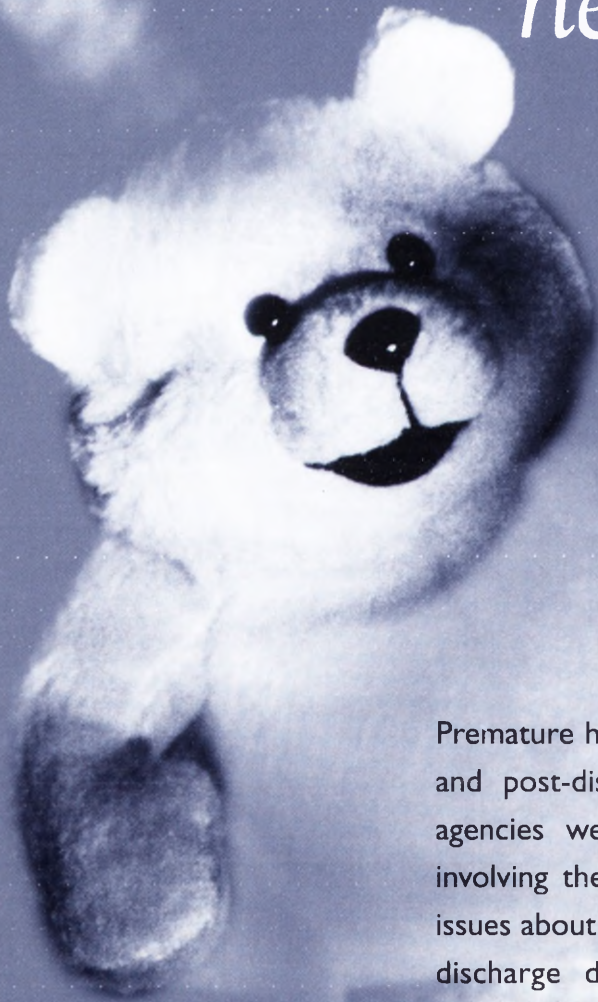
Dimitra Agiannitopoulos, VIC

Duty of care: *early hospital discharge and community health agencies*



Premature hospital discharge, inadequate discharge planning and post-discharge care provided by community health agencies were the focus of a recent Victorian inquest involving the death a premature infant. The finding raises issues about the duty of care of hospitals and doctors in the discharge decision-making process and that of health agencies providing post-discharge care in the community. It highlights the critical importance of appropriate, documented and coordinated discharge planning.

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Candice Burnell died on 29 May 1999 at just 5 weeks of age. On 29 April 2002, Coroner Noreen Toohey handed down her lengthy and detailed findings into Candice's death. She found that Candice had died from failure to thrive resulting from inadequate caloric intake and that both the hospital caring for Candice and a maternal and child health nurse had contributed to her death.[1]

BACKGROUND

Candice was born, just under 33 weeks, on 22 April 1999. Her birth weight was 1,853 grams.

In the three weeks prior to her discharge, Candice underwent phototherapy for mild jaundice, was breast and bottle fed with both expressed milk and formula, and had two, two-day rooming-in periods (separate room stays for mother and baby). During this time, Candice was neither consistently gaining nor maintaining her weight. She lost weight during both of the rooming-in periods when she was being solely breastfed. The second rooming-in period occurred just before her discharge on 18 May 1999 when she weighed 2,175 grams.

Prior to discharge, the hospital arranged for Candice to be visited by a Royal District Nursing Service (RDNS) nurse and a Maternal and Child Health Nurse (MCHN). The Hospital's Discharge Coordinator (HDC), prepared a document called a Newborn Services Nursing Discharge Summary containing information about baby Candice. The summary was sent to the RDNS and placed in the yellow 'Maternal and Child Health Book' to accompany mother and infant. The document did not refer to the difficulties Candice was having with feeding and weight gain.

Candice's mother gave evidence that she had not been told that there had been weight loss during the rooming-in periods and had not been given advice or instruction about supplementing feeds with formula.[2]

A RDNS Domicillary Infant Care Nurse visited baby Candice on 19 May 1999. Candice's mother told the nurse that she thought that a MCHN would be attending the next day. As a result, the nurse did not admit the family to the RDNS and did not weigh or examine the baby.

When the MCHN visited on 25 May she did not examine or weigh baby Candice as she was asleep. A visit to the nearby Maternal and Child Health Centre was arranged for 4.30 pm on 28 May at which the MCHN examined and weighed the baby. Baby Candice's weight of 2,150 grams (25 grams less than at discharge) was entered in the 'yellow book'. the MCHN told Candice's mother to go home and give the baby a feed.

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In the early hours of 29 May 1999, shortly after a feed, baby Candice was found cold and unresponsive. Despite resuscitation attempts, she died.

CORONER TOOHEY'S FINDING

The Discharge

Coroner Toohey found that baby Candice's discharge was premature because she had not yet been established solely on breastfeeds and was continuing to lose weight. She rejected the assertions of the Neonatal Paediatrician and the HDC that the discharge occurred against medical advice and that concerns about discharge and weight loss had been discussed with Candice's mother. There was no record of such advice in the hospital records and she noted that such a course of events was inconsistent with the contents of the hospital's discharge documentation.[3]

The Discharge Plan and its Communication

The Coroner found that although the discharge was premature, it did not contribute to Candice's death. Rather, she found on the balance of probabilities that had adequate post-discharge follow-up arrangements been put in place, it was unlikely that baby Candice would have died.[4] To this extent, she was highly critical of the administrative arrangements which brought about a death that need not have occurred. She found that:

'..[t]he success of the discharge plan was dependent upon the nature of the information provided and the manner in which that information was communicated to the various agencies...' and '...[a]n integral part of the plan was to ensure the various agencies were aware of the condition of the baby at discharge.'[5]

In this case, the hospital had not conveyed to the community agencies the critical issue of weight loss before discharge. The Coroner said that:

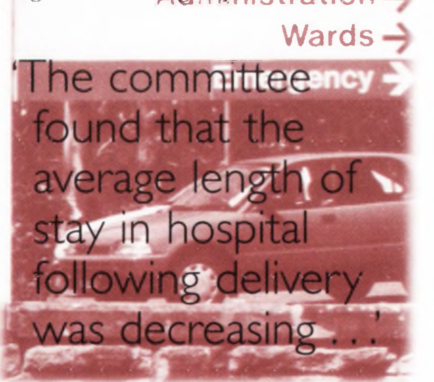
'..[i]t is quite extraordinary in my view that critical information such as

feeding and weight changes, particularly those associated with the two periods of rooming-in, was not included in the discharge summary. Indeed, one would expect such information to be highlighted and recorded in such a manner, as to instantly draw such critical information to the attention of nursing staff.'[6]

According to the Coroner, the plan failed to ensure a coordinated approach to follow-up and placed too much emphasis on detection by the community nursing agencies who had not been equipped with a comprehensive history about feeding and weight.[7]

The Post Discharge Care

The management and care provided by the RDNS was not criticised. The Coroner thought that it was reasonable for the RDNS nurse not to weigh baby Candice and admit her to the RDNS because the baby had just been discharged, no concerns had been flagged on discharge and there was an understanding that a MCHN would be attending the following day.



However, the Coroner found that the post-discharge management of the MCHN should have been different. While the MCHN had not been told about Candice's weight loss and the hospital's concerns about discharge, she had been told that an early visit was needed and that there were 'feeding/breastfeeding problems'. This information should have prompted her to weigh the baby on the first visit on 25 May, even though there was no formal requirement to weigh at the first visit. Also, the MCHN's examination findings on 28 May, which the Coroner found included weight loss of 25 grams, sleepiness and decreased peripheral circulation, should have resulted in an immediate return to the hospital for medical review.

How The Death Could Have Been Avoided

Coroner Toohey found that baby Candice's failure to thrive would most likely have been detected and her death avoided if:

- a medical review had occurred at the hospital within three days or so of discharge;
- Candice had been weighed within the first 48 hours post discharge and thereafter at regular intervals and the results returned to the hospital;
- greater attention had been paid to ensuring each of the agencies were aware of their specific roles and functions and all relevant information had been provided to them;
- Candice's mother had been informed of the weight loss prior to discharge and the importance of weighing, and been counselled as to the signs indicating failure to thrive;
- baby Candice had been weighed at the time of her examination on 25 May;
- the signs that an immediate medical review was needed had been recognised on 28 May.

Coroner Toohey concluded that the hospital, individual hospital staff members and the MCHN contributed to the death.[8]

SENATE COMMITTEE ENQUIRY – ROCKING THE CRADLE

Post-natal care in the context of early hospital discharge was examined as part of a 1999 Senate committee enquiry into childbirth called, *Rocking the Cradle – A Report into Childbirth Procedures*[9]. The committee found that the average length of stay in hospital following delivery was decreasing consistent with shorter stays for other hospital admissions.

Concerns about early discharge identified by the Committee included:

- the adequacy of screening mechanisms to ensure that early discharge did not occur in inappropriate cases;
- the adequacy of support services in the community;
- fragmentation in the funding arrangements and the provision of post-natal care which adversely affected the quality of care;
- increasing reliance on ill-equipped general practitioners to care for neonates.[10]

The Committee referred to a submission which noted that in the United States, legislation had been introduced – the *Newborns' and Mothers' Protection Act 1996* – in response to the growing number of infants being readmitted to hospital for failure to thrive after early discharge.[11] This Federal Act requires health plans and insurance issuers to provide hospital benefits cover for at least 48 hours following vaginal delivery and 96 hours following caesarian section.

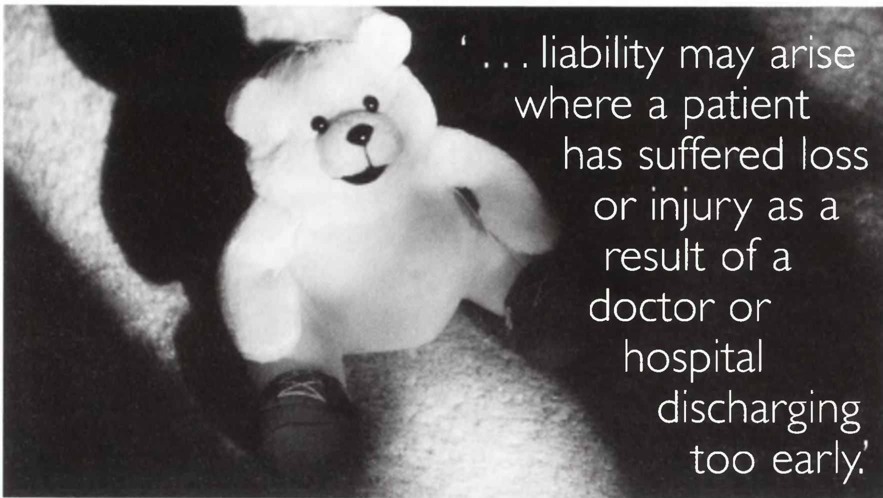
Overwhelmingly, the submissions made to the Committee pointed to an inadequate level of care being provided in the post-natal period. The Committee found that while post-natal care had possibly the greatest potential for long term benefits, it was the most neglected area of maternal and infant care.[12] One of the Committee's recommendations was that the Commonwealth and state governments work together to ensure maternity and infant welfare services were in place to assist women upon their return home after childbirth.[13]

It is poignant to note that the enquiry took place in the same year as baby Candice's birth and death.

IMPLICATIONS FOR MEDICAL NEGLIGENCE CLAIMS

The issues highlighted by the finding into baby Candice's death are not confined to the post-natal setting. They apply equally to other hospital admissions where there has been early or inappropriate hospital discharge.

In such cases, liability may arise where a patient has suffered loss or injury as a result of a doctor or hospital ▶



discharging too early or failing to put into place a cohesive discharge plan which ensures monitoring of a patient's condition and implements a mechanism to identify and act on concerns. Whether there has been a breach of the duty of care or failure to take reasonable care in the discharging process will depend on the circumstances of the particular case.

If the discharge is said to have occurred against medical advice, then the relevant issues will be whether the patient has had the consequences of discharge explained to them and has the capacity to understand and make their own decision about discharge. The hospital records should include reference to the reasons and circumstances of the discharge in such cases. The presence or absence of a signed statement from the patient acknowledging that they are discharging themselves against medical advice will be relevant but will not necessarily dispose of this question.

Akin to a hospital's duty of care in relation to decisions about discharge is the duty of care in relation to decisions about short-term inpatient transfers to hotels, a recent development in hospital care.[14] The purpose of these 'medi-hotels' is said to be the reduction of hospital waiting lists by providing short-term hotel accommodation for patients undergoing tests, day procedures or who do not require ward nursing care. While some of these medi-hotels have a nurse on duty 24 hours a day, others do not. Patients in these hotels remain in the care of the hospital at all times, and should a patient suffer injury in circumstances where transfer is found to have been inappropriate, the hospital may be liable for injury suffered. It is not hard to imagine a situation where post-operative complications might occur and treatment is delayed because the patient is alone in a nearby hotel.

As far as community health agencies are concerned, liability may arise where injury or death occurs as a result of an unreasonable failure to identify and act on a patient's deteriorating condition. The increasing responsibilities of community health agencies in providing care in the community, including care previously provided in hospital, will most likely result in an increase in the potential liability of these agencies.

In each case it will, of course, be necessary to obtain expert evidence as to the standard of care that should have been provided by the agency, the appropriateness of the discharge and the follow-up arrangements put in place.

It will also be useful to ascertain whether there has been a breach of relevant protocols or guidelines. To that end, it will be essential to obtain, in addition to the patient's medical records, the hospital's own protocols about discharge, the community health agency's own service provision protocols and any contractual documents between the discharging hospital and the community health agency dealing with responsibility for care. In the case of public hospitals and community health agencies, such documentation may be sought under relevant freedom of information legislation. In those jurisdictions where there is patient access to medical records, such as in Victoria under the *Health Records Act* 2001, this avenue ought to be pursued. Where proceedings have been issued, medical records, protocols and other relevant documentation should be sought through discovery.

Any relevant publicly available guidelines should also be sourced, for example, National Health and Medical Research Council publications.

Where there has been a death and an inquest held, as in the case of baby Candice, the evidence given at the inquest and the findings of the Coroner will play an important role in determining whether civil proceedings for loss of dependency or 'nervous shock' should be brought.

While there is some overlap between the coronial and civil adversarial process, they are distinct forums serving different purposes and functions. The coronial enquiry is a purely fact-finding one where the rules of evidence are not strictly applied. The Coroner's function is to investigate and determine the cause of death without making findings of blameworthiness or legal responsibility.[15] Having said that, inquests involving hospitals, other medical institutions or individual health care providers will often centre on the adequacy of the treatment and management and its relationship to the death (although in the case of baby Candice both the cause of death and the adequacy of the medical and nursing care were major issues at the inquest).

Coronial findings are not admissible in civil trials and a critical finding is not a prerequisite for determining civil liability (particularly in cases involving consent issues). However, the evidence given at the inquest and the Coroner's findings will often form the basis for deciding whether a medical negligence claim should be pursued. Where the medical care has been strongly criticised and findings of causation between deficient practice and death have been made by the Coroner, this will sometimes result in early discussions and settlement ►

of the civil case. Also, the evidence, including expert evidence, given at the inquest will define the issues in any subsequent legal proceedings. Where the same witness gives inconsistent evidence at a later civil trial, an adverse inference can be drawn.

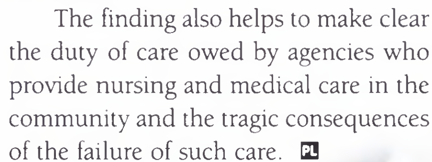
It should be borne in mind that in the civil case, in addition to liability, the plaintiff will have to prove loss and dependency or, in the case of a 'nervous shock' or psychiatric injury claim, that they fit the criteria for pursuing such a case.[16]

While an inquest will focus on the individual circumstances of the death being investigated, the Coroner can also look more broadly at procedures, products or devices connected to the death or other deaths which have occurred in similar circumstances. Inquests therefore serve a broader public interest of exposing poor practices or dangerous products in order to avoid avoidable deaths in the future. An adjunct of the Coroner's role is to make recommendations on matters of public health and safety which may in turn lead to improvements and structural or legislative change. Where recommendations are made, the Coroner will often direct that the finding be brought to the attention of particular organisations and/or government departments.[17]

CONCLUSION

Against an increasing trend towards shortened hospital stays followed by community nursing care provided in the home, the finding into baby Candice's death serves as a sober reminder of the critical importance of proper and appropriate hospital discharge decision-making. It emphasises the need for an integrated and clear approach to post hospital discharge care, planning and implementation.

The finding also helps to make clear the duty of care owed by agencies who provide nursing and medical care in the community and the tragic consequences of the failure of such care. PL



Endnotes:

1. *Record of Investigation into Death of Candice Burnell*, Coroner Noreen Toohey, Case No. 1616/99, 29 April 2002
2. Ibid, at 18.
3. Ibid, at 28 and 29.
4. Ibid, at 30.
5. Ibid, at 35.
6. Ibid, at 36.
7. Ibid, at 37.
8. Section 19 (1)(e) of the *Coroners Act* 1985 (Vic) provided that, where possible, a Coroner was to find the identity of a person who contributed to a death. The section was repealed by Section 10(b) of the *Coroners (Amendment) Act* 1999. A Victorian Coroner is therefore no longer required to make findings of contribution in investigations commenced after the commencement of the amending section, on 1 July 1999. See *Keown v Khan and Another* [1999] 1 VR 69, for discussion on the former section 19(1)(e).
9. "Rocking the Cradle – A Report into Childbirth Procedures", Senate Community Affairs References Committee, December 1999 at http://www.aph.gov.au/senate/committee/clac.
10. Ibid, pp. 149 to 152.
11. Ibid, p. 144.
12. Ibid, p. 4.
13. Ibid, p. 154.
14. Porter, Liz. "Surgery on Tuesday, room service by Thursday", *The Sunday Age*, 24 November 2002, p. 5.
15. See *Keown v Khan and Another* [1999] 1 VR 69.
16. See *Tame v New South Wales; Annetts v Australian Stations Pty Limited* [2002] HCA 35 (5 September 2002 in relation to 'nervous shock' cases in Australia.
17. For a detailed analysis of coronial law see Freckelton, I. and Ranson, D. *Coronial Law and Medicine*, to be published by Oxford University Press later this year.

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