



Review of events surrounding Northam Hospital Emergency Department

Executive Summary

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EXECUTIVE SUMMARY

The unexpected death of a 23 year old woman within 24 hours of attending the Emergency Department (ED) at Northam Hospital on 29 December 2012 came after three other unexpected deaths following visits to the same ED. The three earlier deaths, starting with the death of a young baby on 12 August 2010, have been investigated by the WA Department of Health (DoH) and have, or are being, examined by the Coroner. Following publicity in the popular press linking these deaths to the Northam ED, a further death following a visit to the ED was made public by the deceased's family. In response to these five deaths in just over two years the Director General of WA Department of Health, Kim Snowball, requested that the Chief Medical Officer for WA, Professor Gary Geelhoed, conduct a review to:

- a. examine the circumstances around the death of the 23 year old woman (Case A)
- b. review responses to the four earlier deaths (Cases B, C, D and E)
- c. conduct further investigation as indicated

The formal request for a review was made on 24 January 2013. The reviewer subsequently visited Northam on 25 January, 30 January, 1 February and 12 February 2013. Following the first three visits to Northam, the reviewer believed there was sufficient evidence to suggest that the system in place in the Northam ED has limitations and early recommendations were appropriate at this time to reassure the public. Given the overwhelming public interest, concerns for safety, and a looming pre-election caretaker period which would limit any Ministerial response if indicated, the reviewer provided the Director General and the Minister for Health, Hon Dr Kim Hames MLA, with an early verbal recommendation for the appointment of an emergency medicine specialist to oversee the Northam Hospital ED. The Minister for Health announced on 5 February 2013 that a Fellow of the Australasian College of Emergency Medicine (FACEM), or equivalent, would be employed at Northam Hospital as soon as possible to provide leadership. At the same time a sixth nonfatal case (Case F) was added to the review.

An analysis of background information and interviews of staff and families, who wished to take part, was undertaken and is presented in the complete review, as submitted to the Minister for Health.

The review makes the following findings with regard to the Terms of Reference.

a. Examine the circumstances around the death of Case A

- Case A presented to the Northam ED on 29 December 2012 complaining of a sore neck and vomiting. She was discharged home and died the following morning. Inadequate medical history taking, absence of physical examination and almost no medical documentation did not give the best chance to detect a potentially treatable condition. This review finds that the management of Case A was not consistent with best medical practice.

b. Review responses to the four earlier deaths and Case F

- Case B presented at eleven days of age on 10 August 2010 and was diagnosed as having an Upper Respiratory Tract Infection or “cold” after an appropriate medical consultation. Case B died unexpectedly two days later presumably from a central apnoeic episode from pertussis rather than from progressive respiratory failure, which would be in keeping with the apparently milder symptoms. This case is still to come before the Coroner.
- Case C’s death on 17 September 2010 has been appropriately investigated by the DoH and by the Coroner. This review notes that the Coroner’s recommended changes have been implemented at Northam Hospital.
- Case D, a 53 year old resident of Northam, collapsed at home, developed a severe headache and vomited on 31 July 2011. After transfer to Northam ED she was treated symptomatically for nausea and vomiting and sent home. She remained unwell until she collapsed the following day, was taken to Northam ED and then to Royal Perth Hospital (RPH) where she died on 4 August 2011 from an intracerebral bleed. Inadequate history taking, poor communication between disciplines and lack of appropriate medical examination resulted in Case D being denied appropriate medical care. This case is being considered by the Coroner.
- Case E, a 69 year old Northam resident, presented to Northam ED with a fractured left humerus on 18 June 2012 following a fall. Her past multiple medical conditions included acute renal failure on two occasions in 2011 and 2012. She was seen again on 19, 23 and 28 June 2012. At the last presentation she was transferred to Hollywood Hospital and died seven days later of multiple organ failure due to sepsis of uncertain origin. While a review of her presentations show some problems with communication, it is not possible to ascribe responsibility for her death to her management in Northam Hospital. This case is being considered by the Coroner.
- Case F, a 23 year old indigenous man, presented with chest pain on 17 June 2012. Both the clinical presentation and ECGs suggested he had an inferior ST Elevation Myocardial Infarction (STEMI). His high risk features indicated that he should have been considered for thrombolysis. He was discharged without appropriate treatment. If managed appropriately, a more serious cardiac event on 24 January 2013 may have been avoided.

c. Conduct further investigation as needed

Two broad areas of concern arise from the six cases investigated, namely: lack of medical leadership in the ED; poor communication and uncertain roles both within and between disciplines. This is in the context of, and related to, Northam Hospital ED having evolved in a relatively short period of time from a nurse-led quiet country hospital to a busier regional centre. Many of the factors that originally made for safe practice, such as fewer patients, a smaller number of doctors and less frequent handover of patients, no longer apply. Northam now services a wider catchment, which has resulted in an increased number of “strangers” attending ED. The staffing model has also changed with an increased number of doctors working in ED, some of them doing only occasional shifts. The interaction of

these complex factors has increased the opportunities for omissions, miscommunication and poor outcomes.

The vast majority of patients presenting to Northam ED are dealt with in an efficient and professional manner. However many of the factors mentioned above occurred in the six cases investigated, as well as in reports on other clinical incidents that were provided to the reviewer. These include poor communication, inadequate or absent handover of patients and confusion on who had responsibility for patients at any one time. It must be acknowledged that some work has gone into addressing these shortcomings, such as the introduction of a whiteboard, an admissions book and changes to the staffing model.

A year ago Northam ED was essentially a nurse-led department with doctors available only on an on-call basis. A new system introduced in early 2012 saw a doctor present on the floor of the ED for a 12 hour day shift with close on-call support (less than ten minutes away) overnight. While on balance this is an improved system it has been associated with a number of negative consequences. The new medical model introduced a guaranteed doctor on the floor at Northam Hospital ED. This combined with the departure of a number of GP's in nearby towns and a subsequent undersupply of GP services to the locality has led to an increased number of presentations at the Northam ED. In addition the very fact that a doctor is now present for longer periods has drawn patients who otherwise might go to their GP. It appears that the transition to the new system has not always gone as planned, with some participating doctors continuing to "stack" patients to see in a batch and not being present in the ED for their entire 12 hours shift. The previous model where on-call doctors were over reliant on nursing assessments continues to be used by some doctors, even when they are present in the department, and not all patients who present when a doctor is rostered in the ED actually get seen by a doctor.

The Northam ED is serviced by experienced medical staff that care for their patients, hospital and community. However at present they work as individuals rather than as a cohesive group. This individualised approach to rostering, conditions and communication at times places a difficult burden on nursing staff. The reviewer found the nursing staff share the same positive attitude to their patients, hospital and community and there are generally good relations and respect shown between doctors and nurses. The nursing staff have the added advantage of clear leadership from their Clinical Nurse Coordinator, who has a sound understanding of the challenges that the ED faces and has made significant improvements, within her range of authority, to address these.

It is the opinion of the reviewer that many of the problems encountered in the Northam ED could have been anticipated and avoided by medical leadership with appropriate authority and experience.

RECOMMENDATIONS

1. A medical leadership model be established in Northam Hospital ED with the appointment of a Fellow of the Australasian College of Emergency Medicine (FACEM) or equivalent, giving consistency of approach with appropriate setting and auditing of ED practices.

2. The medical model should be built on the current general practitioner workforce with opportunities for up-skilling, clinical governance and multi-disciplinary team training.
3. Utilisation of new Emergency Telehealth Service is embedded in Northam Hospital protocols to escalate a referral to the ED Specialist Clinician for the more difficult and high risk cases.
4. Appropriate support be given to both Medical and Nursing Staff in Northam Hospital to have access to ongoing education and training, as well as comprehensive appropriate clinical protocols and guidelines.
5. Formal links be established between Northam and metropolitan EDs, the obvious candidate being Swan District Hospital, with possible sharing of staff and shifts.
6. WA Country Health Services establishes an emergency clinical leadership model throughout all its facilities that deliver emergency services.
7. With regard to the three doctors whose professional conduct was thought to be below accepted standards of care, consideration be given by Western Australian Country Health Services to refer them to the Medical Board of Australia and withdrawal of their clinical privileges from the Northam Hospital ED.