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A death raises questions at Rockingham General Hospital

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The Corruption and Crime Commission acknowledges the Traditional Owners of the land on which we work, the Whadjuk people of the Noongar nation. We pay our respect to their elders; past, present and emerging.

Summary

[1] The Commission has completed a preliminary investigation into an allegation that a member of the Rockingham Peel Group (RPG) executive engaged in serious misconduct.[1]

[2] It was alleged that an executive officer attempted to coerce a Medical Service Registrar into changing the date of death on a patient's death certificate contrary to *The Criminal Code* s 85(d).

[3] On 7 October 2022 the Commission approved the matter for preliminary investigation.[2]

[4] At the time of assessment of the allegation, the identity of the executive officer was unknown. The investigation determined the officer was a senior doctor.

[5] The investigation did not substantiate the allegation. The Commission will therefore take no further action.[3] During the preliminary investigation the Commission uncovered a misconduct risk. It will be for the Rockingham General Hospital (RGH) to manage that risk.

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[1] *Corruption, Crime and Misconduct Act 2003* (CCM Act) s 4(c).

[2] CCM Act s 32(2).

[3] CCM Act s 33(1)(d).

THE COMMISSION'S INVESTIGATION

[6] The allegation specifically related to the death certification process for Mr Kevin Reid who died at RGH in September 2022.

[7] Mr Reid was admitted to hospital on 23 August 2022 with shortness of breath and fluid overload. He had a history of cardiomyopathy and chronic kidney disease. Over the next few days, his medical team attempted to reduce the amount of fluid in his body.

[8] On the morning of 5 September 2022 the medical emergency team (MET) was called when Mr Reid's heart rate dropped below 40. He was assessed at that time as being incapable of making treatment decisions. By the middle of the day, the MET call was reactivated. The treating team determined that, having tried all possible interventions, Mr Reid was not improving and further intervention would be futile. His brother, who held an enduring power of guardianship, and his mother agreed Mr Reid should be made comfortable. He was subsequently transferred to the palliative care team for end of life care.

[9] As part of its investigation, the Commission obtained the patient file for Mr Reid. RGH patient records are generally paper based.

[10] At 8.30 pm on 5 September 2022, nursing staff made a handwritten entry in the integrated patient progress notes that Mr Reid appeared settled with no sign of pain.[4]

[11] At 10.14 pm on the same day, nursing staff made the next entry in the integrated progress notes, recording:

> *Handed over by afternoon staff, pt [patient] passed away on handover at 2120 hrs. Contacted mother (NOK) to advise, awaiting doctor certify, family will come in soon.*[5]

[12] RPG's clinical practice standards require that either a doctor or nurse assess and document cessation of life. However, only nurses at RPG's Murray District Hospital (MDH) are required to undertake this responsibility because there are no doctors available at MDH after hours. In practice, a doctor will generally determine life extinct at RGH.[6]

[13] RPG's *Death of a Patient - Last Offices (Acute) Procedure* requires the following extinction of life criteria to be documented when assessing cessation of life:

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[4] Exhibit No. 02847-2022-0011.
[5] Exhibit No. 02847-2022-0011.
[6] Exhibit No. 02847-2022-0008; Registrar transcript, private examination, 27 October 2022, p 22.

(a) absence of heartbeat and respiration on auscultation; and

(b) absence of pupil reaction.[7]

[14] In Mr Reid's case, this was not done.

[15] On 6 September 2022, a Resident Medical Officer recorded in the integrated progress notes that on the evening of 5 September 2022 she performed the death certification exam for a patient on another ward. After attending the evening handover meeting on Mr Reid's ward, she was advised by one of the nursing staff that he had passed away. She informed the nurse she still had to complete the death certification paperwork for the other patient and requested they contact the night team to review Mr Reid.[8]

[16] It appears this did not occur. Whether due to an oversight or a breakdown in communication, the Commission is satisfied there was no serious misconduct involved.

[17] The investigation included private examination of a Medical Service Registrar, a qualified medical practitioner who had been involved in Mr Reid's medical care. The Registrar gave evidence that he last saw Mr Reid alive between 7.00 pm and 8.00 pm on 5 September 2022 when he walked past Mr Reid's room and observed him take a breath. The first he became aware that Mr Reid had passed away was when he was asked to complete the death certification on the morning of 6 September 2022.[9] By this time, Mr Reid's body had been taken to the mortuary.

[18] The Registrar attended the mortuary in the company of two patient care staff, to examine the body. Upon opening the body bag, he observed Mr Reid's left arm up over his right shoulder, his eyes were open and he had a blood clot from an apparent new skin tear on his right arm. The Registrar assessed Mr Reid for cessation of life. He listened to the chest with his stethoscope for approximately three minutes to confirm there was no heartbeat or breathing. He also observed there was no palpable carotid pulse, no pupil reaction and no response to pain stimulus.[10]

[19] After leaving the mortuary, the Registrar discussed his observations with the palliative care team and a member of the RPG executive. He was concerned his findings were inconsistent with a person who was deceased on arrival at the mortuary. He said they discussed this possibility, other

[7] Exhibit No. 02847-2022-0008.
[8] Exhibit No. 02847-2022-0011.
[9] Registrar transcript, private examination, 27 October 2022, p 36.
[10] Registrar transcript, private examination, 27 October 2022, p 66-70.

possible explanations for his observations and whether the death needed to be reported to the Coroner.[11]

[20] The Registrar explained it was agreed his findings did not alter the cause of death and he would complete the paperwork with the time that he reviewed the body recorded as the time he certified death.[12] The Registrar subsequently completed the Life Extinct Form, Death in Hospital Form and Medical Certificate of Cause of Death, recording the date of death as 6 September 2022. The cause of death was given as decompensated heart failure.

[21] The Registrar gave evidence that in addition to completing the death paperwork, he handwrote two sets of notes as a contemporaneous record of what had occurred.[13] One set were clinical notes which he placed on Mr Reid's patient file. These covered his findings in the mortuary, the discussions which occurred afterward and the decision that the death did not need to be immediately reported to the Coroner.

[22] The second set was to inform the Registrar's head of department, another medical practitioner. These covered the events of the day as well as workload statistics at that time. The Registrar placed these notes in the head of department's desk drawer on his instructions.

[23] As part of its investigation, the Commission obtained the notes which were in the desk drawer. However, the Registrar's clinical notes regarding the death certification process were not on Mr Reid's patient file. The Commission made further inquiries but the notes could not be located.

[24] The Commission heard evidence that RGH was undergoing a reaccreditation process around the time that Mr Reid died.[14] Without the second set of notes from the desk drawer, there was no contemporaneous record of the Registrar's findings from the mortuary and no record on the patient file to indicate anything untoward about the death certification process.

[25] The investigation did not identify that any public officer had engaged in serious misconduct by destroying the notes, which constituted a patient record.[15] It did, however, highlight the serious misconduct risks in relying on paper records. While electronic medical records can be costly to implement and maintain in the hospital system, electronic records offer

[11] This issue is outside the Commission's jurisdiction.
[12] Registrar transcript, private examination, 27 October 2022, p 71-76.
[13] Registrar transcript, private examination, 27 October 2022, p 77-81.
[14] Registrar transcript, private examination, 27 October 2022, p 71.
[15] CCM Act s 4(c) and *the Criminal Code* s 85(d).

better security and an audit trail of access. The management of a misconduct risk is a matter for the RPG.

[26] In his examination, the Registrar gave evidence that a couple of weeks after Mr Reid died, a ward clerk informed him the funeral home had enquired whether the date of death could be changed on the paperwork as it appeared to be incorrect. The Registrar told the ward clerk the matter had been escalated to executive and needed to be discussed with them.[16]

[27] The Registrar described subsequently being contacted three times by a senior doctor with respect to Mr Reid's death. On the first occasion, the senior doctor attended the emergency department to speak with him. The Registrar said he was asked if he would change the date of death to 5 September 2022 to avoid distress to Mr Reid's family. The Registrar confirmed this was a suggestion, rather than a directive, before declining to change the date as it was not when he had certified death.[17]

[28] The second occasion occurred later the same day when the senior doctor telephoned him. According to the Registrar, the senior doctor said he had spoken to the nurse coordinator, on shift on the relevant night, who had assured him she had confirmed Mr Reid was deceased before he was taken to the mortuary. The Registrar said he still would not change the date because there was no written record of the nurse coordinator's assessment. The Registrar's evidence was again there was no direction from the senior doctor to change the date and the senior doctor accepted his response.[18]

[29] In his response to a draft of this report, the senior doctor denied asking the Registrar to change the documented date of death and stated the purpose of the first conversation was to determine why the date on the death certificate was different from the date the family attended upon Mr Reid. The purpose of the subsequent telephone call was to advise the Registrar that Mr Reid had, in fact, been confirmed as deceased on 5 September 2022.

[30] As part of its investigation, the Commission obtained the senior doctor's file note from 30 September 2022 regarding the two conversations:

> *19th Sept I had two conversations with [the Registrar] regarding this case. One in person on the flight deck of ED and one on the phone. The conversation was around the date of the death certificate. I initially spoke to [the Registrar] about the death certificate and that the family had raised concerns that the date was incorrect. We had a chat about whether he felt comfortable changing the date to*

[16] Registrar transcript, private examination, 27 October 2022, p 93.
[17] Registrar transcript, private examination, 27 October 2022, p 94.
[18] Registrar transcript, private examination, 27 October 2022, p 95-96.

the date his family had been informed. He said he did not as they [sic] death had not been properly confirmed and the conversation ended at that pointed [sic]. Later I rang him as I had been told the death had been confirmed that night but the nurse had forgotten to document it in the chart. I asked him if that would change his position and he said no and felt the nurse was not telling the truth. I said that was fine and the conversation ended. Both conversations were polite and cordial. At no point did I feel I was intimidating [the Registrar] or trying to coerce him into doing something. He was not directed to do anything.[19]

[31] The third occasion occurred on the morning of 30 September 2022. The Registrar said he was at home after a busy night shift when he received a call from the senior doctor on his mobile phone. The senior doctor enquired how he was coping and they discussed Mr Reid's care.[20]

[32] In his response to the draft report, the senior doctor stated the sole purpose of this call was to undertake a welfare check on the Registrar and there was no discussion regarding Mr Reid's death certification.

[33] The Registrar had the impression from the call that the senior doctor wanted the date of death changed. Whether or not he was correct in his impression, he did not change the date of death.

[34] Correctly, as he had concerns, he sought advice and notified the coroner.

[35] Workplace conflict is not uncommon and can be constructive if managed well. A junior doctor may find it stressful or intimidating being approached directly and repeatedly by a member of the hospital executive. Including their head of department in discussions may allay those concerns.

[36] In the Commission's opinion the Registrar was an honest witness whose testimony was credible. However, taken at its highest the evidence does not reach the threshold of a reasonable suspicion of serious misconduct. The evidence does not establish that the senior doctor attempted to coerce the Registrar to change the date of death on Mr Reid's death certificate. The senior doctor was entitled to ask the Registrar to consider a change of date; the Registrar was entitled to decline.

[19] Exhibit No. 02847-2022-0007.

[20] Registrar transcript, private examination, 27 October 2022, p 96-99.

CONCLUSION

[37] The Commission has completed its investigation and has not identified serious misconduct in relation to the allegation. It will take no further action.

[38] Nothing in this report is to be taken as a finding or opinion as to how Mr Reid's death occurred, the cause of his death, or the particulars needed to register the death under the *Births, Deaths and Marriages Registration Act 1998*.