

Minter Ellison Health News

11 August 2010

Case law

NSW

Inquest into the death of Helani Sirianni

The NSW Coroners Court recently delivered a report on the death of three-day old Helani Sirianni who suffered a subaponeurotic haemorrhage after being delivered by vacuum extraction. This comes less than two weeks after the South Australian Coroners Court delivered its report on 9 July 2010 of a similar incident which caused the death of two babies, Jessica Stemmer and Thomas Mahar.

At 10.30 pm on 7 February 2008, which was the evening of first admission, there were some concerns about the position of the foetus. The doctor was considering a caesarean section and decided to reassess the situation in 2 hours, but did not return until 3 hours later at 1.30am. At that point the foetus was still in the same position but based on a satisfactory CTG trace the doctor left again and invited the mother to continue 2nd stage pushing. By 1.50am the CTG trace had deteriorated from reassuring to non-reassuring, indicating that the foetus was in distress and may have been bleeding, but the doctor did not return until 2.30am. Expert opinion suggested that senior nursing staff should have been in a position to identify problems in the CTG trace and recall the doctor earlier.

On returning the doctor recognised the need for immediate delivery and gave evidence that she presented vacuum delivery as an alternative to caesarean section, explaining the risks. The parents' recollection is that vacuum assisted delivery was presented as the only option, despite their earlier queries about the availability of caesarean section. The coroner accepted the doctor's account of events, citing the considerable pressure the parents were under at the time, and noted that in any case it is accepted that vacuum extraction is preferable to caesarean section once the head is in view.

The vacuum extraction was abandoned when the cup popped off a second time and the baby was delivered with the assistance of McRobert's manoeuvre at 3.05am. The baby was described as being "blue and floppy" initially but had an improved heart rate and colour after the provision of oxygen. The doctor left the hospital at 4.44am. After complications the doctor was recalled at 7.20am and identified the haemorrhage at 8.45am. Helani was transferred to the emergency team and flown to another hospital but died the following day.

It could not be concluded by the Coroner that the bleeding was a result of the vacuum delivery as such complications may also be caused by other factors. Information from the cord pH measurement could have assisted in this but this information was not available. There was some ambiguity in the guidelines which required blood pressure monitoring "every 15 minutes for 1 hour then 4th hourly until stable". The Coroner found that if "4th hourly" was to be taken to mean every four hours thereafter, this was inadequate and went on to recommend that the policy document should be rewritten to eliminate any ambiguity and to require blood pressure monitoring at 15 minute intervals for four hours and then hourly until stable.

[Click here for report](#)

Victoria

Inquest into the death of Lauren Katherine James

Lauren Katherine James died three days after elective liposuction surgery. She was a fit and healthy twenty-six year old woman, with no significant medical history. Ms James contacted The Centre of Cosmetic and Plastic Surgery (COCAPS), an accredited day surgery clinic, to have liposuction performed to her lower buttocks, thighs and knees. Ms James underwent a full medical examination prior to surgery which was reported as normal. On 16 January 2007 Dr Tam Dieu, a plastic and reconstructive surgeon, performed liposuction on Ms James. There were no apparent anaesthetic or surgical complications. She was discharged later that afternoon in the care of her partner Mr Dal Zotto, with oral analgesia (capadex and ibuprofen).

The next day Nurse Bray from COCAPS made a routine call to Ms James, who reported that she had no concerns apart from mild pain which was controlled by oral analgesia. On Sunday 21 January 2007 Mr Dal Zotto contacted COCAPS as Ms James felt 'unwell'. He spoke to Dr Cass who advised more analgesia and to contact the clinic in the morning if she was still unwell. On Monday 22 January 2007, three days post-procedure, Ms James returned to COCAPS complaining of severe pain in her left thigh. She was reviewed by Dr Cass and Mr Sormann at around 11:00am. She was administered an injection of pethidine and given endone (oxycodone) tablets for pain relief. Ms James was then discharged at 11:30am. Dr Dieu was contacted by Mr Sormann and the plan was that Dr Dieu would review her that afternoon.

During the afternoon Mr Dal Zotto made several phone calls to COCAPS, as he was concerned about Ms James's deteriorating state. At 06:30pm Dr Dieu contacted Mr Zotto and reassured him that Ms James' condition was to be expected and that he would review her in the morning if she had not improved. Ms James collapsed twice that evening at around 08:00pm and again at 09:00pm. On the second occasion Mr Zotto contacted emergency services. Ambulance officers arrived and commenced resuscitation, after 45mins Ms James was pronounced dead.

The cause of death was found to be complications of liposuction surgery including *'sepsis, decreased respiratory function secondary to microthrombi, fat emboli, probable inhalation of gastric contents and infection, and central nervous system depression due to combination of drugs (pethidine and propoxyphene).'*

The Coroner found that COCAPS did not provide Ms James with satisfactory post-operative care. On 22 January Ms James was showing signs of post-operative complications which Dr Cass and Mr Sormann failed recognise and investigate. Mr

Sormann's phone call to Dr Dieu released him from any further liability to Ms James' post-operative care. However, Mr Cass had a continuing responsibility to ensure that Dr Dieu reviewed Ms James as planned. Dr Dieu was found to have failed to provide proper care to Ms James. His telephone call to Mr Dal Zotto at 06:30pm was found to be inadequate considering Ms James' symptoms and Mr Zotto's concerns.

Although the Coroner concluded that COCAPS failed in their obligation to provide Ms James with adequate care, there was no recommendation that any charges be laid.

It was noted by the Coroner that to prevent a similar event in the future, COCAPS had introduced protocols and procedures for injectable opiates and restrictions on dispensing endone.

[Click here for report](#)

New Zealand

Health and Disability Commissioner: Registered Nurses Ms D and Ms C, Bellhaven Rest Home Ltd, 29 June 2010

Mrs B complained to the Commissioner about the standard of care provided to her mother, Mrs A, by Belhaven Rest Home Limited, and by registered nurses Ms D and Ms C.

Mrs A lived in Belhaven's dementia unit from November 2006. From April 2008, Mrs A was reported to have periods of wandering, agitation, and being sleepy. These episodes continued to be reported throughout 2008. Caregivers noted that Mrs A had bruises on her arms and legs and developed a rash. Mrs A's walking, appetite and general health were reported to be deteriorating.

In October, Mrs A was transferred to a private hospital. On arrival, Mrs A was found to have blisters on each heel, skin excoriation around her vulval and perineal areas, and broken skin on her left hip. Mrs A died a few days after arriving at the hospital.

The Commissioner found that registered nurse Ms D breached the Code of Health and Disability Services Consumers' Rights in failing to provide Mrs A with appropriate care and skill in a number of areas. The Commissioner found that Ms D "*lacked insight into the level of care Mrs A required*", thus breaching Rights 4(1) and 4(2) of the Code. Registered Nurse Ms C was also found to have breached Rights 4(1) and 4(2) of the Code. The Commissioner noted that Ms C did not review Mrs A's care plan, develop a wound care plan, or recognise that Mrs A was losing a significant amount of weight. Ms C was found to bear responsibility for the fact that Mrs A did not receive quality care.

The Commissioner found that Belhaven breached Rights 4(1) and 4(2). Belhaven failed to ensure that the obligations owed to Mrs A were fulfilled, particularly in relation to the review of Mrs A's care plan, communication with her family, and the need for timely reassessment by Needs Assessment and Service Coordination Services.

A copy of the Commissioner's report was sent to the Nursing Council of New Zealand, the Ministry of Health, and the District Health Board.

[Click here for decision](#)



Health and Disability Commissioner: Counsellor Ms C, 24 May 2010

The Commissioner investigated a complaint about the services provided by a counsellor, Ms C, to Mr A, aged 18, who suffered from depression. Mr A had only one appointment with Ms C, and cancelled by text message the subsequent appointments offered to him by Ms C. Four days after the appointment, Mr A was diagnosed by a mental health team with early psychosis and was prescribed an anti-psychotic medication. He was referred to the Early Psychosis Intervention team at the District Health Board.

Mr A did not take his medication as prescribed. He sent a text message to Ms C asking for her views on the medication. Ms C's reply supported Mr A's decision not to take it, but only if he had "excellent support". Mr A committed suicide about two weeks later.

The Commissioner observed that, although Ms C knew Mr A was depressed, she did not undertake a formal assessment of his depression. There was no indication of how Ms C assessed Mr A's suicide risk beyond asking him directly and taking a short history. The Commissioner noted that Ms C did not seek Mr A's permission to speak with his mother, despite the fact that he was living at home, and observed that in previous cases involving suicide, *"lack of consultation with family members has been consistently identified as a missed opportunity to gather further important information to assist diagnosis and treatment."*

Ms C had overlooked key issues during her session with Mr A, and had used text messages to give advice concerning medication without seeing Mr A or consulting with other providers. Ms C had failed to provide Mr A with services with reasonable care and skill. Accordingly, Ms C had breached Rights 4(1) and 4(5) of the Code of Health and Disability Services Consumers' Rights.

[Click here for decision](#)

Legislation

Queensland

Retirement Villages Regulation 2010 No. 207 (Qld)

The *Retirement Villages Regulation 2010 No. 27* (Qld) has been made under the authority of the *Retirement Villages Act 1999 No. 71* (Qld). The Regulation prescribes: (a) the particulars for an application for registration of a retirement village scheme, for the purposes of s. 27 (Application for registration of a retirement village scheme) of the governing Act; (b) the details for a residence contract, for the purposes of s. 45 (Content of residence contract) of the governing Act; and (c) fees payable, including for applications for registration and inspection of relevant documents. The Regulation commenced on 6 August 2010.

[Click here for legislation](#)



NSW

Health Practitioner Regulation National Law Regulation 2010 No. 309 (NSW)

The *Health Practitioner Regulation National Law Regulation 2010 No. 309* (NSW) has been made under the authority of the *Health Practitioner Regulation (Adoption of National Law) Act 2009 No.86* (NSW). The Regulation sets out modifications of the following federal laws as they apply as laws of a participating jurisdiction for the purposes of the national registration and accreditation scheme: (a) the *Privacy Act 1988 No 119* (Cth), including in relation to matters such as the appointment of National Health Practitioners Privacy Commissioner and staff, interferences with privacy and annual reports; (b) the *Freedom of Information Act 1982 No. 3* (Cth), including to provide that it applies as if a reference to the Federal Court were a reference to the Supreme Court, or another court of competent jurisdiction of a participating jurisdiction; and (c) the *Ombudsman Act 1976 No. 181* (Cth), including in relation to the appointment of National Health Practitioners Ombudsman and staff, financial matters and annual reports. The Regulation commenced on 1 July 2010.

[Click here for legislation](#)

News

E-Health

E-health missing from Abbott plan

The Australian Medical Association has expressed concern over the Coalition's position in relation to e-health policy.

[Click here for story](#)

Government considers alternatives

The Australian Government was considering alternatives to a government-funded e-health record system during public consultations on the Healthcare Identifiers Bill over the past year.

[Click here for story](#)

General Health

Resmed profit soars, plans stock split

ResMed Inc posted a 17 per cent rise in fourth-quarter net profit and unveiled a two-for-one stock split.

[Click here for story](#)

Out-of-pocket medical costs jump 30%

Medical gap costs have reportedly risen by 30 per cent in the past three years.

[Click here for story](#)



Show us your health policies

The Australian Medical Association again raised concern that super clinics were threatening existing practices.

[Click here for story](#)

Coalition confirms parental leave changes

Opposition Leader Tony Abbott has defended plans to make parents wait until 2012 to receive a paid parental leave scheme under a possible Coalition government.

[Click here for story](#)

Generic Medicines

Conditional authorisation for generic medicines code proposed

The ACCC proposes to grant conditional authorisation for three years to the second edition of the Generic Medicines Industry Association's Code of Practice.

[Click here for story](#)

Health Insurance

Health insurers report higher claims

Health insurers continue to report high levels of claims costs and say there has only been a small drop in the number of people covered by health insurance despite averse economic conditions.

[Click here for story](#)

Hospitals

Local boards will run hospitals under Coalition

Opposition Leader Tony Abbott would set up local boards to run public hospitals but would not take over the majority of health funding from the States in the short or medium term.

[Click here for story](#)

Radical surgery for area health services

The way healthcare is delivered to patients in NSW will change under a State Government plan which aims to ensure hospitals can better respond to local needs.

[Click here for story](#)

Preventative Health

Australia ranked in childhood diabetes top 10

Australia ranks in the top 10 OECD (Organisation for Economic Co-operation and Development) countries with the highest rate of diabetes in children.

[Click here for story](#)

[Click here for full report](#)



Quit smoking drug linked to suicides

Hundreds of people have reportedly considered killing themselves while taking the quit-smoking pill Champix and another 15 have committed suicide on the medication since 2008, statistics from the Therapeutic Goods Administration reveal.

[Click here for story](#)

New Zealand

DHB criticised over schizophrenic woman's death

Changes have been made to how mental health units are run following the death of a patient three years ago, the Auckland District Health Board says.

[Click here for full story](#)

Review of allergy protocol after grandmother's death

An 81-year-old woman's death after being given an antibiotic has sparked a major hospital review of how drug allergies are recorded.

[Click here for full story](#)

St John delay not a factor in death, says coroner

St John paramedics have been cleared of any fault relating to the drowning of a man in the Waikato River, a coroner's court has been told.

[Click here for full story](#)

Dietician prescribing of special foods approved

Pharmac has approved a proposal to allow dieticians to prescribe subsidised special foods and related products.

[Click here for full story](#)

Nurse prescribing in diabetes services discussion document released

Submissions are invited on proposed changes to enable suitably qualified nurses working in diabetes services to prescribe a limited range of medicines for people with diabetes.

[Click here for full story](#)

Physios warned over alleged price-fixing bid

The New Zealand Society of Physiotherapists is under fire from the Commerce Commission over claims of anti-competitive behaviour.

[Click here for full story](#)

I can't cut any more, says outgoing DHB boss

Wellington's district health board chief has quit, saying he cannot cut costs any further without undermining patient care.

[Click here for full story](#)

Further Information**Brisbane**

Shane Evans

T +61 (0)7 3119 6450**Sydney**

Lynne Peach

T +61 (0)2 9921 4800**Canberra**

Paul McGinness

T +61 (0)2 6225 3257**Melbourne**

Jacinda de Witts

T +61 (0)3 8608 2276**Adelaide**

Chris Sweet

T +61 (0)8 8233 5406**Perth**

Deborah Templeman

T +61 (0)8 9429 7510**New Zealand**

Paul Radich

T +64 (0)4 498 5019To email Australian lawyers use firstname.lastname@minterellison.comTo email New Zealand lawyers use firstname.lastname@minterellison.co.nz**Disclaimer**

The information contained in this update is intended as a guide only. Professional advice should be sought before applying any of the information to particular circumstances. While every reasonable care has been taken in the preparation of this update, Minter Ellison does not accept liability for any errors it may contain. This Update contains hyperlinks to websites. Minter Ellison does not claim any association with websites which are not clearly identified as Minter Ellison sites. Hyperlink users should observe a website's terms of use and copyright. Minter Ellison disclaims liability for the accuracy or use of material on others' sites.

