IN THE CORONER'S COURT
HELD AT TAURANGA

IN THE MATTER of the Coroners Act 2006

AND

IN THE MATTER of an Inquest into the death of MARLENE JOAN STRONGMAN

Before:	Coroner Wallace Bain
Date of Hearing:	21 March 2014
Appearances:	Constable J Treloar for the Police C Garvey for the Family G Bingham for Bay of Plenty District Health Board
In Attendance:	Mr Strongman (husband) Mr Strongman (son) Patricia Strongman (daughter-in-law) Deborah Taylor (daughter)

FINDINGS OF CORONER WALLACE BAIN

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INTRODUCTION

(1) This Inquest raises extremely important issues about the standards of Hospital care and the multitude of failings that lead to the tragic death of Mrs Marlene Joan Strongman.

(2) This is an Inquest into the death of Marlene Joan Strongman who died at Tauranga hospital on the 23rd June 2010, her cause of death being hypoxic brain injury secondary to aspiration pneumonia against a background of a lack of appropriate medical treatment and systemic errors on the part of the Bay of Plenty District Health Board at Tauranga hospital.

(3) This matter came before the Coroner's Court against a background of a formal investigation by the Health & Disability Commissioner (HDC) after a complaint lodged by Mrs Strongman's daughter. A further background report is an Accident Compensation Corporation inquiry as a result of a claim made which was accepted under the "Treatment Injury" provisions of the Accident Compensation Act 2001.

(4) In respect of the HDC investigation, and opinion published on the 30th April 2013 by HDC found the care provided to Mrs Strongman was in several respects in breach of the Code of Health & Disability Consumer Rights. Two individual clinicians were found to be in breach also.

(5) The ACC accepted the claim on the basis of expert medical opinion which concluded that there was an unreasonable failure to diagnose Mrs Strongman's condition of incarcerated hernia and bowel obstruction and a failure to make an urgent surgical referral. That medical opinion concluded that Mrs Strongman developed aspiration pneumonia, and suffered cardiac arrest and irreversible hypoxic brain injury, caused by lack of appropriate treatment.

Background

(6) Pursuant to a ruling by this Court the Inquest was adjourned pending the conclusion of the ACC investigation. In March of this year the Inquest proceeded on the basis that the cause of Mrs Strongman's death was established without doubt by the autopsy report and that the circumstances leading to Mrs Strongman's death were established by those two earlier investigations.

(7) There had been a detailed pre-Inquest meeting where these matters were finalised in terms of the focus of the Inquest.

(8) Put shortly, the family were appalled at the way they were treated by the BOPDHB and their lack of appropriate response to the HDC recommendations. The family were very concerned that the DHB did not provide them with appropriate material in a timely manner, did not act appropriately in a timely manner and that it was not clear to them in terms of the information provided that all of the recommendations suggested by the HDC had been implemented. The family also wanted the steps taken as a result of this tragic case to be ongoing and that the changes continue. They were concerned because of the tardiness in response to recommendations that there was enthusiasm for change by the DHB. Against that background this Inquest proceeded.

BRIEF EVIDENCE

(9) The executive summary of the HDC report showed there was a misdiagnosis of a hernia and bowel obstruction over a course of three days in a patient that was admitted acutely under the medical team at Tauranga hospital.

(10) On Thursday 17th June 2010 Mrs Strongman was referred by her GP to Tauranga hospital with concerns about vomiting and dehydration, and an irregular pulse and a groin lump. She was reviewed by a junior registrar and she was provisionally diagnosed with an abdominal malignancy. She was reviewed by the junior registrar the next day who then spoke to the GP who again expressed concerns about the vomiting but this was not relayed to the consultant.

(11) Alarmingly the evidence established both in the Coroner's Court and at the ACC Hearing was that Mrs Strongman had no medical review for twenty seven hours at the hospital during which time her vomiting continued and her breathing deteriorated significantly. There was a rapid deterioration in her condition and she subsequently died from a severe hypoxic brain injury which she suffered during here cardiac arrest.

(12) HDC found that the consultant had failed to recognise a hernia with bowel obstruction as a differential diagnosis of her vomiting and groin lump and was in breach of Rights 4(1) of the code of Health & Disability services Consumers' Rights the Code. That stated that every consumer has the right to have services provided with reasonable care and skill.

(13) The junior medical registrar was found to have failed to document an accurate history and failed to appropriately relay to his consultant Mrs Strongman's history and the GP concerns, he was found to be also in breach of Rights 4(1) and 4(2) which concerns the right of every consumer to have services provided that comply with legal, professional, ethical, and other relevant standards.

(14) The BOPDHB was found to have failed in the procedure to provide an appropriate standard of care to Mrs Strongman and breached Right 4(1) of the Code. The inadequate DHB clinical records and inconsistent and floored clinical handover processes by staff involved in Mrs Strongman's care was found to have breached Right 4(5) of the Code.

(15) Having reviewed the reports and heard the evidence the Court agrees with the family's submissions that there were several factors identified in the opinion of the HDC and experts commenting on the case that contributed to the failure to make a diagnosis and consequently, to Mrs Strongman's death. In particular these are:

a) A failure to give adequate consideration and weight to the referral by Mrs Strongman's GP and in particular the GP's concern regarding a hernia.

b) A failure to otherwise find a cause for Mrs Strongman's vomiting in spite of anti-emetic treatment.

c) A failure to ensure timely specialist review and appropriate referral to a surgical team.

d) A failure to properly complete Mrs Strongman's records; meaning that her deterioration was not identified in a timely fashion, with subsequent review indicating a five hour delay in identifying symptoms that warranted an escalation of care.

(16) The Court put to Counsel for the DHB that if there had been appropriate interventions then Mrs Strongman would still be alive. Counsel accepted that this was a fair assumption and was thanked by the Court for their frank admission and it was noted as being very important. There has been no demure from that position by the District Health Board in their subsequent submissions.

(17) In those submissions the BOPDHB accepted the Findings of the HDC investigation and noted that they had acted on those Findings. Their position now was that they had taken them seriously and fully implemented the HDC recommendations.

(18) The High Court case of Matthews v Hunter [1993] 2 NZLR 683 and 687 confirms that Coroner's recommendations and comments on the avoidance of circumstances which directly cause the death under consideration but allows recommendations and comment on all the other implications of the similar circumstances surrounding the death.

(19) It is clear and has been accepted in terms of Coroner Findings that circumstances in a particular death can be highlighted to help prevent deaths in similar circumstances in the future.

(20) The response by the BOPDHB to the HDC recommendations do not initially cover implementation of all the recommendations but these were provided to this Court prior to the Hearing.

Health & Disability Commission Recommendations

(21) It was recommended as follows:

i) Review all off-site clinic commitments to ensure that inpatient consultant cover is not compromised.

ii) Complete the review of the APU processes – including consideration of requiring regular nursing presence on ward rounds.

iii) Reinforce the documentation requirements to start – including completion of the clinical record of fluids balance charts.

iv) Report back on the review of the SMO roster.

v) Review its MEWS protocol regarding escalation directly to senior or ICU level assessment.

vi) Provide education about MEWS to junior medical staff with reinforcement/reiteration to contact senior clinicians for help with any doubt or concerns, including MEWS levels at which senior review may be indicated.

(22) It appears from the evidence that the DHB did conduct an internal review but the initial report did not make any recommendations to address the shortcomings that it had identified. The DHB's witness in respect to this seemed to have no specific knowledge of what happened to the initial report and its implementation if at all. The family of Mrs Strongman were particularly concerned that had they not laid a complaint then all the actions now taken by BOPDHB and as a result of the recommendations by the HDC Commissioner may not have occurred.

(23) The Court agrees with the submissions from the family that the actions taken by BOPDHB in ascertaining and responding to the circumstances of Mrs Strongman were tardy and inadequate. That is clear from the evidence given before the Court and the documents filed which show inadequate initial information, lack of proper communication with the family and considerable delays in taking effective action.

(24) Mrs Strongman's daughter Jane Taylor gave evidence before the Court which was forthright and strong in terms of its criticisms of the DHB. She is a Barrister and Solicitor of the High Court. She read a prepared submission from the family. What she submitted in evidence was not contradicted at all by the DHB and she was not cross-examined in respect of the stinging criticisms that were contained within it. Her evidence is essentially uncontested. Her view was that her mother's tragic death was primarily a result of systemic errors on the part of the Bay of Plenty DHB. She was concerned also that the DHB had failed to take responsibility in any meaningful way. In the Court's view that is right to an extent but it is clear that the DHB has now taken responsibility and the evidence establishes they have implemented the recommendations of the HDC.

(25) Jane Taylor felt that recent changes to policies and procedures as a result of the HDC report would only be successful if they were accompanied by a radical improvement in professional attitude by the hospital leadership and medical staff. Without making any definitive finding in that regard certainly the inference from the evidence before the Court is that this is at least partly true and the DHB could have done much better in their implementation of recommendations and also in communication with the families.

(26) She also submitted that the DHB's attitude to the families concerned is essentially one of denial and evasion. They are strong words but clearly the communication to the family has been poor and the Court notes that the DHB accepts that. The BOPDHB simply needs to do better and the intended publicity from the HDC report and presumably to these Findings should assist in ensuring that this is vastly improved.

(27) She felt there should have been an independent review.

(28) Importantly she noted that the family felt they were being treated as "the enemy" and that the apologies were not genuine and were meaningless.

(29) It was noted that through a combination of doggedness and legal training within the family that they have been able to follow through with both the ACC and HDC investigations and reports and with the Coroner's Inquest. They do not want other families who would not necessarily have these skills to have to go through the same process. She felt that the DHB should accept the responsibility at the very early stage and get on with putting things right.

(30) Certainly the Court is of the view, after hearing and reviewing all the evidence, that had the DHB acted appropriately and in a timely manner then there probably would not have been a complaint to the HDC and certainly there would not have been a necessity from the family's point of view of having an Inquest to draw attention to these failures.

(31) The family simply wanted the DHB to accept full responsibility and be held to account for what they saw as appalling omissions. They saw this as necessary in order to restore public trust and confidence in the medical services provided by Tauranga hospital and the public health system generally.

FINDINGS

(32) I find Marlene Joan Strongman died at Tauranga hospital on the 23rd June 2010, her cause of death being hypoxic brain injury secondary to aspiration pneumonia against a background of a lack of appropriate medical treatment and systemic errors on the part of the Bay of Plenty District Health Board at Tauranga hospital.

COMMENTS AND RECOMMENDATIONS

(33) It remains to be considered whether any recommendations or comments should be made in terms of Section 57(3) In so doing the Court refers to the consideration given to this section by Heron J in Matthews v Hunter [1993] 2NZLR 683. Any recommendations or comments, in terms of the Section are to be for the avoidance of circumstances similar to those in which the death occurred. Section 51(7) of the Coroner's Act 1988 provides:
"A Coroner holds an inquest for the purpose of:

(b) Making any recommendations or comments on the avoidance of circumstances similar to those in which the death occurred, or on the manner in which any persons should act in such circumstances, that, in the opinion of the Coroner, may if drawn to public attention reduce the chances of the occurrence of other deaths in such circumstances."

(34) In *R v. South London Coroner* ex p Thompson (1982) 126 SJ 625 Lord Lane CJ said of Coroner's inquests (emphasising the important distinction that exists between *accusatorial* and *inquisitorial* processes):

"Once again it should not be forgotten *that an inquest is a fact finding exercise and not a method of apportioning guilt.* The procedure and rules of evidence which are suitable for one are unsuitable for the other. In an inquest it should never be forgotten that there are no parties, there is no indictment, there is no prosecution, there is no defence, there is no trial, simply an attempt to establish facts. It is an inquisitorial process, a process of investigation quite unlike a trial where the prosecutor accuses and the accused defends, the Judge holding the balance of the ring, which ever metaphor one chooses to use.

The Brodrick Committee (Report of the Committee on Death Certification and Coroners, dated September 22, 1971, CMND. 4810, chaired by Mr (later Judge) Norman Brodrick QC) exhaustively considered the role of the Coroners inquest in modern society and identified the following grounds of public interest which it believed a Coroner's inquiry should serve:

(i) To determine the medical cause of death;
(ii) *To allay rumours or suspicion*;
(iii) *To draw attention to the existence of circumstances which, if unremedied, might lead to further deaths*;
(iv) To advance medical knowledge;
(v) To preserve the legal interests of the deceased person's family, heirs or other interested parties."

(35) Furthermore case law amplifies how a Coroner should act and in the case of ***Luow v McLean*** C.P. 445/87 Hardie boys J, cited with approval excerpts from the following case which sets out the Coroners roles: -

In the case of Ex Parte Minister of Justice re ***Malcolm*** [1965] NSWR 1598 at 1602

"they can, and should, afford a quick and cheap method of drawing public circumstances attaching to a death, even though there is no suggestion of murder of manslaughter, are one example. Thus the relatives of a deceased person may feel that the deceased died owing to the negligence or inefficiency of medical authorities: there have been, for instance, several recent cases connected with the admission of patients to mental or other hospitals. If there has been any dereliction for duty, the facts are brought out into the open for all to judge; equally if the suspicions are unjustified, this also can be exposed and the persons cleared of unjustified suspicion. A properly conducted inquest has advantages in speed

[1]As stated in Inquest AJD Paterson, Finding 31 May 2000 (Coroner Garry Evans) citing Anderson v Blashki [1993] 2VR 89; The Secretary of the Department of Health and Community Services v Gurrick 1995 2 VR 69; see also Phipson on Evidence (15th ed.), paragraph 4-31 at p. 81.

COMMENTS

(36) The Court has noted the strong submissions from the family and essentially the uncontested acceptance of this by the DHB. This is a very sad case and it is important that the implementation of the recommendations made by HDC are followed through and that the practices, protocols and procedures which DHB has assured the Court and the family have now been implemented, will prevent such a tragedy as occurred to Mrs Strongman ever happening again.

(37) The Inquest follows on from the McLeod Inquest. The criticisms of the BOPDHB are profound and alarming. This DHB has failed badly in these two Inquests and needs to do far better. Citizens in the Bay of Plenty can quite rightly be very concerned at the standard of care being provided.

(38) Submissions were made following reference to media comments following the HDC report. The Court records that it has not considered these and does not feel that this aspect is part of the Inquest.

Adverse Comment

(39) Provisional Findings were released to parties who may be subject to adverse comment, with opportunity to respond. This is a requirement of section 58 of the Coroners Act 2006. Submissions have been received raising a concern with a paragraph in the Press Release but not the substantive Findings.

(40) The submissions have been considered carefully by the Court A minor adjustment has been made which the Court considers fairly reflects the concern raised

RECOMMENDATIONS

(41) The detailed recommendations from the Health & Disability Commissioner are set out above. The Court simply endorses those and notes of the evidence before it shows that they have been implemented and the DHB has given assurances that they will be followed through with and monitored constantly.

(42) The Court thinks there is merit in further recommendations as submitted by the family and accordingly recommends as follows:

i) That the DHB consider providing consultant cover, by virtue of an onsite-consultant, over the weekend and that this be given urgent consideration.

ii) That the BOPDHB continue to conduct many audits to monitor and ensure compliance.

iii) There be a pro-active case-by-case approach adopted and that an independent consultant be retained whenever this is a complaint laid with the HDC or where circumstances indicate there may have been failure to provide optimal medical care, and that this be given priority. This is especially to apply where it appears that the death was as a consequence of failure to provide reasonable care so that there is an external expert assisting the DHB with a review of the case.

iv) That the BOPDHB consider providing educated materials to GPs in its catchment which provide clear guidance on the material to be included in GP referrals.

(43) It is recommended that a copy of these Findings be sent to:

i) The Director-General of Health, Ministry of Health, Wellington

ii) The Minister of Health, Wellington

iii) The Chief Executive of the Bay of Plenty District Health Board

iv) Chairman of the Board of the Bay of Plenty District Health Board

Signed by the Coroner at Rotorua on this 4th July, 2014

Coroner Wallace Bain

Regional Coroner - Bay of Plenty