Inquest into the death of Ann Louise Parsons

Ann Lousie Parsons died on 15 October 2012 at the Royal Brisbane and Women's Hospital. Ms Parsons' death was due to unexpected complications following surgery to remove a brain tumour.

Coroner Christine Clements delivered her findings on 6 October 2017.

The Queensland Government responds to recommendations directed to government agencies at inquests by informing the community if a recommendation will be implemented or the reason why a recommendation is not supported.

The departments named in this response will provide implementation updates until the recommendation is delivered. Further information relating the implementation of recommendations can be obtained from the responsible minister named in the response.

Recommendation 1a

The Royal Brisbane and Women's Hospital conduct in-service training on the importance of documentation and reinforce the policy requirements regarding documentation for all medical staff on the neurosurgical ward, including consultants.

Response and action: the recommendation is implemented.

Responsible agency: Queensland Health.

On 9 April 2018 the Minister for Health and Minister for Ambulance Services responded:

Representatives of Metro North Hospital and Health Service, senior management and clinical leaders will review the recommendation. The outcome of the review team consideration will be reported in 2018.

On 1 November 2018 the Minister for Health and Minister for Ambulance Services responded:

In-service training was conducted with neurosurgical staff including consultants, junior medical staff and nursing staff. The training presented details of Mrs Parson's case including a description of multiple learning points. The documentation policy and the importance of documentation was reinforced at this meeting. Learning points from the presentation will be used in ongoing in-service education.

Recommendation 1b

The Royal Brisbane and Women's Hospital implement regular follow-up audits of medical entries to ensure that policy *74100/Proc: Documentation in the Patient Record* is being complied with.

Response and action: the recommendation is implemented.

Responsible agency: Queensland Health.

On 9 April 2018 the Minister for Health and Minister for Ambulance Services responded:

Representatives of Metro North Hospital and Health Service, senior management and clinical leaders will review the recommendation. The outcome of the review team consideration will be reported in 2018.

On 1 November 2018 the Minister for Health and Minister for Ambulance Services responded:

An audit against *Procedure 74100 Documentation the Patient Record* of 20 neurosurgical patient charts was undertaken in September 2017, prior to the in-service training described in recommendation 1a (above). Documentation has also been discussed at a further two neurosurgical consultant meetings. A new multidisciplinary audit tool for documentation has been developed and will be used in routine six-monthly audits as part of normal business operations.

Recommendation 1c

The Royal Brisbane and Women's Hospital amend the clinical/case pathway for a craniotomy patient with a brain tumour. When a neurosurgical patient presents with preoperative communication deficits, a comprehensive review by either a speech pathologist or member of the neurology team is undertaken to ensure there is a timely baseline assessment undertaken.

Response and action: the recommendation is implemented.

Responsible agency: Queensland Health.

On 9 April 2018 the Minister for Health and Minister for Ambulance Services responded:

Representatives of Metro North Hospital and Health Service, senior management and clinical leaders will review the recommendation. The outcome of the review team consideration will be reported in 2018.

On 1 November 2018 the Minister for Health and Minister for Ambulance Services responded:

Queensland Health agrees a timely baseline assessment of relevant neurological functions needs to be undertaken for craniotomy patients with brain tumours. The importance of preoperative assessment by a senior member of the neurosurgical team with referral to other health professionals (e.g. speech therapist, psychologist) as necessary has been reinforced with the unit and is included in an updated clinical pathway.

Recommendation 1d

The Royal Brisbane and Women's Hospital amend the clinical/case pathway for a craniotomy patient with a brain tumour to require the operating surgeon(s) complete a preoperative comprehensive detailed high cognitive function neurological assessment. The assessment must be clearly documented on the record.

Response and action: the recommendation is implemented.

Responsible agency: Queensland Health.

On 9 April 2018 the Minister for Health and Minister for Ambulance Services responded:

Representatives of Metro North Hospital and Health Service, senior management and clinical leaders will review the recommendation. The outcome of the review team consideration will be reported in 2018.

On 1 November 2018 the Minister for Health and Minister for Ambulance Services responded:

Queensland Health agrees a timely baseline assessment of relevant neurological functions needs to be undertaken for craniotomy patients with brain tumours. The importance of preoperative comprehensive assessment (including cognitive function) by a senior member of the neurosurgical

team with referral to other health professionals (e.g. speech therapist, psychologist) as necessary has been reinforced with the unit and is included in an updated clinical pathway.

Recommendation 1e

The Royal Brisbane and Women's Hospital amend the clinical/case pathway for a craniotomy patient with a brain tumour to consider a preoperative CT/MRI scan within 3-5 days prior to surgery. The surgeon be required to document the reason if a decision is made not to arrange such preoperative imaging.

Response and action: the recommendation was not implemented.

Responsible agency: Queensland Health.

On 9 April 2018 the Minister for Health and Minister for Ambulance Services responded:

Representatives of Metro North Hospital and Health Service, senior management and clinical leaders will review the recommendation. The outcome of the review team consideration will be reported in 2018.

On 1 November 2018 the Minister for Health and Minister for Ambulance Services responded:

The decision not to accept this recommendation was based on clinical feedback that indicated that decisions regarding radiological imaging need to be undertaken in the clinical context of each case by the responsible medical practitioner.

Unnecessary imaging should not be undertaken in patients. This was discussed and agreed at the consultant meeting held on 29 November 2017. Factors which need to be considered in deciding on the need for re-imaging include the type of tumour; size and location of the tumour; the clinical condition of the patient; the duration of the clinical history; and the time since last imaging.

Additionally, as it is now usual practice for brain tumour surgery to be undertaken using image guidance equipment (x-ray machines) further pre-operative imaging is not needed.

Recommendation 1f

The Royal Brisbane and Women's Hospital present Mrs Parsons' case in junior medical and nursing neurological training to highlight the importance of identifying changes in speech, restlessness and a change in the patient's ability to follow commands.

Response and action: the recommendation is implemented.

Responsible agency: Queensland Health.

On 9 April 2018 the Minister for Health and Minister for Ambulance Services responded:

Representatives of Metro North Hospital and Health Service, senior management and clinical leaders will review the recommendation. The outcome of the review team consideration will be reported in 2018.

On 1 November 2018 the Minister for Health and Minister for Ambulance Services responded:

The in-service training undertaken in December 2017 (see response to recommendation 1a) also addressed this recommendation in that the issues were highlighted in the presentation to neurosurgical medical and nursing staff. Further education will be undertaken with the neurosurgery nurse educator working with nursing staff within the ward.

Recommendation 1g

The Royal Brisbane and Women's Hospital undertake an audit to check whether consultant to consultant discharge of neurological patients is occurring in the intensive care unit in accordance with the root cause analysis recommendations.

Response and action: the recommendation was not implemented.

Responsible agency: Queensland Health.

On 9 April 2018 the Minister for Health and Minister for Ambulance Services responded:

Representatives of Metro North Hospital and Health Service, senior management and clinical leaders will review the recommendation. The outcome of the review team consideration will be reported in 2018.

On 1 November 2018 the Minister for Health and Minister for Ambulance Services responded:

A change in the model of care was instituted in the neurosurgical department such that routine craniotomy tumour cases are now managed post-operatively in the neurosurgical unit in a close observation bay, rather than in the Intensive Care Unit. This change in model of care negates the need for handover – the patient does not attend the Intensive Care Unit. The consultant responsible for the entire post-operative period is the neurosurgical consultant.