CORONERS COURT
OF NEW SOUTH WALES

Inquest:	Inquest into the death of George Kimpton
Hearing dates:	5-7 August, 19 and 20 September 2019.
Date of findings:	8 October 2019
Place of findings:	NSW Coroners Court - Lidcombe
Findings of:	Magistrate Elizabeth Ryan, Deputy State Coroner
Catchwords:	CORONIAL LAW – death in hospital following colorectal surgery – cause and manner of death – was Mr Kimpton's medical and nursing care adequate and appropriate?
File number:	2016/172792
Representation:	Counsel Assisting the Coroner: K Sant of Counsel i/b the NSW Crown Solicitor's Office. Sydney Adventist Hospital and others: R Sergi of Counsel i/b HWL Ebsworth. Dr M McNamara and Dr G Bennett: C Magee of Counsel i/b Avant Law. Dr S Wickins: K Burke of Counsel i/b Moray & Agnew.

Findings:	**Identity of deceased:** The person who died is George Kimpton. **Date of death:** George Kimpton died on 5 June 2016**.** **Place of death:** George Kimpton died at the Adventist Hospital, Wahroonga NSW. **Cause of death:** George Kimpton died as a result of vaso dilatory shock and multi organ failure secondary to aspiration and cardiorespiratory arrest. Significant contributing conditions were subacute pneumonia and ischaemic heart disease. **Manner of death:** George Kimpton died in hospital after he developed complications following colorectal surgery.

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The Coroners Act 2009 (NSW) *in s81 (1) requires that when an inquest is held, the coroner must record in writing his or her findings as to various aspects of the death.*

These are the findings of an inquest into the death of George Kimpton.

The role of the Coroner

An inquest is different to other types of court hearings. It is neither criminal nor civil in nature. It does not determine whether a person is guilty of an offence, and it does not make findings and orders that are binding on parties.

A Coroner presiding over an inquest is required to confirm that a particular death occurred and make findings as to:

- The identity of the person who died
- The date and place of the death
- The cause and manner of the death.

In addition, under section 82 of the Act a Coroner may make recommendations that are considered necessary or desirable in relation to any matter connected with the death, including in relation to health and safety.

Introduction

1. On 5 June 2016 George Kimpton aged 80 years died in the Adventist Hospital at Wahroonga [the SAN]. He had been admitted there on 26 May 2016 for elective surgery, which was performed the following day.

2. On the night of 4 June while still in hospital, Mr Kimpton's condition deteriorated and he suffered severe vomiting and respiratory distress, followed by cardiopulmonary arrest. He died five hours later.

George Kimpton's life

3. Mr Kimpton was born on 4 February 1936. He had two sons Drew and Darren, and three grandchildren Vanessa, Georgina and Ned whom he loved to spend time with at their home in Scone NSW. Mr Kimpton was busy in his retirement and was active in many groups including his local Probus club. He also enjoyed travelling with his wife Muriel Joy and liked to create videos for others to share their travel experiences.

4. When Mr Kimpton died Muriel had a number of concerns about the circumstances of his death, but she herself died before this inquest commenced. However Mr Kimpton's son Darren attended the entirety of the inquest, travelling to and from Scone each day.

Mr Kimpton's medical history

5. Mr Kimpton had a medical history of diabetes, hypertension, ischaemic heart disease and mild renal impairment. On 15 April 2016 he underwent a colonoscopy which identified an adenocarcinoma in the lower part of his abdominal cavity. The colorectal surgeon, Dr Matthew McNamara met with Mr Kimpton and his wife Muriel the following week. He discussed with them the risks and potential complications of a right hemicolectomy, which is the surgery needed to remove the adenocarcinoma.

6. Mr Kimpton's pre-existing medical conditions would put him at increased risk of cardiac events with major surgery. For this reason Dr McNamara referred him for review by geriatrician Dr Gregory Bennett, and cardiologist Dr Anil Aggarwala. Their consensus was that Mr Kimpton would be at increased risk of a coronary episode post-operatively. In Dr Bennett's opinion Mr Kimpton was also at risk of post-operative ileus due to the likelihood of adhesions from previous surgery. An ileus is a slowing of gastrointestinal function that can occur after surgery, resulting in the bowel contents being unable to move forward. Despite these risks both specialists considered the surgery needed to proceed due to the cancerous nature of the tumour.

7. I should note that the evidence at inquest provided no basis for criticism of the decision that Mr Kimpton undergo surgery to remove the cancer. I accept that the decision to proceed notwithstanding Mr Kimpton's complications was reasonable and appropriate.

The operation and its aftermath

8. On 26 May 2016 Mr Kimpton was admitted to the SAN Hospital under the care of both Dr McNamara and Dr Bennett. Dr McNamara performed the right hemicolectomy the next day. As predicted, there were significant intra-abdominal adhesions which needed dissecting. There was no indication that the tumour had metastasised. There was also no evidence that Dr McNamara performed the surgery in anything other than a competent and professional manner.

9. After the operation Mr Kimpton was returned to the ward and was given morphine by way of patient controlled anaesthesia [PCA] for pain management. The following day, 28 May, he was reviewed by both Dr McNamara and Dr Bennett.

10. That evening the nurse caring for Mr Kimpton noticed he was experiencing an episode of confusion. He had had a low-grade fever since 10.00am that morning, and during the evening he pulled out his cannula and disconnected his catheter. However his disorientation resolved soon afterwards. At the time neither Dr McNamara nor Dr Bennett was informed of this episode. They

said in evidence they would have liked to have been told, although they agreed the episode appeared to have been short-lived.

11. The next evening, after consultation with Dr McNamara and Dr Bennett the Career Medical Officer Dr Tim Wang commenced Mr Kimpton on the antibiotic Tazocin. Mr Kimpton had been short of breath with a fast pulse, decreased oxygen saturation and a fever. Dr Wang suspected he had developed aspiration pneumonia. 'Aspiration' refers to a situation where as a result of reflux or vomiting, food and fluids enter the body's respiratory structures. When, as sometimes occurs, this causes inflammation and infection this is known as aspiration pneumonia.

12. I note here that according to the consensus of evidence at the inquest, Mr Kimpton's episode of confusion on the previous night was unlikely to have been related to his aspiration pneumonia. It was also agreed that the clinical treatment of the pneumonia was appropriate.

13. On 30 May Dr Bennett recorded that Mr Kimpton had developed a '*not unexpected'* ileus, with typical symptoms of a distended abdomen, hiccups and nausea. These symptoms had emerged the previous day, prompting Dr McNamara to order that a nasogastric tube [NG tube] be placed. An NG tube is a thin tube which is inserted through the nostril, down the oesophagus, and into the stomach. In Mr Kimpton's case its purpose was to drain gastrointestinal fluids from his stomach. The NG tube aspirated a large amount of faecal fluid from Mr Kimpton's abdomen. The presence of the ileus was confirmed on 2 June when an abdominal x-ray showed distended loops of small and large bowel and gas in the large bowel.

14. The distension of Mr Kimpton's abdomen persisted but on 3 June there appeared to be some improvement in his ileus. In the afternoon he had a bowel motion and was passing flatus. A moderate amount of fluid was aspirated from his NG tube.

Events of 4 June

15. This was the day and night on which Mr Kimpton's condition rapidly deteriorated, leading to his death early the next morning.

16. In the earlier part of the day Mr Kimpton had seemed to be improving. Dr Ada Ng had assisted Dr McNamara with Mr Kimpton's surgery and she reviewed him on the morning of 4 June. She thought he looked better. He was able to walk without assistance, his abdomen felt soft, he was not experiencing nausea and he told her he felt hungry. By now there was minimal fluid draining from his NG tube, a positive indication that his ileus was resolving.

17. When Dr McNamara reviewed Mr Kimpton at about midday, he too considered the ileus was resolving. He ordered that he be commenced on clear fluids. The court heard this is an important step in a post-operative patient's recovery. Unnecessary delay in taking fluids by mouth delays the reactivation of a patient's gastric function.

18. Dr McNamara also decided it would be appropriate to remove Mr Kimpton's NG tube. To leave it in place while he was taking fluids by mouth would increase his risk of aspiration. In addition Mr Kimpton, like most patients, found the NG tube to be extremely uncomfortable and was very keen for it to be taken out. It was removed around midday, and he received clear fluids shortly afterwards.

19. That evening Mr Kimpton became increasingly short of breath. Around 6.30pm he developed a cough, which his allocated nurse Registered Nurse Wilson reported to her team leader Registered Nurse Jennifer Funes. RN Funes instructed her to sit him upright and to monitor him. At the inquest she explained that by this she meant that his observations should be taken more frequently. In fact a set of observations was not taken until 9pm, with the exception of an oxygen saturation check made at 8.41pm.

20. Just before 8.30pm Mr Kimpton told RN Funes that he was having trouble breathing. The nurses noticed there was a '*gurgly*' sound to his breathing which had not been there before, but they did not observe signs of respiratory distress. RN Funes made an electronic request for a review by the CMO on duty, Dr Simon Wickins.
    The court heard that in the SAN, summoning a CMO by this means usually meant the CMO would review the patient on the next occasion he or she performed ward rounds. These were next expected at around 10pm.

21. RN Wilson performed a full set of observations at 9pm. All measurements were within the normal zone of the hospital's standard Vital Observation Chart. Nevertheless there were some changes since the previous set of observations. These included the following:

- Pulse rate: 115 beats per minute [bpm], up from 83 bpm at 5.30pm.
- Respiratory rate: 20, up from 18 at 5.30pm.
- Oxygen saturation: 96%, down from 98% at 5.30pm. Mr Kimpton was receiving oxygen supplements delivered by way of a breathing mask.

22. Shortly after 9.30pm Mr Kimpton was assisted to the toilet. On his return his breathing was noticeably laboured and a repeat set of observations showed that his oxygen saturations had fallen to 91%. Mr Kimpton then started to vomit. RN Funes escalated a medical review by paging the CMO Dr Wickins

to attend, which he did shortly afterwards. On arrival he saw that Mr Kimpton was conscious and that his pyjamas were wet with bile stained fluids. Dr Wickins suspected that he had aspirated leading to respiratory compromise.

23. Almost immediately Mr Kimpton began to vomit copiously into the mask fixed to his mouth. As Dr Wickins described it, he was not choking or making retching movements, rather the fluid was welling up into his mouth. He then lost consciousness. An arrest call was made and Mr Kimpton was resuscitated, intubated and transferred to the hospital's Intensive Care Unit [ICU] under the care of Dr Brett Steeves. In the meantime large amounts of gastric fluid were suctioned from his airway. In the opinion of Dr Steeves and Dr Wickins, Mr Kimpton's loss of consciousness had resulted in him no longer being able to protect his airway from upcoming gastric contents.

24. In ICU Mr Kimpton's cardiac function was monitored and showed no evidence of life-threatening arrhythmia. However the ICU team was unable to sustain his blood pressure despite ventilation and the administration of noradrenaline. His condition continued to deteriorate as his organs began to suffer from inadequate supply of oxygen. He proceeded to multi organ failure, and died soon after 3.30am with his wife, son and daughter-in-law by his side.

25. The SAN reported Mr Kimpton's death to the Coroner, Dr Steeves recording that in his opinion the cause of death was '*vaso dilatory shock and multi organ failure secondary to aspiration and cardiorespiratory arrest'.* The nature of vaso dilatory shock and whether it can be identified as the cause of Mr Kimpton's death is discussed below.

Issues at the inquest

26. These were:

- What was the cause of Mr Kimpton's death?
- Did any clinical decisions of Dr McNamara and/or Dr Bennett contribute to Mr Kimpton's death? In particular, was the removal of his NG tube on 4 June premature, and did the maintenance of PCA morphine up until 4 June contribute to his deterioration?
- Did Mr Kimpton receive appropriate nursing care and assessment on the night of 4 June? In particular should a medical review have been secured at an earlier time?

In addressing these issues the court was assisted by evidence from the following independent expert witnesses:

- Dr Kendall Bailey, specialist forensic pathologist
- Dr John Obeid, specialist geriatrician and physician
- Dr Philip Truskett, general surgeon with clinical interests in gastrointestinal, colectomy and emergency surgery.

- Dr Alan Meagher, colorectal surgeon.

28. In addition to providing the inquest with expert reports the above witnesses gave oral evidence, the last named three in conclave. The court also heard opinion evidence where appropriate from Mr Kimpton's treating doctors including Dr McNamara, Dr Bennett, Dr Wickins and Dr Steeves.

What was the cause of Mr Kimpton's death?

29. On 9 June 2016 forensic pathologist Dr Kendall Bailey performed an autopsy. She had access to Mr Kimpton's hospital records but not statements from his treating doctors as these were not available at that time.

30. Dr Bailey's examination found widespread subacute pneumonia in Mr Kimpton's lungs. In addition his heart showed marked calcified atherosclerotic coronary artery disease, with extensive scarring in the wall of the left ventricle. Dr Bailey determined the cause of death to be: *The combined effects of subacute pneumonia and ischaemic heart disease, against a background of recent surgical hemicolectomy and pre-existing conditions of diabetes, hypertension and asthma.*

31. Dr Bailey found no evidence of recent ischaemic heart attack, noting that if Mr Kimpton had suffered such an event around 9.30pm on 4 June she would have expected to have seen early microscopic signs of this at autopsy, given that he had survived a further five hours.

32. Dr Bailey was asked to comment on the likelihood of severe pneumonia as a cause of death, given the evidence that Mr Kimpton had seemed quite improved on the morning of 4 June. She replied that despite his apparent wellness his lung spaces most likely continued to contain fluid at that time. This, combined with his age and pre-existing medical conditions, gave him little in reserve should he have to deal with an adverse clinical event.

33. In his oral evidence Dr Steeves confirmed the opinion he had expressed in the hospital report to the Coroner [see paragraph 26 above]. It is important to note that Dr Steeves, in addition to being an experienced ICU clinician, had the benefit of observing Mr Kimpton throughout much of the acute event which preceded his transfer to ICU. Dr Steeves was asked what he thought had triggered Mr Kimpton's rapid deterioration. In his view, soon after 9.30pm Mr Kimpton suffered a major aspiration event which led to profound vaso dilatory shock. Dr Steeves explained that gastric contents are highly acidic and when they enter the respiratory system they can cause chemical injury and inflammation to the sensitive tissue of the lungs. The body responds by dilating its blood vessels to increase blood flow, which in turn lowers blood

pressure. As the body's organs are starved of oxygen vaso dilatory shock sets in, leading to permanent organ damage and death.

34. Dr Steeves did not consider the cause of death to have been ischaemic heart attack, as the autopsy examination had revealed no relevant tissue changes that might otherwise have been expected to be visible. Nor did the cardiac monitoring which commenced very soon after Mr Kimpton's major aspiration event show any evidence of a life-threatening arrhythmia.

35. At the inquest all four experts were asked to comment on Dr Steeves' opinions regarding the cause of death. In their evidence Dr Meagher, Dr Obeid and Dr Truskett agreed that vaso dilatory shock as a result of aspiration was a plausible and likely sequence of events. In her evidence Dr Bailey stated that her autopsy examination could neither confirm nor exclude this possibility. The presence of pneumonia on Mr Kimpton's lung tissues made it impossible to ascertain if they had suffered chemical damage as a result of aspiration.

36. As to what had caused Mr Kimpton's copious vomiting and resulting aspiration, the medical evidence was less clear. It was beyond the capacity of an autopsy examination to shed light on this question. Dr Obeid considered it possible Mr Kimpton's ileus had recurred or failed to resolve sufficiently, causing reflux of gastric fluid. This also was Dr Bennett's hypothesis. As against this however was the evidence of his improved gastrointestinal function on the morning of 4 June. Given the state of the evidence I accept the submission of Counsel Assisting, that although it is possible Mr Kimpton's severe vomit on the night of 4 June was triggered by a recurring or unresolved ileus, this cannot be concluded on the balance of probabilties.

37. The medical witnesses were also asked what contribution if any Mr Kimpton's underlying pneumonia diagnosed on 29 May had made to his deterioration and death. Doctors Bennett, McNamara, Steeves and Obeid thought Mr Kimpton's underlying pneumonia could not of itself explain Mr Kimpton's death, as he had seemed to be responding well to his treatment. Doctors Meagher and Truskett did not disagree with this opinion, but considered pneumonia could not be discounted from contributing to Mr Kimpton's rapid decline. It most likely had the effect of reducing his capacity to deal with the aspiration event and its consequences for his respiratory system.

38. As a result of the evidence heard at the inquest, I am able to conclude on the balance of probabilities that the cause of Mr Kimpton's death was vaso dilatory shock and multi organ failure secondary to aspiration and cardiorespiratory arrest. Significant contributing conditions were subacute pneumonia and ischaemic heart disease.

Did any clinical decisions of Dr McNamara or Dr Bennett contribute to Mr Kimpton's death? In particular:

- **was the removal of his NG tube on 4 June premature?**
- **did the maintenance of PCA morphine up until 4 June contribute to his deterioration?**

40. In his report to the inquest, Dr Obeid hypothesised that Mr Kimpton's NG tube had been removed before sufficient recovery of his gastrointestinal function, leading to the large volume vomit and severe aspiration of the evening of 4 June.

41. Dr Obeid also suggested it may have been unwise to remove the tube and commence Mr Kimpton on clear fluids on a Saturday evening, when, as Dr Obeid supposed, there were reduced staff levels on site to deal with any adverse consequences. At the inquest however the court heard that during afterhours the SAN maintains the same level of medical and nursing cover as at other times, the only exception being that a Nursing Unit Manager and nursing educator are not rostered. On learning of this Dr Obeid modified his opinion as to that aspect of his report.

42. As to whether it was clinically appropriate for Mr Kimpton's NG tube to be removed on 4 June, at the inquest Dr McNamara and Dr Bennett each maintained that it was. This position was supported by Doctors Meagher and Truskett, based on the following:

- there was sufficient evidence on 4 June of a return to gastrointestinal function. Mr Kimpton had opened his bowels the previous day, he was passing flatus, he was no longer feeling nauseous, his abdomen was no longer distended, he felt hungry, and by then very little fluid was being aspirated from his NG tube.
- Mr Kimpton found the NG tube extremely uncomfortable and expressed that he wanted it removed. It was appropriate to take his wishes into account.
- it was important for his recovery for Mr Kimpton to commence fluids and food by mouth once this was safe. It is common to remove an NG tube at this stage, as introducing fluids by mouth when an NG tube is still in situ can increase the risk of aspiration.

43. At the inquest Dr Obeid appropriately conceded that the decision as to when to remove the NG tube was a surgical one, and that opinion upon the appropriateness of the timing was best left to the expertise of the colorectal surgeons.

44. Given the expert evidence on this issue, I conclude that Dr McNamara's decision to remove Mr Kimpton's NG tube at around midday on 4 June was not unreasonable or inappropriate. Further, given the uncertain state of the

evidence as to the trigger for Mr Kimpton's large vomit that evening, it cannot be concluded that the removal of his NG tube was causally connected to that event.

Administration of PCA morphine

45. Following his surgery on 27 May Mr Kimpton continued to have access to morphine via PCA up until the acute event on the evening of 4 June. The court heard that only a minority of patients remain on PCA morphine for that length of time following their surgery. Furthermore it is accepted that prolonged use of morphine can increase the risk of a patient developing an ileus.

46. In his report Dr Obeid noted that based on the relatively small amounts of PCA morphine which Mr Kimpton had accessed between 3 June and the night of 4 June, he had been mostly pain free. Given that morphine increases the risk for ileus and vomiting, Dr Obeid considered this ought to have prompted consideration of removing the PCA. If on review it appeared Mr Kimpton had an ongoing requirement for analgesia this should have triggered either a clinical review to determine the cause of his pain, or referral to a specialist pain service.

47. However Dr Truskett and Dr Meagher disagreed, stating that it was not unreasonable for a patient in Mr Kimpton's circumstances to have remained on PCA morphine for this period of time. In their view he would have needed analgesia to enable him to mobilise, to cough (thereby reducing the risk of developing pneumonia), to undergo physiotherapy, and to address lingering wound and back pain. As to the type of analgesia, it was accepted that Mr Kimpton's pre-existing medical conditions ruled out other options.

48. I accept the evidence that it was not unreasonable for Dr Bennett and Dr McNamara to have maintained Mr Kimpton's PCA morphine for the period of time they did. I accept further that while it is possible Mr Kimpton's ongoing use of morphine may have led to a recurrence of his ileus and thereby contributed to the acute events, the evidence is not sufficient to conclude this on the balance of probabilities.

49. For the above reasons I conclude there is no basis for criticism of the clinical decisions of Dr McNamara and Dr Bennett regarding the administration of PCA to Mr Kimpton, or the removal of the NG tube on 4 June.

50. It was noted that Dr Bennett did not document his daily reviews of Mr Kimpton's pain levels and need for analgesia. Neither Dr Truskett nor Dr Meager thought this was unusual and stated it was not part of their practice to

do so either. In view of this evidence, and the absence of evidence that the failure to document this aspect of Mr Kimpton's care contributed to his death, it would not be appropriate to criticise Dr Bennett for the omission. Nevertheless it seems to me that the benefits of doing so are evident, given the need for other involved clinicians to be aware of such matters. I leave it for those who manage the SAN to consider this issue for follow up if that is thought appropriate.

Were there any deficiencies in Mr Kimpton's nursing care, and if so did they contribute to his deterioration and death?

51. The inquest also examined whether any of the nursing decisions made on the night of 4 June may have contributed to Mr Kimpton's decline. In particular the question was asked whether it would have been appropriate for his nurses to have sought an earlier and more urgent medical review of his condition.

52. It is evident that Mr Kimpton's nurses were aware that they were able to seek a medical review on a non-urgent basis, that is in circumstances where, although none of his vital sign observations were in the yellow or red zone, there was nevertheless a change in his clinical condition. This is what they did at around 8.30pm, when they noticed the 'gurgly' sound to his breathing. They did so using the least urgent method available to them, by logging an electronic request for a review.

53. It must be acknowledged that a decision about whether and when to seek a medical review is an exercise of clinical judgement, and that it is often only in light of subsequent events that a different decision seems to have been indicated. Regarding the electronic request made at around 8.30pm, the consensus of expert opinion was that at this stage there was no apparent need for undue alarm, and there was little to criticise in the decision.

54. Sometime between 9.30pm and 10pm Mr Kimpton had clearly developed respiratory distress and had started to vomit. In addition his oxygen saturation levels now put him in the yellow zone. These signs prompted RN Funes to page the CMO Dr Wickins. The question again arose, whether the more urgent option of a MET call would have been more appropriate. If it had, Dr Wickins would have been required to attend within thirty minutes.

55. As it happened, Dr Wickins attended at about 10.13pm. Although the time at which RN Funes paged Dr Wickins is not precisely known, his arrival cannot have been much outside the period required with a MET call. It could not therefore be said that his arrival would have occurred much earlier, even if a MET call was considered the more appropriate option.

56. Given all the circumstances, the medical experts were disinclined to conclude that different decisions ought to have been made about the method by which a medical review was sought. Nor were they able to conclude that the outcome for Mr Kimpton would have been any different. For these reasons I have concluded there is no basis to be critical of the decisions made by nursing staff that night when they sought medical review of Mr Kimpton.

57. A further aspect of Mr Kimpton's nursing care was examined at the inquest, being the frequency of vital sign observations. As noted in paragraph 20 above, when around dinner time on 4 June RN Wilson told RN Funes about Mr Kimpton's coughing and his complaints of shortness of breath, she was instructed to 'monitor' him. RN Funes understood this to mean that RN Wilson would conduct more frequent observations. In his expert statement Dr Truskett said that more frequent observations would have been an appropriate response to Mr Kimpton's presenting signs. Indeed it would be in accordance with the SAN's own policy *Recognising and Responding to Clinical Deterioration* [refer paragraph 5.2], which requires that frequency of observations be increased as indicated by the patient's condition, regardless of whether his or her vital signs are abnormal.

58. The court heard evidence about this from Mr Ross Penman, who is the SAN's Director of Medical and Surgical Nursing. He told the court that Mr Kimpton's case demonstrated the importance of reinforcing the need for repeat observations in circumstances such as his. He intended to incorporate Mr Kimpton's case into the hospital's DETECT training program, which is mandatory for employed nursing staff and which includes modules for recognising and responding to deteriorating patients.

59. In my view this is the appropriate response to the failure in Mr Kimpton's case to conduct more frequent observations after he showed signs of deteriorating from dinner time onwards. It cannot be said that had repeat observations been performed this would have altered the tragic outcome; for this reason I do not make the nursing staff involved the subject of any adverse comment.

Changes made at the SAN

60. Through Mr Sergi the SAN offered sincere condolences to Mr Kimpton's family for their loss. At the close of his evidence Mr Penman also offered sincere sympathy on behalf of the hospital.

61. Mr Penman attended each day of the inquest to hear the evidence of the clinicians and experts, and to obtain a better understanding of what changes might be needed at the hospital. He told the court the SAN had conducted its own inquiry into the circumstances of Mr Kimpton's death, and he gave

evidence of changes which have recently been made. In addition to the DETECT training change he intended to recommend, referred to in par 58 above, he told the court of the following:

- SAN nurses now have an enhanced opportunity to recognise that a patient's condition is deteriorating. The SAN uses an electronic medical record known as 'Sancare'. When a nurse makes an entry in its Vital Signs ePage there now appears on the same page a compressed view of the patient's observations for the previous six days. These can be viewed simultaneously with the patient's current observations. In this way staff are able to recognise if a patient's signs are trending towards abnormality and that a medical review may be needed even if the current observations remain 'between the flags'.

- The SAN has very recently established a new Acute Pain Service, a service recommended by Dr Obeid for patients like Mr Kimpton who have prolonged use of PCA opiates. The SAN's Acute Pain Service is staffed by anaesthetists and Clinical Nurse Specialists, and its aim is to provide expert pain management advice to the Admitting Medical Officer and staff responsible for a patient's care. The Service has commenced only very recently, and is still in the process of developing criteria and guidelines for referral and promoting the benefits of the Service to its AMOs and CMOs. Mr Penman's impression was that a large proportion of those already referred were, like Mr Kimpton, on PCA.

62. In addition Mr Penman intended to present the findings and reasons made in this inquest to the SAN's Clinical Governance Committee and to its Education Manager. The changes and proposals outlined by Mr Penman are welcome. They demonstrate an understanding by those who manage the hospital that ongoing review of clinical systems is always needed to ensure patient safety.

Conclusion

I hope this inquest has answered some of the questions of Mr Kimpton's family about how they came to lose him. I hope too that the Kimpton family will accept the sincere sympathy of all of us here at the Coroner's Court.

I thank all who have assisted in this inquest, including the Officer in Charge of the investigation and the legal representatives – in particular Counsel Assisting Dr Kathy Sant and instructing solicitor Ms Christina White.

Findings required by s81(1)

As a result of considering all of the documentary evidence and the oral evidence heard at the inquest, I am able to confirm that the death occurred and make the following findings in relation to it.

The identity of the deceased
The person who died is George Kimpton.

Date of death:
George Kimpton died on 5 June 2016**.**

Place of death:
George Kimpton died at the Adventist Hospital, Wahroonga NSW.

Cause of death:
George Kimpton died as a result of vaso dilatory shock and multi organ failure secondary to aspiration and cardiorespiratory arrest. Significant contributing conditions were subacute pneumonia and ischaemic heart disease.

Manner of death:
George Kimpton died in hospital after he developed complications following colorectal surgery.

I close this inquest.

E Ryan
Deputy State Coroner

8 October 2019