CITATION: *Inquest into the death of LENNIE PINAWRUT @ LEONARD MURIMAL MANBULLOO @ LENNIE MURIMAL MANBULLOO* [2003] NTMC 036

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**REPRESENTATION:**

*Counsel:*

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| Assisting: | Mr Thomas Berkley |

*Solicitors:*

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| For Department of Health and Community Services | Ms Sally Sievers |

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IN THE CORONERS COURT
AT DARWIN IN THE NORTHERN
TERRITORY OF AUSTRALIA

No. D0106/2002

In the matter of an Inquest into the death of

**LENNIE PINAWRUT @ LEONARD MURIMAL MANBULLO @ LENNIE MURIMAL MANBULLO**

**ON 26 NOVEMBER 2002**

**AT KATHERINE DISTRICT HOSPITAL KATHERINE, NORTHERN TERRITORY**

**FINDINGS**

(Delivered 17 July 2003)

Mrs McDade Deputy Coroner:

## THE NATURE AND SCOPE OF THE INQUEST

1. Lennie Pinuwrut ("the deceased") was a 67 year old Aboriginal male who died in Katherine Hospital at about 2200 hours on 26 November 2001. The cause of his death was acute renal failure, a condition accompanied at the time with severe acidosis and hyperkalemia. The deceased also suffered from dementia, which had been diagnosed as either "mild" or "moderate" by various medical professionals who had treated the deceased before his death.

2. The deceased had been admitted to Katherine Hospital on 25 September 2001 with suspected pneumonia. Whilst there he was noted to have blood in his urine and a slightly raised serum creatinine level, indicating a renal problem. His treating doctor referred him to Royal Darwin Hospital ("RDH") on 1 October 2001.

3. On 4 October 2001 at RDH, a specialist doctor Jonathan Richard Wardill ("Mr Wardill") performed a cystoscopy to examine the deceased's bladder for evidence of cancer. No evidence was found. In consultation with a visiting urologist from Adelaide, a Mr Kim Pese, it was thought that the deceased's bladder was obstructed, so Mr Wardill performed a bladder neck incision on the deceased on 22 October 2001 for the purpose of relieving that obstruction.

4. During ward rounds on 3 November 2001, Mr Wardill, accompanied by his Registrar and Nurse Ranasinghe, decided that the deceased could be transferred to the self care units and discharged and sent home by bus on 4 November 2001. The deceased was to have a follow up in Mr Wardill's clinic in Katherine sometime after discharge.

5. The deceased returned to Katherine by bus on 4 November 2001. He was found under a tree near the tourist information centre in Katherine by relatives at about 1700 hours that day. The circumstances of the deceased's arrival in Katherine will be addressed later. He was dressed in his hospital pyjamas, and his only possession was his bus ticket. His relatives cared for him until his death, including taking him to Wurli Wurlinjang Medical Centre at Katherine for assessment and treatment on 8 November 2001.

6. No autopsy was performed after the death, however, concern about the treatment of the deceased led the then Medical Director of Katherine Hospital, Dr Fred McConnel, to write to the Director of Surgery at RDH on 30 November 2001, enquiring into the circumstances surrounding the discharge of the deceased from RDH. Dr McConnel suggested in that letter that it was:

> "…appropriate for this case to be more fully investigated and the Coroner notified…"

7. The Director of Surgery at RDH shared Dr McConnel's concerns about the treatment of the deceased.

8. An exchange of correspondence followed, culminating on 19 June 2002, with the succeeding District Medical Director at Katherine, Dr Tony Watson, writing to the Northern Territory Coroner to report the death of the deceased. Dr Watson wrote because he thought that there was a "…possibility that appropriate treatment had not been provided" to the deceased prior to his death.

9. Oral evidence was taken, in person and via video teleconference facilities, over five days from 26 to 30 May 2003 inclusive. On the first sitting day the witnesses were Senior Constable Lade, the officer in charge of the investigation into the death and the circumstances surrounding the death of the deceased; Nursing Director Sykes who gave evidence of the role and responsibilities of nurses in the patient discharge process; Dr Peter Arnold-Knott who treated the deceased immediately prior to his death and who pronounced the death; Dr Watson (via video link with Katherine) who reported the death to the Coroner; and Pauline Murrimal (via video link with Katherine), the daughter of the deceased who cared for him on his return to Katherine and up until his death.

10. On the second sitting day the witnesses comprised Nurse Ranasinghe (via video link with Monash University), who accompanied the specialist and Registrar on the ward rounds which led to the discharge of the deceased; Mr Wardill, the specialist surgeon who treated the deceased at RDH and ordered his discharge from Hospital on 4 November 2001; and Dr Chung (via video link with Sydney), who had intermittently treated the deceased since July 2000 and last saw him on 8 November 2001.

11. On the third sitting day evidence was given by Dr Tilakaratne (via video link with Sydney), who was the intern who prepared the discharge summary pertaining to the deceased; and Dr McConnel (via video link with

Hobart), who first queried the medical treatment given to the deceased by RDH.

12. On the fifth day of sitting the witnesses comprised Dr Hunter, a specialist Otorhinolaryngologist, who wrote to Dr McConnel on 8 April 2002 concerning the deceased's treatment in RDH; Mr Treacy, who chaired a professional review of the treatment of the deceased by RDH staff and consultants; and Dr Carson, the associate professor and Director of General Surgery at RDH concerning communication between staff regarding the medical condition of, and discharge planning, for patients.

13. In addition to those witnesses a number of documents were tendered including an investigation file compiled by Senior Constable Lade and various other reports and articles tendered by Ms Sievers, counsel for the Department of Health and Community Services, which have been exhibited.

**FORMAL FINDINGS**

14. Pursuant to Section 34 of the Act, I find, as a result of the evidence adduced at the Inquest the following:

1. The identity of the deceased was Lennie Pinawrut @ Leonard Murimal Manbulloo @ Lennie Murimal Manbulloo, a male Aborigine who was born 1 July 1934 at Port Keats in the Northern Territory.

2. The time and place of death was Katherine District Hospital, Katherine in the Northern Territory at about 2200 hours on 26 November 2001.

3. The cause of death was acute renal failure with associated severe acidosis and hyperkalemia.

4. Particulars required to register the death are:

(a) The deceased was a male.

(b) The deceased was Lennie Pinawrut.

(c) The deceased was an Australian resident of Aboriginal origin.

(d) The death was reported to the Coroner (albeit belatedly).

(e) The cause of death was acute renal failure. The cause of death was not confirmed by post mortem examination.

(f) The deceased's mother is unknown.

(g) The deceased's father is unknown.

(h) The deceased resided in Katherine.

(i) The deceased was a pensioner.

(j) The deceased was married to Lily Ginginna.

(k) The deceased was about 67 years old having been born in 1934.

**RELEVANT CIRCUMSTANCES SURROUNDING THE DEATH**

15. The compelling and overriding issue that has arisen in this Inquest is the quality and quantity of communication between medical and nursing staff at RDH concerning:

(a) the actual pre-discharge state of health of the deceased; and

(b) the discharge planning for the deceased.

## Communication Regarding the Deceased's Health

16. It should be noted that there is no criticism offered of the clinical quality of health and nursing care provided to the deceased until just prior to his discharge from RDH. The deceased's medical records show that he initially sought treatment from Wurli Wurlinjang at Katherine where Dr Chung made a provisional diagnosis of atypical pneumonia. She referred the deceased to Katherine Hospital for hydration and antibiotics. Of note is that the tests done at Wurli Wurlinjang show an unremarkable creatinine level.

17. Doctors at Katherine Hospital were concerned that the deceased had carcinoma of the bladder and referred him to RDH for examination. At RDH the deceased underwent a cystoscopy and later a bladder neck incision. After the latter procedure a bladder ultrasound was performed on the deceased on 2 November 2001 which did not show any obstruction of the bladder or retention of urine. The report was interpreted to mean that the deceased was successfully voiding his bladder, and that he could be returned home with follow up consultations planned to monitor his health. This interpretation of the ultra sound results subsequently proved to be inaccurate due to communication errors, which are set out below.

## Creatinine Levels

18. The deceased's creatinine levels were monitored throughout his admission to RDH. The recorded levels indicate the following:

| | |
|---|---|
| 22 October 2001 | 200 mmol/c |
| 23 October 2001 | 157 mmol/c |
| 24 October 2001 | 179 mmol/c |
| 25 October 2001 | 215 mmol/c |
| 27 October 2001 | 200 mmol/c |
| 1 November 2001 | 234 mmol/c |

19. On 25 October 2001, his creatinine level was 215 mmol/c. This was the last creatinine level that Mr Wardill had been appraised of at the time of his ward rounds on 3 November 2001. He was not appraised of the results of testing done on 27 October (200 mmol/c) or 1 November (234 mmol/c) 2001. In his oral evidence he conceded that if he had been appraised of those creatinine levels the deceased would not have been discharged, even though 234 mmol/c was not a creatinine level that in itself would demand the patient's retention in hospital. (The deceased's creatinine level was over 1500 mmol/c on the day of his death). Rather, if Mr Wardill had known of the current creatinine levels, he deposed that he would have retained the patient in hospital for further testing. The failure to inform him of the most recent levels of creatinine was therefore one of the two most important factors surrounding the untimely discharge of the deceased. The other was the quality of the ultrasound request form, which will be discussed later. The significance of the failure to inform Mr Wardill of the creatinine levels is dealt with in the statement of Dr Snelling in his letter of 28 May 2003 (Exhibit K (2)). He said of the creatinine level recorded for 1 November 2001:

> "In and of itself, the creatinine level of this level is not dangerous, however, the clinical scenario should have alerted people to an acute insult which had potential further rapid loss of renal function… … Thus, I would not call the serum creatinine level on its own dangerous, but rather the change is a marker of a potentially serious medical condition which needs further investigation and management."

20. The failure of the passage of information in this case is due to the system used in RDH to convey vital patient information to the consultant. The post-operative assessment of patients in the surgical wards is done in teams, with the order of seniority from the highest being the consultant, followed by the Registrar and then the resident. It is up to the resident to inform the Registrar and the consultant of all relevant medical information pertinent to the assessment of the patient's health state. Evidence given at the Inquest

by Drs Treacy, Hunter and Carson confirm that this method of communicating patient information is still in use. The consultant takes ultimate responsibility for the medical management of the patient, including ordering the patient's discharge, but, as Dr Carson said in his report (Exhibit J):

> "The most junior of the team, the Intern or Resident Medical Officer, takes the bulk of responsibility for day to day assessment, effecting treatment orders and coordinating care. The Registrar (Specialist in training) makes critical day to day decisions and in the case of a surgical team, spends a considerable portion of their day operating in theatre or seeing and reviewing new patients in the outpatient clinic.
>
> In this system the Consultant and surgical trainee do not look over every test result and would depend on the RMO or Intern to flag important, abnormal results and discuss management as a team …"

21. Dr Tilakaratne, the resident, remembered the medical treatment of the deceased as being mainly concerned with getting him to void his bladder. She ordered the blood tests for, amongst other things, creatinine levels on 24, 25 and 27 October 2001 and 1 November 2001. She sighted and initialled the report of 27 October 2001 but failed to inform the consultant of the last two test results, which, as the consultant deposed to at the Inquest, would have altered his decision to discharge the deceased. Dr Tilakaratne said that she tried to tell the surgical registrar of the test results but that he was very busy. She was not expecting the discharge of the deceased over the weekend, and, and she explained to Senior Constable Lade (Enclosure 12 to Exhibit A):

> "…I thought that I would speak with him on Monday or whenever I next saw him."

22. It would be easy to criticise Dr Tilakaratne for this communication failure, but to do so would be to ignore the frank evidence of Dr Carson at Exhibit J, re-iterated in oral evidence, concerning:

> "…the excessive workload of junior medical staff and the non-availability of technological systems and support in the form of a easily accessible functional computer system."

23. Mr Treacy said in oral evidence to the Inquest that improvements had been made in this regard by ensuring that a separate dedicated computer was now available in each surgical ward for the use of residents and registrars to access test results in a timely manner. Another improvement, yet to be implemented, is the ability of junior medical staff to be able to electronically notify the consultant of test results, should that be thought necessary.

24. In a letter tendered by Counsel for the Department of Health and Community Services, written by Stephen Moo on 27 May 2003, it is said that the Northern Territory Hospitals are making good progress in implementing a fully integrated Clinical System Repository containing discharge summaries, pathology results, radiology reports, specialist reports, operating theatre procedures, and in the future, medication histories for all patients treated in any Northern Territory hospital. Whilst that improvement in the ability to communicate patient information is laudable, in the present case the failures in communication regarding creatinine levels were due to the failure of the most junior of the medical team, the resident, to chase up the test results for the deceased and to communicate them to senior medical staff. The problem was not with the availability of the information, but the failure to access it through the existing means.

**The Ultrasound Request**

25. With the benefit of hindsight both Drs Wardill and Tilakaratne conceded in evidence that greater care should have gone into the request for the bladder ultrasound. In his statement (Enclosure 10 to Exhibit A – confirmed in his oral evidence of 27 May 2003), Mr Wardill said that if the words "post void" had been added to the ultrasound request form:

> "…it would indicate that the patient should be asked to pass urine before the ultrasound was done, and this may have alerted staff to a problem with renal function."

26. Again, with the benefit of hindsight, Mr Wardill concedes in his statement and in oral evidence that the empty bladder noted on the ultrasound may have been from the absence of urine (anuria) rather than successful voiding, however there is now insufficient evidence for that diagnosis. His oral evidence to the Inquest on this point may be summarised as saying that knowledge of the rising creatinine levels would have resulted in further testing, probably including further ultrasound testing. There were other tests that could have been administered, but were not considered because of the apparently successful voiding by the deceased of his bladder.

27. It should be noted that Dr Tilakaratne was herself somewhat of a victim of communication failure regarding the ultrasound request form. In relation to questioning from Senior Constable Lade as to why "post void" was not put on the ultrasound request form, she said (Enclosure 12 to Exhibit A):

> "I think at the time I was instructed or asked to arrange that I wasn't 100 per cent clear on why we were doing it."

28. Notwithstanding that concession, the evidence of Mr Wardill is that it was not thought of by him either. In the end, the ultrasound test results showed a bladder devoid of urine, which was interpreted to mean that the surgical treatment to relieve bladder obstruction had been successful. The real problem of renal failure was not identified.

**The Urinary Tract Infection**

29. It was initially thought by Dr McConnel that the failure to note the treatment for the infection of the urinary tract was somewhat noteworthy, although the oral evidence of Dr Carson is that the type of infection (*pseudomonas*) was commonly associated with the placement of catheters and not indicative of possible problems with renal failure. In any event, gentamicine was

administered at RDH to treat the infection. The presence of an infection associated with the insertion of a catheter cannot be said on the evidence to be relevant to the death of the deceased.

**The Involvement of a Renal Team**

30. This issue was dealt with in a letter dated 15 October 2002 by Dr Snelling, the head of Top-End Renal Services, tendered at Exhibit K (1). The point made in that letter is that renal specialist advice is sought by invitation. In the case of the deceased, Mr Wardill did consult a visiting urologist to decide the best course of treatment for the deceased, and followed that decided course. Unfortunately, Mr Wardill did not further consult with renal specialists prior to the deceased's discharge. As Dr Snelling notes:

> "Looking through the notes, it was apparent that from the 16th, Mr Pinawrut's renal function began to deteriorate. The Renal Team should have been notified of this deterioration, and asked to assist in elucidating the underlying cause."

31. I note and accept the submission by Counsel for Department of Community and Health Services:

> "At the time of Mr Pinawrut's discharge, Dr Snelling who was consulted initially in relation to his care and who reviewed his records stated that he had acute on chronic renal failure, also described as moderately advanced renal failure. Mr Pinawrut should have been seen by the renal team prior to discharge for further investigation and management. Part of his follow up should have been an appointment in the visiting renal outpatient clinic in Katherine within three months of his discharge."

32. Mr Wardill may well have sought the involvement of the Renal Team, had he not made the assessment that the 22 October 2001 procedure had been successful, for the reasons set out above. Further, I accept his evidence that had he been informed of the increasing creatinine levels he would not have authorised the deceased's discharge and would have carried out further investigation which would have involved the renal team.

**The Dementia of the Deceased**

33. The deceased has been variously described as suffering from mild (Mr Wardill, Dr Tilakaratne) to moderate (Dr Chung) dementia. The level of the dementia is not the issue here, but rather, the effect the dementia should have had on both the medical discharge decision, and the discharge planning process. Mr Wardill at once thought that the deceased could look after himself sufficiently in the Self Care Unit prior to his discharge, but at the same time was surprised that the deceased was not escorted back to Katherine. His expression of surprise is unusual, given that it was up to Mr Wardill to consider the availability of escorts before making the discharge decision.

34. Great weight should be given to the evidence of Dr Carson on this issue. He said, in Exhibit J, that:

> "Dementia, if present, will be listed on the problem list of a patient, and be taken into account in all medical and/or social decisions surrounding the patient. A combination of dementia and cross culture communication will continue to create great difficulties. It is possible that the full extent of the dementia may not have been fully appreciated in this combined circumstance."

35. Dr Tilakaratne noted that the deceased was suffering from dementia on the medical discharge summary. Due consideration was not given to the deceased's dementia when Mr Wardill was making the discharge decision. There was no reason why the deceased could not be returned to Katherine on a week-day when the discharge planners would have been able to, presumably, make suitable arrangements for his return home. It was the responsibility of Mr Wardill to ensure that any directions he gave regarding the discharge of the deceased would have been taken into account, both his dementia and the naturally occurring problems of cross cultural communication. It was wholly within Mr Wardill's powers, regardless of any other ailment of the deceased, to direct that the deceased either stay in a hospital bed or the Self Care Unit for as long as it took to make appropriate

arrangements for the deceased's return home. The assumption that can be drawn from Nurse Ranasighe's note of the ward rounds on 3 November 2001 is that it was either Mr Wardill, or the registrar Dr Joseph, who directed that the deceased be returned home by bus the very next day. This was an entirely inappropriate direction in circumstances where the medical staff had failed to satisfy themselves, individually or collectively, of the availability of escorts, family support and reception of the deceased in Katherine.

**Discharge Planning for the Deceased**

36. The Inquest was assisted by the written evidence (Exhibit E) and the oral evidence of Sharon Sykes, the Nursing Director of Surgery at RDH, given on 26 May 2003. After a consideration of her evidence I am satisfied that:

(i) the discharge decision is made by medical staff and the medical discharge summary is the responsibility of medical staff;

(ii) the arrangements for effecting a discharge are the responsibility of nursing staff;

(iii) an unplanned discharge occurring on a weekend is managed by the nurse in charge of the particular ward (paragraph 9 of Exhibit E);

(iv) the nurse in charge is to complete the nursing discharge documentation and put in place necessary arrangements such as travel, contact with family, escorts etc;

(v) the discharge planning process commences on admission (Discharge Planning Manual) with the partial completion of the nursing discharge summary and Nursing History and Inpatient Admission/Discharge Record forms;

(vi) that the failure to discover any discharge documentation for the deceased is probably due to the fact that it was never prepared; and

(vii) the deceased was not referred to a Community Resource Coordinator as he should have been, to plan his discharge.

37. The nurse in charge of the deceased's ward 2B on 3 November 2001 was Nurse Ranasinghe. She gave written evidence (Enclosure 14 to Exhibit A) and oral evidence to the Inquest on 27 May 2003 by video link from Victoria. She made the entries in the "Inpatient Clinical Progress" sheet concerning the decision of Mr Wardill to discharge the deceased on 3 November 2001. She cannot remember who decided that the deceased should go home to Katherine by bus but thinks it was made by either Mr Wardill or the registrar, Dr Joseph. Dr Joseph was not available to the Inquest to be examined in relation to the discharge decision. According to Nurse Sykes, it was Nurse Ranasinghe's responsibility to complete the discharge documentation and to notify the deceased's family of his pending return to Katherine. This was not done.

38. Mr Wardill deposed to the Inquest that he thought that the deceased may have spent some more time in the Self Care Unit, but this evidence belies the entries Nurse Ranasinghe made that:

> "Patient allowed home. Nil requirements for discharge medications as per Dr Joseph. **Pt transferred to self care unit and will be sent home tomorrow by bus**. NRC or 2B staff to notify self care unit with travel details. Pt to have follow up in Katherine in Mr Wardill's clinic."

39. There is no record of who made what arrangements to get the deceased back to Katherine. Nurse Ranasinghe's memory is deficient on that aspect of the case. This may be understandable due to the large volume of discharges that she was ultimately responsible for, and the fact that she left RDH in

December 2002, before any internal or external examination of the medical treatment of the deceased had commenced. It wasn't until 16 December 2002 that she provided a statement to the officer in charge of the coronial investigation. It is surprising that all of the medical and nursing staff who gave evidence to the Inquest thought that junior medical staff and nursing staff could question the consultant's discharge decision, but no-one involved in the discharge of the deceased from RDH did so.

40. In any event, what occurred was that a demented, sick, old aboriginal man was returned to Katherine by bus, in his hospital pyjamas, possessing only his bus ticket. He had no-one to meet him, and was obviously incapable of contacting his family in Katherine, as evidenced by the circumstances of him being found in Katherine by family. He was found under a tree near the tourism centre. It beggars belief that no-one involved in his discharge, from the medical staff, nursing staff or Self Care Unit staff, would not have appreciated that they were sending a demented old man to Katherine without an escort. Clothing was available (Exhibit I), but not provided. The lack of thought, and in particular communication, exhibited by the staff led to the deceased suffering considerable discomfort on the day of his discharge from RDH. It was only fortuitous that he was found by members of his family that afternoon, under a tree near the tourist information centre. Bearing in mind that the family had not been informed of his discharge, it was very fortuitous that they found the deceased after his arrival in Katherine, alone.

41. The systemic failure of the RDH discharge process regarding the deceased was further exacerbated by the failure of the resident, Dr Tilakaratne to get around to writing a medical discharge summary for the deceased until probably 22 November 2001. It was faxed to Katherine Hospital, the referring hospital, but not to Wurli Wurlinjang, his regular medical provider. It should have been available to Dr Chung when the family of the deceased brought him to see her on 8 November 2001. Dr Chung rang RDH to obtain one, but it could not be found, as it had not been written. It is speculative as

to what Dr Chung might have done had she had available to her an accurate medical discharge summary and the ability to check the deceased's most recent pathology tests. Certainly the deceased could have been in no worse position. As it was, Dr Chung relied on the deceased having no complaints and told the family to bring him back to see her should complaints develop. She left Wurli Wurlinjang before the death of the deceased.

42. Once again, the failure to prepare a discharge summary for 18 days was not seen as unusual. A little longer than normal, but no unusual. Dr Carson puts this situation down to:

    a. extreme pressure to early discharge (to free up bed space);

    b. very high through put rates of patients;

    c. excessive workload of junior medical staff; and

    d. non-availability of technological support.

43. Of particular note is Dr Carson's oral evidence to the Inquest. Notwithstanding the evidence of Mr Treacy regarding improvements to the discharge planning process, it was obvious that Dr Carson, the Director of General Surgery, thought that nothing had really changed in the methodology and considerations employed when discharging a patient. The entire system still relied on accurate and timely oral communication between the various staff departments and the patient.

**SUMMARY**

44. The failure of communication between junior staff and the consultant relating to the deceased's creatinine levels, and the inadequacies of the bladder ultrasound results, lead to the decision on 3 November 2001 to the untimely discharge of the deceased from RDH on 4 November 2001.

45. The failure to prepare a medical discharge summary in a timely manner meant that the deceased may have been denied the opportunity for informed and effective medical treatment on 8 November 2001, which may have included arrangements being made for his follow up by Mr Wardill as per the requirement noted in his discharge summary.

46. The systematic failures of the discharge process in RDH concerning the deceased did not directly cause his death, but had they not occurred, the lifespan, quality of medical treatment post discharge from RDH, and the quality of life of the deceased, would probably have been better. Given the evidence of Mr Wardill that had the deceased's true medical condition been ascertained before discharge, other treatments would have been provided to him, it can be said in all probability the deceased's lifespan was shortened by his premature discharge from RDH.

47. No-one involved in the discharge of the deceased from RDH gave an appropriate level of thought to the deceased's needs on discharge from RDH.

**RECOMMENDATIONS**

48. I recommend that RDH continue to review and enhance its admission / discharge procedures. The implementation of procedures to allow admission under a number of medical teams is noted.

49. I accept on the evidence adduced at the Inquest that discharge procedures employed at RDH are continually being refined, however, in the absence of some technological fail-safe system, the quality of discharges from that facility will continue to be reliant on the ability of staff to properly communicate and consider the needs of the patient on discharge. The proceedings of this Inquest exemplify what happens when human failings affect the quality of that communication. There is a probability that failures in the discharge planning process at RDH will occur again to other patients,

with varying effects on their lifespan and quality of life post-discharge. Every effort should be made to prevent that occurring.

50. The suggestion by Dr Snelling that all patients with moderate to advanced chronic renal insufficiency be notified to the renal team, and reviewed by the renal team prior to discharge has great merit. I recommend that procedures be introduced to facilitate reporting of such patients and ensure they are reviewed by the renal team prior to discharge.

51. That medical personnel when ordering patients be discharged do so in writing in the patients records and clearly specify all post discharge care.

52. That RDH continue to implement procedures that facilitate the timely completion and circulation to other relevant medical organisations of Medical Discharge Summaries.

Dated this 17th day of July 2003.

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LYN MCDADE
DEPUTY CORONER