharge after five days.[18]

19. Ms Windie's next admission at Carnarvon Hospital was on 27 August 2013 for constipation and reduced flows through the ACE. The treating doctor contacted the gastroenterology unit at Fremantle Hospital (FH), who advised trying the laxatives that had been successful in the past and then glycerol and Picolax if they were not effective. An abdomen X-ray and a physical examination showed a loaded colon and a narrow anus that would admit only one finger so, on the next morning, a transfer to FH was arranged. On 30 August 2013, Ms Windie underwent manual dis-impaction under general anaesthetic at FH.[19]

20. On 11 March 2014, Ms Windie was admitted to Carnarvon Hospital with severe constipation. She was treated with laxatives and enemas over four days and was discharged home on 15 March 2014 in satisfactory condition. During that admission, Dr Dijkwel managed her care and treatment.[20]

EVENTS LEADING UP TO DEATH

21. On 20 October 2016, Ms Windie attended the emergency department at Carnarvon Hospital with complaints of constipation and right lower quadrant pain. Dr Dijkwel examined her and noted that her abdomen was not tender. He gave her a mix of laxatives and asked her to return the next day for a review.[21]

22. On 21 October 2016, Ms Windie attended Carnarvon Medical Services Aboriginal Corporation (CMSAC) in order to convert her prescription for laxatives from Carnarvon Hospital to a CMSAC prescription. She saw Dr Alan Shortt and told him that the medications she had been given at Carnarvon Hospital had started to work, but that she needed another script. Dr Shortt considered that it might be overkill, but he issued the prescription.[22]

[18] Exhibits 1.1.10 and 1.2 3rd Admission
[19] Exhibits 1.1.10 and 1.2 4th Admission
[20] Exhibits 1.1.10 and 1.2 5th Admission
[21] Exhibits 1.1.14 and 1.2 ED/OPD
[22] Exhibits 1.14 and 1.1.16

23. At about midday on 26 October 2016, Ms Windie returned to the emergency department at Carnarvon Hospital with symptoms of constipation, including abdominal pain and overflow faecal incontinence. She saw Dr Batsirayi Chiureki and told him that she had been constipated for two weeks and had not been able to pass any stools for the last two days.[23]

24. Dr Chiureki noted Ms Windie's complicated history of congenital abnormalities and chronic constipation. He examined her and found that she was well-hydrated and that her vital signs were normal. She was not in any distress and was able to mobilise well. Her abdomen was soft and not tender, and her bowel sounds were normal.[24]

25. Dr Chiureki ordered a full blood count and electrolytes analysis, and the results were normal. An abdominal X-ray showed faecal loading with no fluid air levels, no sign of perforation, no acute obstruction and no distension of the small bowel. He attempted manual removal of the faecal loading while Ms Windie was under nitrous oxide and fentanyl, but he could only insert one finger and could only break and remove a small amount of the solid mass of stool before Ms Windie could tolerate no more of the attempts.[25]

26. Dr Chiureki called SCGH on the afternoon of 26 October 2016 and spoke to a gastroenterology registrar because he felt that Ms Windie may have needed manual evacuation under general anaesthesia, and Carnarvon Hospital did not have the capacity to perform a laparotomy and dis-impaction. The registrar reviewed the X-ray, reviewed Ms Windie's past medical history, and recommended attempting Fleet enema and a laxative by way of Ms Windie's ACE tube. The registrar recommended that, if Ms Windie was unable to move anything or became unwell, Dr Chiureki should discuss her case further with the SCGH gastroenterology team to consider a transfer to Perth.

27. Dr Chiureki considered that plan to be reasonable, so he admitted Ms Windie to the general ward and arranged for her to be given intravenous fluids and the Fleet enema and a laxative.[26]

[23] Exhibit 1.1.12
[24] Exhibit 1.1.12
[25] Exhibit 1.1.12
[26] Exhibit 1.1.12

28. At about 6.00 pm on 26 October 2017, Dr Chiureki handed over Ms Windie's care to Dr Dijkwel.[27]

29. Dr Dijkwel saw Ms Windie at about 10.00 am on 27 October 2016. He noted that she had had some soft movement, and she remained optimistic that she would be able to pass stools unassisted. She told him that her condition on her previous admissions was worse. Her vital signs were stable and she was able to eat and drink. He palpated her abdomen and found that it was not tender. He concluded that it was appropriate to continue with conservative treatment given that, at times in the past, it had taken three days of persistent laxatives to manage her successfully.[28]

30. Ms Windie was stable during the day of 27 October 2016. She ate a small amount of soft food for dinner but, at 7.00 pm, she experienced some abdominal pain and, at 10.45 pm, she vomited about 200 ml of fluid.[29]

31. At 6.00 am on 28 October 2016, Ms Windie experienced more intense pain and she vomited again.[30] Dr Dijkwel reviewed her at about 9.00 am and learned about her pain and vomiting. He noted that she was not guarding her abdomen when he palpated it. He called the on-call gastroenterology registrar at SCGH to discuss transferring Mr Windie to Perth, but the registrar explained that SCGH had three other transfers coming and suggested that Dr Dijkwel try the bowel preparation PicoPrep through the ACE tube first.[31]

32. Dr Dijkwel thought that the registrar's suggestion was reasonable because Ms Windie had responded well to PicoPrep in the past. After the PicoPrep had been administered to Ms Windie, Dr Dijkwel became more optimistic because she was attempting to empty her bowels and was more ambulant and comfortable.[32]

33. In the early afternoon on 28 October 2016, the doctors at Carnarvon Hospital had a meeting at which they discussed Ms Windie's care. Dr Dijkwel explained that the plan was to continue laxatives and PicoPrep through the ACE tube but that a transfer to SCGH may be necessary if the conservative treatment continued to fail.[33]

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[27] Exhibit 1.1.12
[28] Exhibit 1.1.11
[29] Exhibit 1.1.1
[30] Exhibit 1.2 6th Admission
[31] Exhibit 1.1.11
[32] Exhibit 1.1.11
[33] Exhibit 1.1.11

34. During the day, Ms Windie's pain levels varied from 3/10 to 8/10. She was given regular heat packs and IV paracetamol, but she was not able to manage off the bed for longer than 10 minutes, and she had another small vomit.[34]

35. At 6.00 pm, a nurse performed another attempted manual evacuation and removed a small amount of stool. Another Fleet enema by way of the ACE was also administered.

36. At 8.00 pm, Ms Windie's father told nursing staff that he wanted something done about her pain.[35] The after-hours nurse manager, Alex Dickinson, attended and noticed immediately that Ms Windie had deteriorated. He contacted Dr James Read in the emergency department and told him about her severe pain. Dr Read was busy dealing with a methylamphetamine-intoxicated patient, so he could not leave the emergency department. He asked that Ms Windie be transferred there for rapid assessment and management.[36]

37. When Ms Windie was transferred back to the emergency department, Dr Read assessed her and reviewed her history. She had an elevated heart rate from the high level of pain, and her abdomen was distended. He prescribed fentanyl and hyoscine for her pain, with good effect. [37]

38. After Dr Read had finished treating the other patient, he returned to Ms Windie and noted that she had a grossly distended, diffusely tender abdomen with hyper-tympanic percussion note. That, with her persistent high heart rate, caused him concern that she needed immediate transfer to a tertiary hospital. He requested a venous blood gas analysis and abdominal X-rays to exclude perforation and obstruction of the bowel.

39. Dr Read was aware that the RFDS would need an accepting doctor and hospital before commencing her transfer so, while waiting for the imaging, he called the gastroenterology registrar at SCGH in order to get acceptance of Ms Windie's transfer to SCGH. The registrar referred him to the surgical registrar. Dr Read called the surgical registrar, but the surgical registrar was temporarily unavailable. Dr Read then called the emergency department at SCGH and spoke to the on-call physician,

[34] Exhibit 1.2 6th Admission
[35] Exhibit 1.2 6th Admission
[36] Exhibit 1.1.18
[37] Exhibit 1.1.18

Dr Jason Armstrong, who was happy to accept Ms Windie for immediate transfer.[38]

40. Dr Read then called the RFDS to arrange urgent transfer. He then accompanied Ms Windie to the radiology department at Carnarvon Hospital in order to see the X-rays as soon as possible, but she was unable to stand up for the abdominal X-rays due to the pain she experienced as the fentanyl wore off. Following discussions with Dr Armstrong, at about 9.00 pm, Dr Read elected to proceed with an urgent CT scan with contrast.[39]

41. The CT image suggested megacolon, which may have occurred from perforation or necrotic bowel. Even more concerning was intermittent contrast flow in the aorta, which suggested very high intra-abdominal pressures which may have been secondary to abdominal compartment syndrome. Ms Windie needed urgent laparotomy and surgical decompression, but that surgical procedure was not available at Carnarvon Hospital.[40]

42. Ms Windie was transferred back to the emergency department. Five attempts were made to decompress her abdomen with a nasogastric tube, but they were unsuccessful because, as it was later discovered, the oesophagus was pinched at the diaphragm from the high intra-abdominal pressures.[41]

43. Ms Windie became increasingly agitated and complained of significant pain. Dr Read then had regular contact with consultants at SCGH and RFDS while Ms Windie's condition became increasingly difficult to manage. At 00.36 am on 29 October 2016, a venous blood gas analysis indicated that she had severe life-threatening acidosis from abdominal compartment syndrome.[42]

44. The RFDS team led by anaesthetist and ICU specialist Dr Dennis Millard arrived at Carnarvon Hospital at about 2.00 am.

45. Dr Millard took over Ms Windie's care but, at 4.40 am, he and Dr Read were obliged to inform her father that she would not survive. Mr Windie

[38] Exhibit 1.1.18
[39] Exhibit 1.1.18
[40] Exhibit 1.1.18
[41] Exhibit 1.1.1.18
[42] Exhibit 1.1.1.18

elected to have Ms Windie provided with palliative care and to attempt to keep her alive long enough for her brothers to arrive.[43]

46. At 5.49 am on 29 October 2016, Dr Read certified that Ms Windie's life was extinct.[44]

THE CAUSE OF DEATH AND HOW DEATH OCCURRED

47. On 23 November 2016, Chief Forensic Pathologist Dr C T Cooke performed a post-mortem examination of Ms Windie's body and found features of bowel obstruction due to faecal impaction. There was five kilograms of faeces in the large intestine and discolouration of the inner lining of the wall of the large intestine.[45]

48. Further investigations by way of microscopic examination of the major body tissues, microbiological testing of lung tissue, and toxicological analysis showed no further significant findings.[46]

49. On 27 February 2017, Dr Cooke formed the opinion, which I adopt as my finding, that the cause of Ms Windie's death was bowel obstruction due to faecal impaction.[47]

50. I find that death occurred by way of natural causes.

DISCUSSION OF MS WINDIE'S CARE AT CARNARVON HOSPITAL

51. In his report, Professor Platell provided a description of Ms Windie's attendance and admission to Carnarvon Hospital, noting that the CT scan at 9.00 pm on 28 October 2016 was a critical moment because it was likely that at that time Ms Windie had abdominal compartment syndrome from severe constipation and repeated attempts to fill her bowel with laxatives that were not proving effective.[48]

[43] Exhibit 1.1.1.18
[44] Exhibit 1.1.2
[45] Exhibit 1.1.06
[46] Exhibit 1.1.06
[47] Exhibit 1.1.06
[48] Exhibit 1.1.09

52. Professor Platell considered that, at that stage the only thing that would have saved Ms Windie's life would have been rapid laparotomy and decompression of her abdomen.[49] That procedure was not available in Carnarvon Hospital.

53. Professor Platell believed that Ms Windie would have benefitted from an earlier dis-impaction of her rectum under a general anaesthetic. In his view, she clearly had a chronic health issue with her bowel due to her congenital abnormalities, and the severity of her symptoms meant that she was at risk of developing such severe constipation that it would compromise the integrity of her bowel and lead to possible perforation. Ms Windie represented a difficult management problem and was at a high risk of not responding to simple laxative measures.[50]

54. Professor Platell considered that Ms Windie's initial management at Carnarvon Hospital, involving laxatives and seeking advice from SCGH, was appropriate. However, he stated that there did not seem to be a clear plan to treat her problem if she did not respond to the initial treatment. He believed that, if Carnarvon Hospital was not capable of performing surgical dis-impaction under general anaesthetic or simple laparotomy and decompression of the abdominal compartment, it would have been appropriate to transfer her to Perth on 28 October 2016.[51]

55. In oral evidence, Professor Platell said that, considering Ms Windie's entire history, transferring her to Perth would have been appropriate following Dr Chiureki's failed attempt at manual dis-impaction on 26 October 2016.[52]

56. In relation to Dr Dijkwel's call to the gastroenterology registrar on the morning of 28 October 2016, Professor Platell said that it would have been appropriate for him to have tried to convince the registrar of the urgency of the situation. [53] He said that, in a complicated case like this which a registrar might not have seen before, talking directly to a consultant surgeon would have been reasonable.[54]

57. Dr Platell said that the doctors in Carnarvon Hospital needed better support from tertiary hospitals because Ms Windie needed to be

[49] Exhibit 1.1.09
[50] Exhibit 1.1.09
[51] Exhibit 1.1.09
[52] ts 7 Platell, C
[53] ts 16 Platell, C
[54] ts 23 Platell, C

transferred quicker. He thought that it would have been more appropriate for the doctors to have talked to a consultant if they considered that Ms Windie's management was difficult and worrying.[55]

58. Dr Read said that he believed that the doctors in Carnarvon Hospital were very competent, but Ms Windie's condition of pseudo-obstruction was incredibly rare, with an incidence of two in one million presentations, and her ACE device was very uncommon, so it was difficult to assess what was normal for her.[56] The challenge for the doctors was that there were no red flags apart from the pain because all her vital signs were normal. Normally, when dealing with bowel obstruction, doctors are concerned about the patient not passing any faeces at all, including fluids and gas, so the fact that Ms Windie was passing faeces was reassuring.[57]

59. Dr Read explained that in most bowel obstructions there is a mechanical cause, such as a twisted bowel, a cancer or adhesions which act as a physical obstruction after which nothing passes. That was not the case with Ms Windie, whose bowel muscle was not working due to the lack of nerves to stimulate it to contract properly. He said that doctors manage constipation and bowel obstructions frequently but not pseudo-obstruction. The signs that are reassuring for bowel obstruction would be falsely reassuring in this case and most doctors would be unfamiliar with the subtle differences.[58]

60. Dr Chiureki said that Ms Windie had previously been successfully treated at Carnarvon Hospital with consultation with the SCGH team, so he did not feel any need to push the SCGH registrar to accept Ms Windie's transfer. At the time he saw Ms Windie, he had no concerns about her management or the advice provided by the registrar. If he had seen her stay clinically the same or deteriorating in the next 24 hours, he would have called the SCGH team again.[59]

61. Dr Dijkwel said that, when he called a different registrar on the morning of 28 October 2016, he was losing the confidence to manage Ms Windie conservatively and wanted to transfer her. He did not believe at the time that there was a high urgency, so he did not feel that he had a good argument to escalate his request. He thought that the advice to try PicoPrep

[55] ts 25 Plattell, C
[56] ts 30 Read, J
[57] ts 36 Read, J
[58] ts 40 Read, J
[59] ts 53 Chiureki, B

was probably reasonable given that, in the past, Ms Windie had three or four days of inpatient treatment with success.[60]

62. Dr Dijkwel said that, when he called the registrar, he relied on the registrar's experience. Usually, in such cases, the person is a senior registrar. He said that it is important that the registrar is experienced enough to add to the experience of the GP who calls.[61]

63. Dr Pelkowitz said that the system of doctors calling registrars who then pass along information to consultants can lead to the registrar making the decision about what is important in the information. He considered that a shorter cut to the consultant would be more effective.[62]

64. On a related issue, Dr Read noted that he was obliged to make three phone calls before he reached Dr Armstrong in order to have Ms Windie's transfer accepted at SCGH. Dr Armstrong said that situation could be a relatively frequent occurrence.[63]

65. Dr Read said that some places at which he worked in New South Wales had a central link to call, who would then put him through to each relevant person. In some cases, there would be several persons on the phone at the same time, which would obviate the need for him to make three or four calls while he had his hands full with a critically unwell patient. He said that was a game-changer for efficiency.[64]

66. Dr Dijkwel said that he had recently worked in Queensland where, when seeking a transfer for a patient, he was able to go through a central point and discuss the case with retrieval doctors and the specialist at the tertiary centre. He said that he found that process very helpful in streamlining the whole process. He said that it would be ideal as long as he was able to speak to people with the right experience.[65]

67. Dr Armstrong agreed that making a number of phone calls, particularly as a sole practitioner, does take up valuable time when other treatments could be attempted or other management initiated.[66]

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[60] ts 74 – 75 Dijkwel, G A
[61] ts 78 Dijkwel, GA
[62] ts 95 Pelkowitz, A R
[63] ts 64 Armstrong, J
[64] ts 34, 37 Read, J
[65] ts 78 – 79 Dijkwel, G A
[66] ts 69 – 70 Armstrong, J

68. In his report, Dr Pelkowitz said that WACHS had recently opened a Command Centre in Perth to provide the Emergency Telehealth Service, the Inpatient Telehealth Service and the Mental Health Telehealth Service. More relevant to Ms Windie's case, the Command Centre was expected to centralise and coordinate transfer requests.[67]

CONCLUSION ABOUT THE CARE PROVIDED TO MS WINDIE AT CARNARVON HOSPITAL

69. In my view, the evidence indicates that the doctors at Carnarvon Hospital were very committed clinicians who attempted to provide Ms Windie with the most appropriate care that was available to them, but it is clear that they were unable to deal successfully with her specific needs. Each of the doctors was aware of the need for assistance so, for that reason, they each contacted specialists at SCGH in order to ensure that Ms Windie was managed appropriately.

70. Dr Pelkowitz said that, until Ms Windie deteriorated on the night of 28 October 2016, she had been clinically stable and had no signs of acute deterioration of decompensation. He did not think that any rural doctor would think about calling an emergency department in those circumstances because there was no apparent emergency; it was an inpatient transfer. He said that no-one would have predicted that Ms Windie's condition would change so quickly, and in hindsight that was tragically wrong.[68]

71. I accept that the evidence supports Dr Pelkowitz's view so far as it relates to the doctors at Carnarvon Hospital.

FAILURE TO TRANSFER SOONER

72. Unfortunately, a combination of what may have been a lack of appreciation of the complexity and potential severity of Ms Windie's condition by the registrars to whom the doctors spoke and an understandable deference shown by the doctors to the registrars, the urgency of the need to transfer Ms Windie for surgical care was not identified until it was too late. That may have occurred despite what Ms Windie's father indicated through Ms Woods was his consistent

[67] Exhibit 1.1.17
[68] ts 97 – 98 Pelkowitz, A R

request for her to be transferred,[69] though I am unable to find a record of his request in the Carnarvon Hospital notes or in his statement to police.[70]

73. The evidence suggests that the process by which rural doctors seek advice from specialty teams in tertiary hospitals; namely by speaking with registrars in those teams rather than consultants, contributed to the failure to transfer Ms Windie in time to save her life.

74. It is not clear that the registrar who spoke to Dr Dijkwel reviewed Ms Windie's case or was aware of her complicated medical history. The doctor who was likely the registrar and spoke to Dr Dijkwel had no recollection of the phone call.[71] However, neither Professor Platell nor Dr Armstrong raised this as an issue, presumably because, as part of the process, the registrar would have been expected to check Ms Windie's medical history if available, or to elicit the relevant information from Dr Dijkwel.[72]

75. Of more importance was the fact that, due to the nature of the process, a relatively inexperienced registrar may have been dealing with Dr Dijkwel's request for a transfer.

76. Professor Platell said that when a rural doctor is speaking to a registrar in a tertiary hospital, the registrar might have four or five years of training in the speciality or might have only been there for two months. That is the reality of the training program. In a complex case like Ms Windie's, it would be quite reasonable for the doctor to talk to a consultant surgeon about it.[73] He also said that it would have been nicer to see that the tertiary hospital gave a bit more support in her case.[74]

77. Dr Armstrong said that registrars in at least some specialty teams in SCGH were the first port of call to discuss a transfer. He said that the same practice exists in most hospitals in Australia, and it works by a system of good governance that registrars are supervised.[75]

78. Dr Armstrong said that the system revolves around a very close interaction between a registrar and the supervising consultant so that, until the registrar gains experience and has demonstrated the required competence,

[69] ts 43 Read, J
[70] Exhibit 1.2 Sixth Admission; Exhibit 1.1.8
[71] Email Ms Richardson to Ms Allen 22/10/19
[72] ts 65 Armstrong, J
[73] ts 23 Platell, C
[74] ts 11 Platell, C
[75] ts 65 Armstrong, J

he or she is expected to discuss each call with the consultant immediately. Once the registrar has exhibited a good knowledge base and good skills, discussion of the calls could be deferred until later in the day and they might be done together. The registrar has to be responsible for interpreting the call and making a considered decision about what advice to give. There is an ability to discuss the advice with senior colleagues as required.[76]

79. Dr Armstrong said that, if a rural doctor calling SCGH was not content with the advice provided by a registrar, there is the possibility to escalate the request or ask for a second opinion, but it does depend on the initiative of the rural doctor to interpret the advice and to decide whether it is adequate and competent.[77]

80. Dr Armstrong agreed that a rural doctor may be seeking advice from a specialist team in a tertiary hospital in relation to an unusual situation, and the registrar providing advice may be relatively inexperienced. When asked how the rural doctor would be able to determine whether the advice was competent, Dr Armstrong said that it was a good question.[78]

81. Dr Pelkowitz noted that there is a lot of individual variability in how people respond to calls from regional doctors. From what he had heard, there is the potential for the person who takes the call to decide what is important before discussing it with a consultant. In his view, a short cut to the decision maker would help.[79]

82. Dr Pelkowitz said that he had worked in Auckland, where all calls from the regions were taken in a particular part of the emergency department by a senior physician who decided whether admissions were required and then, after talking to colleagues, who was going to take the patients. In that way, the negotiation was out of the hands of the regional doctors.[80]

83. Dr Dijkwel said that, when he called the registrar, he was asking for advice about a very complicated and rare situation, and he was relying on the experience of the registrar to recognise whether Ms Windie had a straightforward case of constipation or whether there was something that he needed to take into account. He said that it is important that they talk to senior registrars or consultants, but that is not always the case. [81]

[76] ts 65 Armstrong, J
[77] ts 63 Armstrong, J
[78] ts 70 Armstrong, J
[79] ts 95 Pelkowitz, A R
[80] ts 94 - 95 Pelkowitz, A R
[81] ts 78 Dijkwel, G A

84. Dr Read said that when rural doctors call tertiary specialist teams, the default system is for the doctors to speak to registrars, who may have a lot less experience than a rural GP with 20 years' experience. He said that, in a complex situation like Ms Windie's, if the default system was for the doctors to speak to a consultant, it was more likely that the person would understand it.[82]

CHANGES SINCE 2016

85. Dr Pelkowitz described the implementation of a Command Centre about five weeks before the inquest. In addition to providing a number of telehealth services, that facility was expected to centralise and coordinate transfer requests in 2020.[83] As I am aware, it is yet to commence as of the date of this report.[84]

86. Another initiative implemented at WACHS is called the Call and Respond Early (CARE) call, which is an opportunity for family members who are concerned that the treating doctors or nurses are not listening to their concerns to call WACHS executives who are on call. The availability of the CARE call is advertised around WACHS hospitals.[85]

87. A more significant change to the approach of hospitals in relation to requests from rural hospital for transfers was also in place by the time of the inquest. Dr Dijkwel said that he had previously experienced difficulties trying to transfer a patient out of Carnarvon, but in recent years there appeared to be a default answer of 'yes' when a request was made. He said that, sometimes, the answer would be that it seems unnecessary but that, if he was worried, SCGH would take the patient.[86]

88. Dr Armstrong confirmed Dr Dijkwel's evidence. He said that any call from a remote or rural location requesting transfer is almost automatically accepted because the doctors at SCGH realise the difficulties inherent with managing patients in locations far away from the bigger centres. Sometimes they discuss the case and come to an agreement that there are

[82] Ts 33 Read J
[83] ts 88 Pelkowitz, A R
[84] http://www.wacountry.health.wa.gov.au/index.php?id=433&no_cache=1
[85] ts 89 Pelkowitz, A R
[86] ts 77 Dijkwel, G A

other management options available in the remote location, but they do not put up impediments to transfer if that is requested.[87]

CONCLUSION

89. Ms Windie died from a complication of her rare, life-long condition, when the complication was readily treatable had she been transferred to a tertiary hospital in time.

90. The evidence does not suggest that any of the doctors involved with Ms Windie's care, including the relevant registrars at SCGH, acted unreasonably in the circumstances with which they were faced.

91. However, in Ms Windie's unusual case, the process in which registrars were given the responsibility to determine whether to accept transfers of patients from rural hospitals had an increased potential for the urgency in her situation to be overlooked.

92. It is not beyond doubt that a consultant would have recognised the urgent need for Ms Windie to be transferred to SCGH, but I infer from the evidence that a consultant would have been much more likely to have done so than a junior registrar would have. It follows that the process in place at that time failed Ms Windie to that extent.

93. Since Ms Windie's death, there have been improvements to the process of accepting the transfers of patients into tertiary hospitals from rural hospitals, and the proposed acute patient transport coordination service at the WACHS Command Centre will also be welcome.

94. While those improvements were too late for Ms Windie, they may provide her family with some consolation from the fact that, partly as a result of her untimely death, a similar situation will be less likely to happen in future.

B P King
Deputy State Coroner
13 August 2020

[87] ts 64 Armstrong, J