QUEENSLAND COURTS

# OFFICE OF THE STATE CORONER

# FINDING OF INQUEST

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| CITATION: | **Inquest into the death of June WOO** |
| TITLE OF COURT: | **Coroner's Court** |
| JURISDICTION: | Brisbane |
| FILE NO(s): | COR 2713/02 |
| DELIVERED ON: | 01 June 2009 |
| DELIVERED AT: | Brisbane |
| HEARING DATE(s): | 14 December 2007, 26 February 2008, 8-10 July 2008 & 03 September 2008 |
| FINDINGS OF: | Mr Michael Barnes, State Coroner |
| **CATCHWORDS:** | **CORONERS: Inquest, Palliative care for terminally ill patients, consent to with holding life sustaining measures, *Guardianship and Administration Act 2000*** |

**REPRESENTATION:**

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| Counsel Assisting: | Ms Jennifer Rosengren |
| Princess Alexandra Health Service District:: | Mr Kevin Parrott (Crown Law) |
| Family of Mrs Woo: | Mr Francis Chais (Chais Law)<br>The Honourable Tim Carmody SC (instructed by Russo Lawyers) |

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*The Coroners Act 1958* provides in s43(1) that after considering all of the evidence given before a coroner at an inquest the coroner shall give his or her findings in open court. What follows are my findings in the inquest held into the death of June Woo. They will be distributed to all those who were granted leave to appear and posted on the web site of the Office of the State Coroner

## Introduction

In the early evening of 14 November 2002, Mrs June Woo, an 82 year old woman with a history of pulmonary fibrosis and chronic respiratory failure, was admitted to the Princess Alexandra Hospital in Brisbane. She was assessed in the Emergency Department. Initially, she was minimally responsive. However, after an hour or so she become combative and was confused and distressed. She was sedated. At about midnight she was moved to a respiratory ward. At about 9.10pm the following night Mrs Woo stopped breathing. As a "*not for resuscitation*" order had been made the evening before, resuscitation was not attempted. One of the attending doctors later issued a cause of death certificate listing hyperkalaemia (higher than normal levels of potassium in the blood) as the principle cause of death. The family did not accept this and so, after some delay, the death was referred to the Brisbane Coroner for investigation.

These findings address the following issues:-

- Did the cause of death certificate and autopsy report accurately identify the cause of death?
- Did any of the drugs administered to Mrs Woo contribute to her death?
- Was the medical care appropriate and in particular were adequate attempts made to treat Mrs Woo's illnesses?
- Did the treating team adequately communicate with Mrs Woo's family?
- Did the making of the "*not for resuscitation"* order comply with the law and the policy then in place and is the current NFR policy of the Princess Alexandra Hospital appropriate?

## Jurisdiction

Although this inquest commenced in 2008 and concluded in 2009, as Mrs Woo died in 2002, her death is a "*pre-commencement death*" within the terms of s100 of the *Coroners Act 2003* and so the provisions of the *Coroners Act 1958* (the Act) are preserved in relation to it.

A doctor at the Princess Alexandra Hospital (PAH) who had been involved in treating Mrs Woo, issued a cause of death certificate showing hyperkalemia as the primary cause of her death. Her family did not accept this and alleged the death had been caused or contributed to by inadequate care at the hospital. They raised their concerns

with the Brisbane Coroner who accepted she had jurisdiction to investigate the circumstances of the death.[1]

The Brisbane Coroner caused an autopsy to be undertaken and had the medical records and the autopsy report reviewed by an appropriate expert. She concluded an inquest was not necessary: in her view the cause of death was as had been previously certified and there was no basis on which to conclude the treatment provided to Mrs Woo by the doctors at the Princess Alexandra Hospital had contributed to the death. The Coroner advised the family accordingly and on 17 June 2005 she closed the file.

The family did not accept this decision. They petitioned the then Minister for Justice for an order that an inquest be convened. The Minister determined she would await the findings of a Health Quality and Complaints Commission (HQCC) investigation before making a determination. The HQCC examined 23 concerns and sought a response from the hospital and a number of independent expert reviews. In a letter dated 10 August 2006, it concluded that none of the family's concerns could be substantiated.

By this stage a new Minister had assumed responsibility for coronial matters. The family renewed their request for an order that an inquest be held and on 12 July 2007, the then Minster directed pursuant to s7B of the Act that I convene an inquest into Mrs Woo's death.

## *The inquest*

Further expert reports and statements from each member of the treating team who could be located were obtained.

A directions hearing was held on 14 December 2007. Ms Rosengren was appointed Counsel Assisting. Leave to appear was granted to the Princess Alexandra Health Service District and to the family of Mrs Woo. At the first hearing a number of further statements and documents were requested and the matter was adjourned to 26 February 2008 to allow for these to be prepared and disseminated. When the hearing resumed most of the material had been received but some additional information was still required. The matter was adjourned to a date to be fixed to allow the additional material to be provided.

On 12 June the parties were advised the inquest would resume on the week of 7 July 2008.

On 30 June the family advised they had terminated the retainer of the law firm that had been acting for them. It was determined the inquest would commence on 8 July to allow some time for the family's new legal representatives to read the material.

The inquest proceeded for three days. The inquest was then adjourned to a date to be fixed to hear further oral evidence.

Evidence was heard on 3 September 2008 and the inquest was adjourned to enable written submissions to be made on the basis that those granted leave to appear would respond to a draft list of issues disseminated by counsel assisting.

[1] The file does not contain a record of the basis of this decision. However, I consider it was reasonable for the Coroner to have concluded Mrs Woo had "*died in such circumstances as to require the cause of death or the circumstances of death or both to be ascertained or more clearly and definitely ascertained*", giving the coroner jurisdiction to inquire into the death pursuant to s7(1)(a)(ix).

On 28 October 2008, the family advised they had terminated the retainer of the lawyers who represented them at the inquest.

On 30 October 2008, a list of issues for submissions was sent to the parties for response. A finalised issues list was distributed to the parties on 17 November.

Ms Rosengren's final submissions were disseminated to the parties on 19 December with advice that responses were required by 30 January 2009.

On 28 January the State Coroner received an application from the family for a four week extension. This extension was granted.

On 30 January 2009 submissions were received on behalf of the Princess Alexandra Health Services District.

Submissions on behalf of the family drafted by Ms Felicity Madison, Carer Advocate, Carers Queensland, were received on 27 February 2009. However the following week the family attended the Office of the State Coroner and advised they were unhappy with the submissions provided and would like to provide their own submissions. This request was granted and the family were given till Friday 6 March 2009. A Ms Dianna Hutchings then contacted the office advising she was now assisting the family and she required additional time to consider the material and provide the family's submissions. An extension was granted.

A further request for an extension of time was received on 10 March 2009. An extension was granted until 20 March 2009.

A further request for an extension was received on 24 March 2009 and was granted until 30 March 2009. The second set of submissions on behalf of the family, drafted by Ms Hutchins was received on 31 March 2009. In the intervening period submissions were also received from another lay advocate who at various times has been communicating on behalf of the family. Since then the family has continued to write to the court raising new issues and reiterating matters contained in previous correspondence.

In view of the amount of material submitted on behalf of the family of Mrs Woo, it is impossible for me to be sure I have dealt in these findings with all of the allegations and arguments. However, I believe I have responded to the main issues. I have consciously striven to ensure the frustration generated by the way the family have complicated these proceedings has not influenced my assessment of the evidence.

## The evidence

### *Social history*

June Woo was an 82 year old Catholic Cantonese lady, who was happily married to her husband Thomas Yu for more than 60 years. They had five daughters and two sons. She completed her piano teaching levels and a university degree in Education in Shanghai before relocating with her family to Hong Kong in the 1950s. In 1988, the family migrated to Australia and made their home in Brisbane. In February 2001, Thomas died of natural causes at the age of 93. Mrs Woo had a strong, caring and loving relationship with all her children.

## *Medical history*

Mrs Woo's medical history was complex. She had chronic restrictive airways disease secondary to tuberculoses. She also had high blood pressure, chronic renal impairment and a cystic left ovary.

In 1994, part of her liver and one of her adrenal glands were removed as a result of a rare malignancy.

The medical records from the PAH indicate that Mrs Woo required twenty one inpatient admissions between September 1990 and September 2002.

There can be no doubt that her respiratory disease was terminal and she had borderline renal function over the preceding couple of years. She had been on home oxygen for about 2.5 years at the time of her death and had periodic respiratory failure in the setting of excessive oxygen use. In his autopsy report, Dr Lampe indicated that inquiries made of respiratory physicians indicated that the average life expectancy of patients on home oxygen is 12 to 18 months. An expert who gave evidence at the inquest confirmed this.

At the time of her death, Mrs Woo weighed approximately 48 kgs.

## *The final admission*

At approximately 6.40pm on 14 November 2002, Mrs Woo was driven by her family to the Queensland Ambulance Station at Mt Gravatt complaining of central chest pain radiating into her arms. She was found to be pale, sweaty and cool with an irregular and low heart rate. She was transported by ambulance to the PAH.

Mrs Woo arrived in the Emergency Department at about 7.10pm and was noted to be unwell and was triaged category 2. She was placed in a monitored cubicle and was attended to by Dr Sean Lawrence, a senior registrar. On examination, she was found to have low blood pressure – 76/43, an abnormally slow heart beat – 40 beats per minute, and shortness of breath. She was minimally responsive and was moved to a resuscitation cubicle. She was treated with aspirin for her chest pain, atropine and adrenaline for her low heart rate and blood pressure, and frusemide to address the shortness of breath that was likely to have been caused by pulmonary oedema consequent upon the low heart rate. She was also given nebulised salbutamol and ipratropium bromide – both broncho-dilators – to treat possible contributants to her shortness of breath such as asthma or bronchospasm. Mrs Woo was given oxygen via nasal prongs.

An urgent arterial blood gas analysis revealed life threatening hyperkalaemia (higher than normal levels of potassium in the blood stream 8.3mmol/L) and metabolic acidosis. This was treated with calcium gluconate, sodium bicarbonate, insulin and glucose.

These therapies were effective: Mrs Woo's blood pressure, heart rate and blood potassium returned to acceptable levels.

An ECG showed no acute ischaemic changes that might explain her chest pain.

At approximately 8.15pm, she became agitated, distressed and combative. She was trying to get out of bed and apparently saying in Cantonese that she wanted to go home.

In response Dr Lawrence prescribed 2.5 mg of both haloperidol and morphine which were administered intravenously. Haloperidol is an antipsychotic drug and morphine is a narcotic analgesic which produces sedation and is normally used for control of severe pain. Dr Lawrence explained he chose to use Haloperidol because it does not repress respiration and has few other side effects. He acknowledged that morphine can repress respiration but said he was confident such a small dose as he gave - 2.5 mg - was not likely to do that to Mrs Woo, and in any event he knew its effects were reversible. That soon became necessary.

After initially improving, Mrs Woo's condition deteriorated. She became less responsive with poor respiratory effort. She was given more broncho-dilators at about 8.30pm and her oxygen delivery was changed to a Venturi mask set at 24%.

When a further analysis of her blood gases was reviewed shortly afterwards, it was noticed her acidosis had worsened as a result of rising arterial carbon dioxide. She was given 100 mcg of Naloxone at 8.40pm and a further 300 mcg about three minutes later, in case her decline was related to the effects of the morphine. This had no discernable effect on her respiration rate although her oxygen saturation did improve.

Dr Lawrence considered the only other treatment option which might assist Mrs Woo was non-invasive positive pressure ventilation – that is, the provision of respiration gases through a tight fitting mask which is less traumatic and distressing than inserting a tube into the patient's trachea. This could only occur in the respiratory unit, so he discussed her condition with Dr Michelle Murphy, a senior respiratory registrar who had seen Mrs Woo on previous admissions, and Dr Craig Hukins, the consultant on call for the Department of Respiratory Medicine. The doctors collectively concluded the treatment would be inappropriate for Mrs Woo having regard to her high level of metabolic acidosis related to acute renal failure and its potential to worsen Mrs Woo's hypotension and the futility of such treatment in a patient with such severe, irreversible respiratory illness. This decision was made in accordance with published guidelines.[2]

In evidence, Dr Lawrence put more concisely the reasons for not proceeding with mechanical ventilation when he said,

*"The fundamental reason for not offering it was that it was felt that she was going to die during the admission, and that wasn't going to change the outcome, and it would just make it uncomfortable during her final time."*[3]

Obviously, Dr Lawrence considered Mrs Woo's prognosis was very poor and that she was unlikely to survive her illnesses. He says he based this assessment on Mrs Woo's history that he gleaned from the chart and discussions with the respiratory physicians who had treated Mrs Woo previously. He summarised her condition as "*acute respiratory failure on a background of end stage restrictive lung disease and chronic CO2 retention, hyperkalaemia due to medication and worsened renal function."* He says he discussed this with her family members and made a note in the chart to this effect. He formulated a care plan documented in part as "*Keep comfortable, try Haloperidol initially then titrated morphine, medical registrar to review."*

[2] Non invasive ventilation in acute respiratory failure – British Thoracic Society Standards of Care Committee, Thorax 2002; 57:192 - 211
[3] T1. 35

Mrs Woo's daughters believe he told them that if the patient was young he would save the patient but because of Mrs Woo's age, he would not. Dr Lawrence does not remember the precise terms of the conversation but considers it likely he told the family that in view of their mother's age and numerous co-morbidities there was nothing that would change the outcome, whereas with a much younger person, different therapies could lead to the patient's survival.

## *"Not for resuscitation"*

Mrs Woo was referred for inpatient admission to Ward 2D, with the plan to continue oxygen and provide nursing care. Before she left the Emergency Department, Dr Lawrence made a "*not for resuscitation"* order in Mrs Woo's chart which meant that attempts would not be made to resuscitate her in the event of a cardio respiratory arrest. Dr Lawrence considered this order to be medically appropriate on account of the irreversible nature of her severe lung disease and worsening renal failure. In a statement, Dr Lawrence explained that he considered CPR would be ineffective and therefore inappropriate. In those circumstances, he did not consider the decision was one the relatives could consent or object to.[4]

The progress notes record the *"family are aware of prognosis, has been visited by priest".* Dr Lawrence had no independent recollection of the conversation he had with Mrs Woo's family. He said in evidence, his usual practice would have been to discuss with the family the nature and severity of their mother's illness, the treatment plan and her poor prognosis. He would then explain that in the event of her deterioration that resuscitation would not be medically appropriate. He said he would use lay language and simple medical terms because although he was cognisant of the fact that some of the family were able to converse in English, this did not necessarily mean they were able to readily comprehend the information provided by him. He generally repeats the information on three or four separate occasions and enquires as to whether the family members have any questions. He said had the family requested an interpreter or had there been any apparent need for an interpreter, arrangements would have been made for one to be present. [5]

Reconstructing, Dr Lawrence considered it unlikely the family expressed any disagreement with the order as he believes he would have made some relevant entry in Mrs Woo's progress notes to this effect. Further, he would have involved other medical practitioners in the discussion, such as the respiratory consultant, intensive care consultant or medical superintendent. He believes the family would have been informed of the order as part of the treatment plan.[6]

The medication chart indicates that at about 9.30pm, Mrs Woo was given further doses of the broncho-dilators and a further 2.5mg of haloperidol. Dr Lawrence considered this additional medication would have been given for further agitation and distress.[7] At about the same time he wrote an order for more Haloperidol or morphine in 1 mg titrated doses "*PRN*". This authorised the nursing staff to give the drugs as they considered necessary to keep Mrs Woo comfortable. Mrs Woo's family claim she was already non responsive when she was given this second dose of Haloperidol. Dr Lawrence did not claim to be

[4] Exhibit 3.2 p2
[5] T1.32, 36, 64-65
[6] T1.37-9
[7] T1.32

able to specifically remember her condition when it was given but denies it would have been administered unless Mrs Woo was manifesting some distress and/or agitation.

As part of the admission procedure, Mrs Woo was reviewed by a medical registrar, Dr Massarotto. In a note in the charts shown as having been made at 9.20pm, he recorded her history in the emergency department and noted that she was unresponsive. Dr Massarotto varied the care plan slightly in that he listed morphine and "*midaz"* (presumably midazolam) as the drugs she should be given, in place of the morphine and Haloperidol Dr Lawrence had ordered. This suggests it was made after the drugs said to have been administered at 9.30 had been given.

Dr Massarotto was obviously also persuaded that Mrs Woo's condition was terminal because he wrote in the chart; "*In the event of cardio pulmonary arrest, it would be inappropriate and* ***against family wishes*** *to proceed,"*(emphasis added). The family deny there was any discussion with them about this issue. Unfortunately, Dr Massoratto returned to the United Kingdom in 2003 and it was not possible to call him to give evidence at the inquest.

## *Transfer to the ward*

The observation chart indicates that Mrs Woo's vital signs were monitored until 10.15pm. There are then no notes until she is admitted to ward 2D, the respiratory ward, at about midnight on 14 November. It seems that she was placed in a bed in a corridor in the Emergency Department awaiting admission to the ward and during this period she did not receive any monitoring, medications or oxygen therapy.

Kam Maurici was the registered nurse on duty and provided nursing care to Mrs Woo until 7.00am. The care plan required Mrs Woo's observations to be taken every six hours. The medical records confirm that such observations were taken by Ms Maurici at 12.00am and 6.00am and that soon after admissions the Venturi mask was replaced with a Hudson mask with a flow rate of 8 litres per minute that was subsequently reduced to 6 litres per minute.[8] It is not clear who made the decision to change the delivery method or the basis for the decision.

The family were concerned that their mother received no attention from nursing staff between midnight and 6am. Ms Maurici categorically denied this.[9] Further, the care plan confirms that Mrs Woo's pressure areas were attended to during this time.[10] I accept Mrs Woo was checked every hour and the absence of any record of these observations in the medical notes is a result of her vital signs not changing significantly. RN Maurici said she would not have woken Mrs Woo when making the hourly checks.[11]

The care plan noted the "*not for resuscitation order*" and RN Maurici gave evidence that in these circumstances she would have had a discussion with the family to ensure they comprehended the effect of the order. She understood the effect of the order to be that Mrs Woo would not be resuscitated if she stopped breathing and that a doctor would be immediately notified.[12] RN Maurici was able to converse with the family as she speaks fluent Cantonese. She had no specific recollection of her conversation with the family

[8] Exhibit H6 p1075
[9] 2.20-1
[10] Exhibit H6 p1071
[11] T2.7-12
[12] T2.6-8

but considered she would have made a notation in the progress notes if any of the family had disagreed with this order.

RN Colless assumed responsibility for the nursing care of Mrs Woo from 7.00am until 1.00pm.

Dr Vishva Wijesekera, senior house officer, commenced his shift in Ward 2D at 8.00am. He examined Mrs Woo at about 10.00am. Her Glascow Coma Score was 6/15. She was semi-conscious and unresponsive. Dr Wijesekera considered that Mrs Woo was very unwell with severe lung disease, kidney failure and an impaired state of consciousness. He did not consider her condition was reversible and he thought her prognosis was poor. Dr Wijesekera changed the oxygen delivery method from the Hudson mask to nasal prongs because Mrs Woo's saturations were at 99%, which he considered excessive. The nasal prongs delivered a lower amount of oxygen than the mask.[13]

Dr Wijesekera ordered a blood test to check the levels of potassium, electrolytes, urea and creatinine. Mrs Woo was turned regularly and the drying effect of the nasal prongs was responded to appropriately. The doctor noted Mrs Woo was "*not for resus in the event of a c-r* (cardio- respiratory) *arrest.*"

He re-examined her at 1.00pm by which time the blood tests had been reported. They showed the potassium level had risen to 8.9mmol/L from 6.0 at approximately 8.00pm the previous evening. Dr Wijesekera noted his diagnosis as "*Acute on chronic renal failure, fluid overload, end stage lung disease."* A decision was made not to attempt aggressive treatment in an attempt to again reduce the metabolic imbalance but rather to provide "*comfort cares."* However, 50ml of 50% dextrose and Actrapid 10u was given indicating that attempts were made to treat Mrs Woo's hyperkalaemia.

On three occasions Dr Wijesekera attempted to take an arterial blood gas measurement but was unsuccessful on account of Mrs Woo's poor peripheral perfusion.[14] No further attempts were made at the request of Mrs Woo's family. Dr Wijesekera decided that in the interests of Mrs Woo's comfort, he would seek information about blood gases by taking venous blood samples.[15]

Dr Wijesekera had a limited recollection of speaking with Mrs Woo's daughters at the time of the initial examination. He recalled that one of the daughters was fluent in English and another daughter also spoke reasonable English. He says he explained that Mrs Woo was very ill. He could not remember discussing the "*not for resuscitation order*" at this stage, although he gave evidence that it would be his usual practice to do so. This witness also said that had the family expressed any disagreement with the order, he would have noted it in the progress notes and spoken to his registrar.[16]

The progress notes that were made contemporaneously with the review indicate that Dr Wijesekera *"explained to the daughters that mother's condition rapidly deteriorating"* and *"agrees that in the event of a cardio respiratory arrest resuscitation would not be appropriate".* Dr Wijesekera was adamant that he would not have used complicated

[13] T2.41-2
[14] T2.38, 73

[15] T2.38-41
[16] T43-4

medical terminology. The examples he gave of the explanations he would have provided as to the effect of the "*not for resuscitation*" order were that *"if the heart stops we won't shock the heart because it's not considered appropriate"* and that if she stopped breathing *"we won't put a tube down her throat and put her on a machine to do her breathing".* He did not recall the family expressing any disagreement regarding the proposed treatment plan and considered the absence of any relevant notation in the progress notes would suggest that no such disagreement was expressed by any family member.[17]

It was Dr Wijesekera's impression that while the daughters understood the information provided to them, they did not want to accept that their mother was gravely unwell because she had always recovered following her earlier admissions to the PAH.[18] He recalls one of the daughters insisting that her mother be given Lasix, a diuretic, or antibiotics and his having to repeatedly explain that these would not address Mrs Woo's ailments.

RN Oakland had a clear recollection of providing nursing care to Mrs Woo from about 1.00pm. She recalled that some of the family spoke sufficient English so that she could converse with them.[19] At the request of Dr Wijesekera, she made arrangements for an interpreter to attend the ward so that Dr Wijesekera could ensure the family had fully understood his previous conversations with them. It was her usual practice when making such arrangements to ask the family what dialect of the Chinese language they spoke and to then request the services of an interpreter who spoke the same dialect.

The progress notes confirm that a Cantonese speaking interpreter attended the ward at approximately 3.00pm on 15 November 2002 and that a discussion with the interpreter took place in the interview room. While RN Oakland thought that the discussion took place next to Mrs Woo's bed, she was sure that she was present for the duration of the conversation between the interpreter, Dr Wijesekera and Mrs Woo's daughters.[20] She recalled Dr Wijesekera speaking at length and explaining to the daughters through the interpreter, that their mother was not expected to survive and that for this reason there was a "*not for resuscitation*" order in place. She recalled Dr Wijesekera discussing with them the meaning of the order and the effect of it in the context of the treatment plan.[21] The daughters nodded their heads in response and were asked whether they had any questions. Ms Oakland recalled the daughters asking for special medicine to help their mother recover. It was her impression that while they understood the information provided to them, they were struggling to accept their mother's passing was imminent.[22] One of the daughters suggested to Dr Wijesekera that he prescribe antibiotics and Lasix to Mrs Woo to reverse her kidney failure. Dr Wijesekera explained that neither of these medications would improve their mother's renal failure. He made a note in the charts "*Explained that it is very likely that Mrs Woo would not survive the night."*

According to Nurse Oakland there was no suggestion at any stage of the conversation that the interpreter spoke a different dialect from the family or that they did not understand the information being conveyed to them.[23]

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[17] T2.45-6
[18] T2.66-7
[19] T2.115
[20] T2.89
[21] T
[22] T2.95, 113
[23] T2.48

Ms Winnie Scheelings was the interpreter involved. In 1989 she had accredited as a level 2 interpreter for Cantonese by the National Accreditation Authority for Translators and Interpreters. She had been providing interpreting services relevant to medical issues for the previous two years and estimated that she had done this between 50 and 100 times before the day in question.[24]

Ms Scheelings could recall having interpreted for Mrs Woo's family on a number of occasions but could not specially recall the day in question. She did remember an occasion when she had interpreted for Mrs Woo's family, that some of her family could speak sufficient English and it had not been necessary to translate all of the discussions. She said in evidence; "*The daughters can speak English themselves because I remember I don't have to do any talking they were just talking to the doctor themselves.*"[25]

This is consistent with what I observed in court. The interpreter who had been retained by the Court to translate the proceedings to Mrs Woo's daughters was only required to explain a small part of what transpired. For the majority of the time, it was obvious the daughters were following what was being said unaided. This was confirmed by the lawyers then acting for her.

A plan was put in place for the nursing staff to administer small doses of morphine, midazolam and hyoscine (used to suppress bronchial secretions), if Mrs Woo was to become uncomfortable or distressed and this was noted in her chart.

At about 3.20pm, Mrs Woo was given normal saline, via a catheter inserted in her abdomen.

RN Oakland remembered Mrs Woo waking for a short time in the afternoon and being agitated, distressed and restless. RN Oakland says she discussed with at least two of Mrs Woo's daughters her plan to administer small doses of the medications to make their mother more comfortable. RN Oakland says Mrs Woo's daughters were happy for this to occur. The medical records indicate that at 5.30pm, Mrs Woo was given 5mg of morphine, 2.5mg of midazolam[26] and 0.4mg of hyoscine, with good effect. The morphine and midazolam where given for their sedative effect. Hyoscine was given to dry up oral and nasal secretions because Mrs Woo was a bit "*gurgly*". All of the drugs were administered subcutaneously in the patient's abdomen. It seems they were given in response to agitation in a setting of terminal or agonal restlessness.

In their statements, the daughters give a different account. They say their mother woke between 3.45 and 4.30pm and after some conversation and being given a drink she went back to sleep. They say their mother was resting peacefully when one of the nurses administered the injections.

I don't accept their account. There is no basis on which to suspect the nursing staff would give sedatives to Mrs Woo if she were asleep and comfortable. I conclude her daughters are mistaken.

[24] T1.13-15
[25] T1.18
[26] There was some uncertainty about the timing of this dose. The chart appears to show it was given at 19.30 but when giving evidence RN Oakland indicated it more likely to have been given with the other drugs at 17.30

## *Mrs Woo dies*

At approximately 7.00pm, a change in Mrs Woo's breathing pattern was observed. Mrs Woo's family requested that observations be taken and they were noted in the chart. The family requested RN Oakland give their mother "*special medicine"* to make her better again. RN Oakland asked them if they had fully understood what the doctor and interpreter had told them earlier that day. RN Oakland recalled Mrs Woo's daughters indicating words to the effect of "*Yes we understand she could die but in the past they have said that and she never has so why should she die this time."*[27]

At about 9.10pm, Mrs Woo's family informed RN Oakland that their mother had passed on. On examination, RN Oakland found no signs of life. The on-call resident medical officer, Dr Cavallucci was called. He confirmed life was extinct.

Some of her family members immediately began manifesting severe distress and irrationality; stripping the sheets from Mrs Woo's bed and taking photographs of her. The nursing staff attempted to comfort them and to restore some dignity to the dead woman by washing and dressing her. A priest was called and attended.

Dr Wijesekera had already left the hospital when Mrs Woo died. When next he worked on 18 November, he signed a certificate indicating her death was caused by hyperkalaemia, due to acute renal failure on a background of end stage pulmonary fibrosis, secondary to tuberculosis.

## *The family's reaction*

Mrs Woo's children, or some of them, did not accept the cause of death as certified nor that it was not preventable. They complained to the Safety and Quality Department of the PAH that the medication given to their mother had been responsible for her death. Before the hospital could respond they also approached the counselling section at the John Tonge Centre, as they had dealt with the staff there previously when their father died. One of the counsellors wrote to the hospital detailing the family's concerns and Dr Graves, who was then the hospital's Deputy Director of Medical Services, convened a meeting of the treating team.

The meeting discussed the concerns articulated in the letter from the counsellor, reviewed the chart and concluded that Mrs Woo's condition had been managed correctly from a medical perspective but queried whether there had been communication difficulties. The meeting therefore resolved to invite the family to a meeting with the treating team and an interpreter so the hospital's views about the treatment of Mrs Woo could be explained.

Dr Murphy, the respiratory registrar who saw Mrs Woo on the evening of her last admission, wrote a response to the counsellor's letter.

On 25 November, Dr Graves rang the Brisbane Coroner and discussed the case with her. The Coroner advised Dr Graves that on the information provided, the death was not reportable but if the family wished to refer it to the Coroner, she would look further into the matter.

The proposed meeting never occurred as the family did not wish to participate. The family also refused to make arrangements for Mrs Woo's funeral and instead contacted

[27] Exhibit C1 p2

the then Acting Brisbane Coroner on 12 or 13 December 2002. The allegations of wrongful death were repeated and the Acting Coroner instructed police to cause Mrs Woo's body to be moved to the John Tonge Centre so that an autopsy could be conducted.

## *The autopsy results*

On 18 December 2002, Dr Guy Lampe, an experienced and well respected pathologist undertook an autopsy on Mrs Woo's body. He was provided with the PAH medical charts and was aware that the family had concerns about the circumstances of her death.

He found extensive pulmonary fibrosis consistent with end stage lung disease. He noted that typically patients with this degree of lung fibrosis only survive for about twelve to eighteen months after beginning home oxygen. He also noted evidence of "*acute (on borderline chronic) renal failure with wasted renal parenchyma and clinical evidence of critical hyperkalaemia.*" He noticed she was oedematous (swollen), and suggested this was most likely due to her hypoalbuminaemia – abnormally low levels of albumin in the blood - as a result of renal failure.

Analysis of blood taken at autopsy revealed morphine levels of 0.07 mg/kg, total morphine at 0.09 mg/kg, Lignocaine at 0.1 mg/kg and 0.2 mg/kg of Verapamil.

Dr Lampe expressed the opinion that "*the levels of morphine, Lignocaine and Verapamil* appear to be *to be within an acceptable therapeutic range, and far below what would be considered fatal in a typical healthy person.*" However, he went on to observe, "*even so when using narcotics in patients with respiratory failure, it is difficult to predict the drug's action with respect to dose; it would be useful to have an expert opinion from a clinical pharmacologist on this matter.*"

Dr Lampe concluded that in his opinion the cause of death was hyperkalaemia due to or as a consequence of acute renal failure. He noted under the heading "*Other significant conditions*" "*End stage pulmonary fibrosis."*

His conclusion in this regard was based on the potassium level of 8.9mmol/L in the blood tests results taken at 1.00pm on the day of Mrs Woo's death, her clinical symptoms indicating renal failure and her extensive history of worsening pulmonary fibrosis.

Dr Lampe had a counsellor from the John Tonge Centre contact the family after the autopsy in order to arrange a case conference so that he could explain his findings to them personally. They declined this offer.

## *Expert evidence as to cause of death and treatment*

As the morphine and sedatives given to Mrs Woo are central to the concerns about her care, a table showing the times and doses in which they were administered may be useful when considering the expert's evidence.

| Date | Time | Medication | Dose |
|---|---|---|---|
| 14/11/02 | 8:12pm | Haloperidol | 2.5 mg |
| | 8:15pm | Morphine | 2.5 mg |
| | 8:40pm | Naloxone | 100 mcg |
| | 8:43pm | Naloxone | 300 mcg |

| | | | |
|---|---|---|---|
| | 9:32pm | Haloperidol | 2.5 mg |
| 15/11/02 | 5:30pm | Morphine | 5 mg |
| | 5.30 or 7:30pm | Midazolam | 2.5 mg |

Neither Haloperidol nor midazolam was found at analysis. This was because the former had been given approximately 24 hours before her death and the latter is very quickly eliminated from the blood – its terminal elimination half life is only 1.5 to 2.5 hours. This strongly suggests these drugs played no part in Mrs Woo' death and consequently, when considering this question the experts focussed principally on the morphine that was administered to Mrs Woo about 3 hours and 40 minutes before she died. The potential accumulative and/or potentiating effect of the drugs when given in combination and the effect the drugs may have otherwise had on Mrs Woo's condition, were however considered and commented on by each of the experts.

**Professor Olaf Drummer** is a forensic pharmacologist and a toxicologist employed at the Victorian Institute of Forensic Medicine as Head, Scientific Services. He is also an Adjunct Professor at the Department of Forensic Medicine at Monash University. He has been involved in the analysis of drugs and the interpretation of their biological affect for over 25 years. He has published over 200 papers in scientific journals and given expert evidence in court in over 200 cases. I have no doubt about his expertise to give evidence in relation to the effect of the drugs given to Mrs Woo during her last admission at the PAH in November 2002.

After reviewing the doses and timing of the drugs given to Mrs Woo, Professor Drummer concluded "*there is nothing unusual about the quantity of drugs prescribed, their frequency of use and their combination. It is therefore unlikely in the circumstances of the death that they played any significant role in her death.*"

With reference to the 5 mgs of morphine given at 5:30pm on 15 November he said, "*usual doses of morphine range from 5 milligrams to 30 milligrams*".

Professor Drummer indicated morphine is eliminated by the body very quickly – probably within six to eight hours - and so the doses given on 14 November would not accumulate with the dose given on 15 November.

He also expressed the view the Haloperidol given to Mrs Woo on 14 November would have left her body by the evening of 15 November. It is therefore unlikely to have played any part in her death.

He indicated an advantage of giving morphine and midazolam together is that the desired sedation can be achieved with smaller doses.

He also indicated the greatest impact of the drugs on Mrs Woo's respiration would have been within 15 or 20 minutes of their administration.

Professor Drummer was careful to stress that he was not a clinician and could not critique the treatment of Mrs Woo, but he was adamant that from a pharmacological perspective - that is, looking at the level of the drugs found by toxicological analysis - there was no reason to be concerned about the drugs that were given to her.

He also discounted the family's concerns that Mrs Woo's urine had not been analysed by pointing out the drugs in her blood were a better means of assessing what contribution, if any, they may have made to her death.

**Dr Paul Kubler** is the Director of the Department of Clinical Pharmacology at the Royal Brisbane and Women's Hospital. He has extensive experience in caring for elderly people with severe multi organ failure.

Dr Kubler gave evidence that severe life threatening hyperkalaemia occurs when the serum potassium exceeds 7.0mmol/L predisposing the sufferer to sudden fatal arrhythmias. He said hyperkalaemia is often due to acute renal failure.

Dr Kubler expressed the view the treatment Mrs Woo received when she presented at the PAH on 14 November was appropriate to respond to her hyperkalaemia. He also considered "*her subsequent follow up care for the acute renal failure and any associated electrolytic abnormalities was appropriate in the context of irreversible, non responsive severe acute illness.*"

Dr Kubler concluded "*there are no pharmacological misuse issues that contributed to the death of Mrs Woo during her inpatient management at the Princess Alexandra Hospital during November 14 – 15 2002. In particular, the types of drugs prescribed and administered, their frequency of use and their combination were not a significant factor contributing to her health decline culminating in death.*"

He considered the drugs given to Mrs Woo on the night of her admission may have been responsible for her drowsiness but also pointed out "*there was a multitude of factors occurring simultaneously that can result in a reduced level of consciousness"*: in particular, hypercapnia and renal failure.

Dr Kubler was also adamant Mrs Woo's ailments were likely to predispose her to delirium. Her fluctuating levels of consciousness, as evidenced by her apparent lucidity mid afternoon on 15 November, indicated to him delirium was more likely than sedation to explain her confusion and drowsiness at other times.

He expressed the view the doses of Haloperidol and morphine were both at the low end of the range he would expect to be given to a person in Mrs Woo's condition. The lack of more than a transient beneficial clinical response to the naloxone given to Mrs Woo on the evening of her admission indicated to Dr Kubler that her declining respiratory function was due to her medical conditions rather than the sedatives that had been given to her earlier.

Dr Kubler considered the use of morphine as an analgesic and an anxiolytic to respond to the pain and delirium that resulted in Mrs Woo being combative, agitated and distressed soon after she arrived at the PAH was entirely appropriate – *"essentially a textbook description of how you would manage someone with those problems."*

Like Professor Drummer, Dr Kubler dismissed the suggestion the drugs given at 5.30 pm on 15 November contributed to Mrs Woo's death because her breathing did not change until after 7.00pm and she did not die until after 9.00pm; whereas the negative effect of these drugs on her respiration would have been maximal within 15 to 20 minutes.

Dr Kubler rejected the suggestion Mrs Woo may have benefited from invasive ventilation or haemodialysis – "*all of the other therapies would not have changed the natural history of what happened and would have evoked quite considerable distress."*

Having regard to Mrs Woo's condition on presentation, Dr Kubler considered her multi-organ failure and her history meant there was a 95% chance she would die in the next 30 days no matter what treatment she received. In his view, none of the drugs she was given hastened her death and no therapies or treatment regimes should have been attempted. On this admission, unlike previously, Mrs Woo presented with multi-organ failure: her heart, her lungs and her kidneys were all failing in a manner that contributed to her irreversible decline and death.

A report and evidence was also obtained from **Professor Jeffrey Lipman**, Professor and Head of Anaesthesiology and Critical Care at the University of Queensland and Director of the Department of Intensive Care Medicine Royal Brisbane and Women's Hospital. He has held the last position since 1997.

In his report, Professor Lipman indicated he had read Mrs Woo's medical records and all "*relevant previous information needed to form an assessment of her prognosis and comment on the management of her in her last couple of days in November 2002.*"

As a result of considering that material Dr Lipman "*could find limited evidence of reversibility in her disease processes.*" He agreed with the decision not to provide Mrs Woo with non invasive positive pressure ventilation and considered there were no other treatment options that should have been explored. He agreed that a Venturi mask does enable a clinician to more accurately monitor the oxygen flow to a patient but says in this case that was not an issue. Those tending to Mrs Woo were able to monitor her CO2 retention and adjust the oxygen if it became a problem. Nasal prongs were obviously more comfortable and less invasive and so the switch to that method on the morning of 15 November was also appropriate. He could see no evidence that the way the oxygen was provided to Mrs Woo depressed her respiration or otherwise negatively impacted on her.

Professor Lipman was of the opinion no excessive doses of morphine or other drugs were administered and "*the use of these drugs played no role in the demise of Mrs Woo*". He was also of the view, if there was any observable improvement in Mrs Woo's condition after she was administered Naloxone in the emergency department, it was so slight and transient it indicated her decline was due to her medical condition, and not to the morphine she had been given. He rejected the family's suggestion that the drugs administered could "*weaken her heart.*"

He said; *"My interpretation of what happened is that the drugs were not excessive, that I personally would have used similar drugs, and in fact, even bigger doses*."[28]

He expressed some reservation about giving morphine in combination with midazolam, as was done on the afternoon of 15 November, but said, having regard to the low doses of both, he had no real concern. He acknowledged those drugs in combination, given to alleviate agitation and restlessness, could also repress respiration – what Dr Lipman referred to as the dual effect – but he was adamant this could be controlled and there was no evidence of it happening in this case.

[28] T/s 3 - 60

## *The family's submissions*

As indicated earlier, a number of submissions were made on behalf of the family. The first were received from Ms Madison who engaged with some of the issues and has some regard to the expert evidence. The same can not be said for the submissions made by other self proclaimed patient advocates and/or the family themselves. Regrettably, soon after Ms Madison's submissions were received the family disavowed them. All of the submissions fail to have due regard to the knowledge and experience of the independent experts who gave evidence.

Strictly speaking, I do not need to have regard to submissions from the family unless I am considering making findings critical of them.[29] My obligation is to attempt to establish the cause and circumstances of Mrs Woo's death; not respond to every claim made by any interested party. However, there is a growing body of literature that seeks to position the coronial jurisdiction within what is called therapeutic jurisprudence – a philosophical approach that recognises that court processes and practices, not just a court's decision, can impact positively or negatively upon the parties to the proceedings.[30] I have therefore endeavoured to respond to the main arguments in the various submissions lodged on behalf of Mrs Woo's family. For reasons I expand upon below, I anticipate those attempts will be largely futile.

In the submissions received from Ms Hutchings, the family seem to have moved away from their initial claim that the drugs administered to Mrs Woo caused her death and are instead focussed on whether she received appropriate care during her final admission.

For example, they query whether Mrs Woo received any fluids during her admission. They point out the order for one litre of normal saline made on 14 November is not signed and a commencement date and time does not appear on the sheet. The family allege that Mrs Woo was given no fluids until 1640 on 15 November.

They also contend the "*not for resuscitation"* order was not discussed with the family and note that Dr Lawrence acknowledges he did not discuss with them the drugs he administered to Mrs Woo in the emergency department.

They contend it was inappropriate and premature of Dr Murphy to recommend treating Mrs Woo with "*palliative intent*" without first investigating other possible treatment for her hyperkalaemia, metabolic acidosis and renal failure.

They assert it was inappropriate to give Mrs Woo such large numbers of medications in an absence of fluids when she was known to have ailing kidneys. They query why she was given a second dose of Haloperidol in the emergency department when she was apparently already unconscious.

The family allege after she was moved from a cubicle in the emergency department, Mrs Woo was left in a hallway for approximately two and a half hours with no oxygen or other care.

[29] Annetts v McCann (1990) 170 CLR 596

[30] See for example, King M., "*Non adversarial justice and the coroner's court: A proposed therapeutic, restorative, problem solving model*." JL&M Vol 16 No. 3 December 2008, 442

They also allege she was given a dangerously high oxygen flow rate when first admitted to the respiratory ward, which was inappropriate having regard to her known carbon dioxide retention.

They claim the interpreter, Ms Scheelings, indicated there was an argument or a disagreement between the family and the doctor when he was talking to them about their mother's prognosis.

They claim there was no basis on which she should have been given morphine and Midazolam in the afternoon of 15 November and say that it was only after she was given these drugs that her breathing changed.

The family contend that nurse Oakland told them that the injections given on 15 November were given so that "*your mother's heart will slow down, slow down and finally stop*". And that she also told them "*we will tell you the truth that the doctors won't tell you.*"

They allege the hospital staff knew their own failure to treat Mrs Woo's worsening renal impairment and rising creatinine levels and to stop Mrs Woo's potassium tablets and ACE inhibitor treatment during prior presentations to the PAH in the months preceding her death provided a motive to withhold proactive treatment. The *"not for resuscitation"* order, the taking away of the Venturi mask, and leaving her in a hallway for hours unattended without oxygen, fluids, sustenance was part of that calculated plan to end her life.

They submit at the very least a "*fluid – diuretic loop*" should have been instituted to assist her kidneys to eliminate the excess potassium and other toxins she was given on 14 and 15 November.

They point out that the Verapamil – a calcium channel blocker that is used to counter arrhythmia and angina - and Lignocaine – a local anaesthetic that also has anti-arrhythmic properties - are not recorded in charts and not accounted for in the statements or testimony of any of the clinicians.

The family allege there is insufficient data on Mrs Woo's potassium levels to support Dr Lampe's claim that the cause of death was hyperkalaemia. They point out that on 14 November her levels were 6.0 and 6.1 apart from the first result of 8.4 which they claim was footnoted by the lab as "*specimen haemolysis*". They say this may also explain the high reading the next day. They refer to the entry made by Dr Wijesekera in the progress notes at 13.00hrs on 15 November "*haemolysed sample k+8.3.*"

The family also raises concerns that Dr Lampe failed to have regard to Mrs Woo's high potassium levels, renal failure and metabolic acidosis being associated with ACE inhibitors and the potassium tablets that Mrs Woo had previously been on. They suggest Dr Lampe deliberately minimises this aspect of the case. They acknowledge that he does say in his report "*raised potassium may have been due to another drug she was on (ACE inhibitor treatment) but this cannot be proved*" but he makes no reference to the absence of fluids or a diuretic loop that could have been used to reduce the potassium.

I shall attempt to deal with these assertions sequentially.

## Conclusion as to cause, time and place of death

I reject the suggestion that Dr Lampe manifested bias or lack of independence in reaching the conclusions contained in his autopsy report or in the evidence he gave in court. Dr Lampe is a highly respected and experienced anatomical pathologist who practiced in forensic pathology for a number of years. There is nothing untoward about him relying on what he found in the medical charts when he was attempting to reconstruct what transpired on the last days of Mrs Woo's life.

His report cited sound evidence to support his conclusions. Dr Lampe quite properly alerts the reader to the limitations of his expertise in toxicology and recommends a specialist opinion be sought. This is hardly an approach that would be adopted by someone seeking to "cover up" some malfeasance. He acknowledged a transcription error in relation to Mrs Woo's height and concedes a date he cited for an operation performed in 1994 may have been wrong. These minor errors are irrelevant. The attacks on Dr Lampe's integrity and competence are offensive and baseless. They are rejected.

I have had the benefit of reading reports by and hearing evidence from a number of highly qualified medical experts who reviewed Mrs Woo's medical charts and the autopsy results and responded to challenges to their conclusions when they gave evidence. I was greatly assisted by their evidence. There can be no credible suggestion that any of them sought to mislead the court in order to protect other medical professionals.

None of them disagreed with Dr Lampe's conclusion as to the cause of Mrs Woo's death; and none of them was surprised that events transpired as they did.

The assertion of a conspiracy by PAH staff to end Mrs Woo's life to conceal their inadequate treatment of her in the months preceding her death is odious and ridiculous. It was not put to any of the clinicians who gave evidence and there is no evidence to support it. I reject it.

The toxicology testing found small amounts of Lignocaine in Mrs Woo's blood. It is not mentioned in the charts but is a common local anaesthetic. It is likely it was administered when attempts were made to take arterial blood gas, or when the intima was inserted in Mrs Woo's abdomen. It is of no significance.

A small amount of Verapamil - a calcium channel blocker - was also found. It works by relaxing the muscles of the heart and blood vessels. It is frequently used for angina. It is likely that it was given to Mrs Woo when she presented to the Emergency Department complaining of chest pain and in the rush to stabilize her it was not recorded. It is of no concern.

**I find that Mrs June Woo died on 15 November 2002, at the Princess Alexandra Hospital in Brisbane as a result of hyperkalaemia due to or as a consequence of acute renal failure while suffering from end stage pulmonary fibrosis.**

## Conclusion as to treatment

Having regard to the information found in the medical reports, the autopsy report and the reports and oral evidence of the eminent, independent experts consulted, I am able to make the following conclusions concerning the treatment of Mrs Woo.

I find that when she presented at the emergency department on the evening of 14 November 2002, Dr Lawrence correctly diagnosed Mrs Woo's condition and treated her symptoms appropriately. Contrary to the family's continuing belief, she was not in the same condition as when she had been admitted previously: her respiratory disease had progressed, as inevitably it would, and renal impairment was more marked than it had been. It seems likely her heart was also failing.

In consultation with respiratory physicians, Dr Lawrence quiet reasonably determined non invasive positive pressure ventilation was not appropriate, having regard to internationally recognised treatment guidelines relevant to that decision. Dr Lawrence and the respiratory physicians, in my view, and in the view of the independent experts, correctly determined Mrs Woo's respiratory disease and other co-morbidities were not reversible or susceptible to treatment or therapy that would enable her to recover. Accordingly they determined it was appropriate to limit her suffering by administering analgesia to minimise her pain and sedatives to minimise her agitation and distress.

Having regard to the expert evidence in relation to those issues, I am satisfied the drugs used and the frequency and size of the doses administered were appropriate for those purposes. For the reasons articulated by each of the independent experts, I find the drugs given to Mrs Woo on 14 and 15 November 2002 did not cause, contribute or hasten her death.

Part of the "*comfort cares*" provided, when the clinicians reasonably concluded that Mrs Woo's death was imminent, involved the administration of oxygen. This was done by three mechanisms which were varied and adjusted as different clinicians assumed responsibility for Mrs Woo's care. I am satisfied that each of those clinicians made considered decisions in relation to the issue and that the provision of oxygen did not cause, contribute or hasten Mrs Woo's death. It seems Mrs Woo was moved from an examination cubicle in the emergency department and had to wait on a trolley bed in a corridor in the emergency department from 10.15pm until she was admitted to the ward at about midnight. I can understand the family would find this distressing, but it in no way contributed to her death.

I am persuaded there was no therapy or treatment available to the doctors at the Princess Alexandra Hospital that would have been likely to extend Mrs Woo's life or that should reasonably have been attempted.

## Not for resuscitation

When Mrs Woo stopped breathing at about 9:10pm on 15 November, her family notified nursing staff who examined Mrs Woo, confirmed she was not breathing; her heart was not beating; and her pupils were fixed and dilated. The nurses formed the view Mrs Woo had died. Rather than summoning a multi-disciplinary team to commence emergency resuscitation procedures, the nurses sought to comfort the family and clean and reposition Mrs Woo's body with the aim to preserving her dignity. They did this because they knew there was in place a "*not for resuscitation"* order. The on-call doctor examined Mrs Woo, confirmed she was dead and completed a life extinct certificate.

It is necessary for me to consider whether this response was appropriate, having regard to the law and hospital policies governing such matters.

The legal framework regulating the withholding of life sustaining measures is complex.[31] It is found in the *Powers of Attorney Act 1998* (PAA), the *Guardian and Administration Act 2000* (GAA) and the common law.

As a starting point, it is clear a competent adult may refuse treatment even if that is likely to result in his/her death.[32] However, when, as in Mrs Woo's case, decisions about treatment need to be made when the patient is incapable of participating in them, the regime set out in the aforementioned Acts comes into play.

It is apparent the measures that might have been attempted in Mrs Woo's case – cardio pulmonary resuscitation followed by assisted ventilation are a "*life sustaining measure*" within both the PAA and the GAA.[33]

The legislation provides if an adult lacks the capacity to make a decision concerning the withdrawing of a life sustaining measure, the hierarchy of alternative decision makers created by the Act is activated. If the highest in the hierarchy of potential decision makers is not apposite or available, the next potential decision maker needs to be consulted. In this case, as Mrs Woo did not have an advanced health care directive; the Guardianship and Administration Tribunal had not appointed a guardian; and Mrs Woo had not created an enduring power of attorney, the decision would fall to a "*statutory health attorney.*"[34] The Act creates a priority list with the statutory health attorney being the first person on the list who is "*readily available and culturally appropriate"* to make the decision. In Mrs Woo's case, as her spouse predeceased her, the next potential statutory health attorney was her adult carer, namely, one of her daughters with whom she lived.

Statutory health attorneys do not have an unfettered right to make decisions about the withholding of life sustaining measures in the same way an individual can consider his/her own situation. Rather, the principles that must inform these decisions are set out in schedule 1 to the PAA and the GAA. In the issues paper cited earlier, Dr White and Associate Professor Wilmot usefully summarise the principles that are likely to be relevant to a decision to withhold life sustaining measures.[35] They are:

- the patient's views and wishes, if they are known;
- whether the decision is least restrictive of the patient's rights;
- what is in the patient's best interests; and
- the patient's dignity.

Further, consent to withhold the life sustaining measures made by the statutory health attorney cannot be acted on unless the patient's health provider reasonably considers the commencement of the measure is inconsistent with "*good medical practice.*'[36]

At the time of Mrs Woo's death the PAH had in place a policy that sought to reflect these legal requirements. It required;

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[31] The law concerning the withdrawal or withholding of life sustaining measures is usefully summarised and analysed in a comprehensive and thoughtful issues paper, "*Rethinking life sustaining measures: Questions for Queensland*" by Dr Ben White and Associate Professor Lindy Wilmot, February 2005, QUT.
[32] *Re B(Adult: Refusal of treatment)* [2002] 2 All ER449
[33] See schedule 2 section 5A in both Acts
[34] PAA section 63
[35] White and Willmott *op cit* p15
[36] See White and Willmott *op cit* p16 and GAA section 66A

- the patient and their family to be involved in the formation of the decision and to be fully informed in the process;
- in the event of a disagreement between the patient, family or a member of the health care team regarding the decision, the Executive Director of Medical Services or the Medical Superintendent on-call to be notified*;*
- involvement in the decision making process by appropriate senior members of the health care team;
- the recording of the NFR order in the patient's chart including a statement of the medical condition to justify the order.

Before seeking to apply these criteria to Mrs Woo's situation, it is first necessary to consider whether she consented to treatment when she was *compos mentis*. There is no doubt that when Mrs Woo was brought by ambulance to the PAH emergency department, she was seeking treatment and at least impliedly consented to the tests and drugs the doctors administered. However, after an hour or so she became agitated and combative. Her daughters now say she was speaking in Cantonese and saying she wanted to go home. None of them suggests she told the hospital staff that her mother did not want any further treatment. Indeed the evidence is the daughters were continuing to urge the doctors to do all they could to save their mother. It is in those circumstances Dr Lawrence was entitled to believe he had Mrs Woo's continuing consent when he ordered she be given morphine and Haloperidol before she lapsed into semi-consciousness. In that state she could no longer make decisions about her on-going care and, under the regime discussed earlier, her daughters assumed authority to make decision on her behalf.

Dr Lawrence discussed the possible therapies for Mrs Woo with the respiratory physicians who confirmed his view nothing could be done for her and her death was imminent. He then made a "*not for resuscitation"* order. This meant in the event of cardiac or respiratory arrest, resuscitation efforts such as intubation and mechanical ventilation, injection of inotropes and the use of a defibrillator to attempt to re-start her heart and chest compressions to restart her breathing would not be attempted.

He says because CPR would be ineffective, he did not consider the decision was one the relatives could consent or object to although he claims he did discuss it with them. In addition to the "*not for resuscitation*" order he wrote in the charts "*family are aware of prognosis, has been visited by a priest*". Dr Lawrence may well have been correct when he concluded CPR would be futile, but that is not the end of the matter. The regime requires he have the consent of the *statutory health attorney* before withholding *life sustaining measures* such as CPR. Had Mrs Woo arrested in the emergency department and Dr Lawrence acted on the order, significant legal consequences may have followed.

As we know this did not happen. Instead she was admitted to the respiratory ward where other doctors and nurses had numerous discussions with Mrs Woo's daughters about her prognosis.

The next doctor to review Mrs Woo, Dr Masarato came to a similar conclusion about her poor prognosis and wrote in the charts "*in the event of cardiac pulmonary arrest, it would be inappropriate and against family's wishes to proceed.*" The family deny there was any discussion with them about this issue at that time and Dr Masarato was not available to give evidence.

Nurse Maurici was initially responsible for Mrs Woo's care when she was transferred to the respiratory ward. She spoke Cantonese. Although she doesn't claim to actually remember all of the conversations she had with the family, she is adamant that in view of the "*not for resuscitation*" order she would have taken steps to ensure they comprehended its effect. She considers that as she made no notation in the progress notes of any concerns by the family in relation to the order, none was expressed to her.

Early in the afternoon on the day of Mrs Woo's death, Nurse Oakland and Dr Wijesekera also took steps to ensure that the family were aware of their mother's imminent demise. They arranged the attendance of an accredited Cantonese speaking interpreter. Contrary to the families assertions I am satisfied the interpreter was able to communicate effectively with Mrs Woo's family and had done so on previous occasions.

I also accept Dr Wijesekera's evidence that he was at pains to ensure they understood what was planned in relation to Mrs Woo's care and what would not happen if she died.

Quite simply, I do not accept that all of the doctors and nurses who gave evidence or made notes in Mrs Woo's chart are lying when they indicate they made committed and continuing efforts to ensure the family were aware that Mrs Woo's life was draining away and that painful, distressing and futile attempts to revive her would not be made if she died. Her sons came to say good bye and brought the grandchildren to see her.

Family members argued with the doctors about what could be done to make their mother better. Of course they did not want her to die. However, they did not engage with the issue of whether resuscitation should be attempted if she arrested. When she died there was no suggestion by family members that CPR should be attempted; rather they very soon began blaming the staff for failing to make Mrs Woo recover.

I accept that despite all the attempts of the hospital staff, it is quite possible the family did not fully comprehend what they were being told. This was in my view not due to a language difficulty but rather their unwillingness to accept the reality of the situation – they simply would not acknowledge Mrs Woo's death was imminent and so did not respond to advice that when it occurred CPR would not be attempted. Even now, after numerous independent experts have testified that Mrs Woo was in the terminal stages of irreversible disease, the family appears to believe that something could have been done to save her. In those circumstances no communication would have been effective.

In view of the steps they had taken to make clear to the family what would happen if their mother arrested, and the absence of any rejection of those proposals, I consider the doctors and nurses were entitled to consider they had the family's consent to the order.

I must also consider whether that tacit consent complied with the PAA schedule 1 principles.

We have no evidence about Mrs Woo's wishes in such a situation. I accept the family's contention that she was against euthanasia but that is quite different from refraining from attempting CPR in a hopeless case. I am confident the other principles that must inform or accompany a statutory attorney's consent to withhold life sustaining measures were extant.

All of the experts who gave evidence or opinions indicated the chances of resuscitating Mrs Woo in the event of an arrest were extremely low. Dr Kubler suggested that it would only be 1 in 10,000. [37]

Dr Lipman expressed the view even if resuscitation was successful and Mrs Woo's heart and respiration could be maintained by artificial means, it would not reverse the terminal disease and in his opinion that be pointless: it would achieve nothing and "*would be cruel.*" This was based on Dr Lipman's knowledge that resuscitation would involve attempts at inserting a tube into Mrs Woo's trachea, with likely tearing and trauma to the tissues, the undertaking of external cardiac massage that would be likely to break her ribs and the administration of drugs and the application of defibrillators to try and shock her heart back into rhythm in circumstances where those measures would almost certainly fail. Accordingly, he thought it was "*totally appropriate to move to comfort measures: that is alleviate pain and suffering, and not to resuscitate Mrs Woo in the event of a cardio-respiratory arrest.*"

## Conclusion concerning "not for resuscitation"

Having regard to Mrs Woo's family's tacit acceptance of the "*not for resuscitation*" order despite it being explained to them on numerous occasions, I consider the hospital staff was entitled to consider they were consenting to it.

I consider the preconditions to such consent being validly acted on, namely that Mrs Woo had not previously expressed opposition to it; the withholding of CPR was in Mrs Woo's best interest; it was the least intrusive response; it best preserved her dignity; and it was consistent with good medical practice, were met. The order was entirely appropriate.

## The PAH "not for resuscitation" policy

I do however have concerns about the PAH's policy in relation to this issue which does not seem to have changed significantly since Mrs Woo's death. It makes no mention of the PAA or the GAA and requires only that "*the patient and their family are involved"* in the formulation of such an order. The law makes clear the patient or a person authorised under the GAA must consent to the withholding of life sustaining measures. Nor are any of the other pre-conditions to such a course being adopted referred to.

### Recommendation – Review of PAH "*No CPR*" policy

*I recommend the PAH policy governing the making of "not for resuscitation" orders be reviewed to ensure compliance with the Guardianship and Administration Act and the Powers of Attorney Act.*

*While forms are no substitute for substance, to avoid claims patients or family members have not consented to such an order being put in place, the PAH should develop a consent form that demonstrates a patient, statutory health attorney or other authorised person has made a fully informed consent that complies with the law relating to the withholding of life sustaining measures.*

[37] T/s 3 - 12

## Pathological grief

The shattering impact of Mrs Woo's death on her daughters is demonstrated by their inability to accept basic information about its circumstances and their failure to make arrangements for the appropriate burial or cremation of her body.

Professor Beverley Raphael, an internationally recognised expert on grief and loss, has written extensively about grief reactions and notes the bereaved frequently, initially respond to news of a loved one's death with "*shock, numbness, and disbelief.*" However this is eventually superseded in most case by an acceptance of the death. Central to this process is the "*engagement of reality"* that occurs as the family takes practical steps to respond to the death such as arranging a funeral: "*Many bereaved people find this is a turning point where the full reality of the death hits directly home."*[38]

Another grief researcher, Therese A. Rando, observes complications can result from sustained anger when bereaved people believe, however misguidedly, that others are responsible for the death. While she considers anger is, to some degree, invariably present following the death of a loved one "*intransigence and exclusivity"* of the response can be related to strong feelings of helplessness, dependency and a grief not easily resolved.[39]

Mrs Woo's family have failed to arrange for the burial or cremation of her body six and a half years after her death; they continue to harbour anger toward those they wrongly hold responsible for the death in the face of all available evidence to the contrary; and they appear unwilling to accept the findings of a number of independent investigations into the death. This is suggestive of a complex grief response which remains unresolved. They have my sincere sympathy and I regret being unable to assist them. They have rejected numerous offers from expert grief counsellors who may have assisted with their acceptance of their loss.

Although her children's loss is great, Mrs Woo's death has also impacted others. The doctors and nurses of the PAH who treated and cared for her have been unfairly maligned. Dr Lampe and other independent experts have been accused of being biased and unprofessional. I hope these findings vindicate them. They do not deserve to be so harshly and unfairly criticised.

And June Woo has also been treated inappropriately as a result of her daughters' unnatural reaction to her death. It is obvious they loved her dearly. No doubt she cared for them when they were young, as they cared for her when she became old and frail. Their caring should extend to ensuring she receives a dignified funeral. Instead, since her death, her body has lain in a freezer in the mortuary at the Queensland Health Scientific Services facility at Coopers Plains.

That should not be allowed to continue. Section 3 of the *Burials Assistance Act 1965* provides the Director-General of the Department of Justice has a duty to bury or cremate a deceased person where it appears to her no suitable arrangements for the disposal of the body have been or are being made.

[38] Raphael B., *The Anatomy of Bereavement,* Jason Aronson, 1994, p37
[39] Rando T. A., *Treatment of Complicated Mourning,* Research Press 1992, p463

## Recommendation – Mrs Woo's burial

*I recommend, unless within 28 days of these findings being delivered, the family of Mrs Woo has made arrangements for her burial, the chief executive of the Department of Justice take action pursuant to s3 of the Burials Assistance Act 1965 to cause Mrs Woo's body to be buried.*

I close this inquest.

Michael Barnes

State Coroner

Brisbane

1 June 2009