Submission No 717

INQUIRY INTO HEALTH OUTCOMES AND ACCESS TO HEALTH AND HOSPITAL SERVICES IN RURAL, REGIONAL AND REMOTE NEW SOUTH WALES

Name: Caroline Coulston

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COMPLAINT ABOUT DOCTORS AND STAFF PORT MACQUARIE BASE HOSPITAL ON BEHALF OF ANTHONY GLEN ("TONY") COULSTON DECEASED

Friday 22nd January 2021

6.40 pm Call made to 000 for Ambulance by Christina.

Ambulance attended, Dad was in bad health due to stage 4 cancer and recent immunotherapy treatment for it. He was having trouble breathing and wanted help. He was sedated due to taking Ordine plus a new medication MS Contin that palliative care were trialling. Christina was told by the ambulance staff to wait an hour before coming to the hospital.

7.40 pm Christina arrived at Port Macquarie Base hospital and Dad was slumped in a wheelchair in the emergency waiting room. She waited with him and asked a number of times how long it would be until he could get a bed.

10.11 pm Christina's 3rd approach to the Emergency staff window to request that Dad be able to rest somewhere. Christina could see a vacant bed behind the glass and was informed that it was for 'emergencies'. She debated leaving the hospital and taking Dad home again. If only she had done this, Dad would not have ended up brain damaged and dead but this is hindsight and we feel very guilty that we entrusted our sick, weak father to the Port Macquarie Base Hospital.

11 pm Dad is finally admitted and reviewed by Dr A. Dad was very weak and sick, coughing up large volumes of bright red blood.

Dr A and the nursing team gave Dad Ordine to treat his pain, and then commenced questioning Dad. After no rest sitting in the emergency room with no water, food and then being given Ordine Dad was exhausted and drugged and struggled to answer. Dr A commented that 'he seemed confused'. Christina said he was affected by the medication and exhausted. She asked that they obtain further information about his 'end of life plan' in the morning after he had rested.

Christina helped Dad into his PJs so he would be comfortable and warm. We are incredulous. This is just dumb. Is this kind of treatment reserved for the elderly to ensure they feel they aren't worth treating?

Dad's blood pressure was very high when he was admitted to hospital. Blood pressure medication was commenced and by Saturday it had normalised. We know that pain or stress on the body can increase blood pressure.

We have texts between us with Dad, proving that Dad had his full faculties prior to attending the Port Macquarie Base Hospital. Any suggestion otherwise is staff and hospital trying to cover up their own cruelty, lack of timely care and ineptitude.

Saturday 23rd January 2021

10.04 am Christina visited the Hospital and helped Dad eat some food.

Dr B VMO visited as did staff to take blood. Staff taking blood left Dad precariously positioned on the bed with both arms fully wrapped in pillow cases and heat packs without support.

Dr B VMO attending suggested to Christina to hold onto Dad so he didn't slip off the bed. Also, Dad's brother had to grab Dad's legs when the staff moved him back onto the bed so he didn't fall out the other side of the bed. The staff were consistently very bad at moving Dad around in bed.

Palliative care were trialling Dad on MS Contin once per day small dose. He tolerated this but they added an extra dose the day prior to Dad being admitted to hospital. We believe that this drug caused large hives on Dad and we have photographs of this. Christina asked Dr B to reduce the dose of MS Contin.

6.00 pm Christina visited Dad and helped him eat some food.

Christina asked Dad if he felt like he was improving since he had been admitted to hospital and he said no. She also asked him if he wanted to come home or to go to palliative care. He said he wanted to go to palliative care.

Christina called Caroline and Arthur (sister and brother-in-law) to advise Dad was weak and they should come asap.

Sunday 24th January 2021

Caroline and Arthur arrived and the family visited Dad in hospital in the late afternoon. He was drowsy due to medication but glad to see us.

Monday 25th January 2021

8.15 am Phone call from the hospital to say Dad has had a bad fall and is "a bit confused". Staff lied to us regarding brain damage. We went to the hospital immediately.

8.30 am We arrived at the Port Macquarie Base Hospital. Dad in room 4. Sitting upright in a chair highly agitated squirming dazed reaching for water but not able to drink and although several staff members were in the room none helped him drink or attended to his injuries which we realised later in the day. He didn't acknowledge us and at this stage we didn't realise that Dad would never be able to speak to us again. The staff, hovering around, doing little to aid him. Dad is bruised. No advice to us that Dad had likely had a stroke. Concerned re brain bleed or was concussed and suggested CT scan. We left so they could attend to Dad and get the scan done.

9 am We saw a nurse who said she was going to give Dad a small dose of morphine and we warned that he's allergic to sulfur based medicines and morphine. When we returned at 12pm we found he'd had a small dose of morphine. Obviously without anti-nausea medication based on the volume of vomiting we saw later.

11.14 am Call from the Hospital. Still no CT when we returned after receiving a phone call advising of a suspected brain bleed. No scan yet or ever. We reinforced the need for the scan and pain relief.

12.15 pm approx we (Christina, Caroline, Arthur, Richard) arrived at the Port Macquarie Base Hospital. Dad had been moved to ward 1c room 12. This is the high vis ward. He was

covered in a sheet, kicking it/forcing it off him. Agitated and grabbing at the rails and our arms. Highly agitated. Wearing paper disposable pants and a hospital gown.

We spent a long time standing around, trying to calm Dad. Hoping someone would give him pain relief medication to ease his distress. We waited for Dr C who let us know sedation can have a bad impact on survival. At that stage we still trusted the doctors and went along with the plan for no sedation and us accompanying Dad to the scan to keep him calm. Security arrived and wheeled his bed out to the corridor. They were headed for the "big lift" when Dad started massively vomiting large volumes of brown bloody looking liquid before he even got out of the ward. It spouted, flooded. We were extremely distressed by this and will never forget it. Dad must have been feeling so nauseated and suffering, on top of sickness from immunotherapy treatment for cancer recently, and intense pain from the fall, along with the head and facial injuries. He was returned to the room where he continued to vomit multiple times and the nurses tried to control it and clean him up. This upset Christina greatly so she stood in the hall while Caroline talked to the nurse who also mentioned this was a terrible situation and she would call the Dr to come back as soon as possible. Caroline left the room to talk to Christina and when we returned a visiting palliative care nurse called D was there soothing Dad using both her arms to try and control his writhing. We talked to her and she said we could speak with Dr E. We joined both of them in a room on the other side of the ward.

Prior to seeing Dr E from Palliative care a nurse handed us a brochure called REACH and suggested we call a number in it to escalate Dad's case as the 'Dr team' was not prioritising a visit to advise on treatment for Dad. We were advised that the nursing staff could not do anything until the doctor team came to review the case.

Sitting with the palliative care team we talked about Dad and his terrible situation since being admitted to the Port Macquarie Base Hospital. We were told that Dr F would not be able to see Dad until 5pm. We said that was too long and we needed a Dr to help Dad immediately. Dr E said he would escalate it for us and called the number in the brochure immediately. He used the word "horrific" to describe Dad's situation.

At that time G introduced herself as did H. Both of these people are from that nursing unit.

On returning to wait for Dr F to see Dad, Dad was lying uncovered in the high vis ward writhing around in disposable paper pants. Uncovered, no privacy or dignity. People walked past and looked in while we were standing there. Not to mention the other patients in that room.

We waited with Dad assuming that with the escalation that the Dr team would respond promptly within half an hour as per the escalation process. We waited until 4.45pm for the doctor to arrive.

4.45 pm Dr F told us that he saw Dad in the morning and he was calm. Having seen Dad in the morning at 8.30am and his state of agitation we seriously doubt this.

The doctor initially tried to introduce the narrative that Dad had been admitted in a state of mental decline. Christina corrected this as the last conversation we had with Dad was whether she had brought additional clothes to the hospital for him. Dad had come to the hospital because of breathing issues and had no issue with his cognition.

Dr F also stated that Dad was calm in the morning when he saw him at 8.30am or thereabouts. We arrived just after 8.30am and Dad was very agitated and confused. Dr F

used medical jargon/language which suggested to us that we not medicate him as he wanted to see what happened with the brain bleed.

We stated we want Dad to be at peace and pain free with no nausea. We asked couldn't he have an injection for his nausea? Dr F agreed and made suggestions. We asked if the nursing staff would have authority to continue to medicate Dad in the night so he would be pain free. The nurse standing with us held up crossed fingers and said she hoped so. It was decided that Dad would have the syringe driver which would contain anti-nausea, and a sedative to stop agitation as well as pain relief. At no time did Dr F address Dad's broken nose, massive head wound, black eyes and broken teeth. We still don't know if Dad had broken limbs as a result of the fall. Was he examined by anyone? Dad also had large hives on his back as a reaction to the morphine which all staff refused to acknowledge or address **though patient safety have since told us that Dad had been given an antihistamine**. Christina applied calamine lotion on them for Dad and took photographs. Staff guaranteed us Dad would not be in pain or agitated once he had the driver but when we returned to the hospital at 6.30pm he had been moved to room 9 to die and was still writhing in his bed. We had to ask the nurse to give him medication although on our arrival she happily told us that Dad was calm and settled.

6.30pm We heard for the first time that Dad had likely had a stroke due to the weakness on one side of his body.

We stayed with Dad the whole night and stayed awake to ensure that if he needed assistance we could get the nurse. The nurse came in once after Dad started writhing again. And again later without us needing to ask.

7.15pm Nurses attended to Dad and administered by syringe Glycopyrrolate to help clear mucus from his lungs as he was gurgling. They commented that they were surprised this had not been added to the syringe driver and required an additional injection to administer it.

8pm Dad was turned on his left side

10.30pm A nurse checked on the Glycopyrrolate

10.43pm A nurse administered more of the Glycopyrrolate

Tuesday 26th January 2021

We attended at 10am to complain about Dad's treatment. The person we asked for G was on holiday. We talked to the acting head of the unit. We suggested it be in private as we had a complaint. She initially told us we could complain to her or wait until the next day when G would be back. We said we wanted to do both. She said twice to put all this in writing. She said she would make a report but took no notes during the meeting. She listened to us but really gave us superficial and neutral feedback.

We requested a copy of Dad's hospital notes twice and were told we would have to request these from G. We had the chance to actually see some of these entries and know that staff thought Dad had had a stroke but we were not informed. They mentioned strength in both hands/arms differed suggesting a stroke. We'd assumed that staff hadn't raised the sides of Dad's bed and he was sedated and stood up, fell over and hit his head very hard breaking his nose, teeth, giving him two black eyes and a head wound. We will never forget seeing Dad sitting there wobbling disoriented unable to talk with many staff milling around doing stuff all to help him or treat him. This went on all day with three nurses voicing their unhappiness to us and trying to get the doctor to attend to Dad.

We asked Arthur to attend and sit with Dad from 6am on 26th January so we could have some sleep. Dad's brother Richard also attended and stayed with Dad. Collectively we have no faith in Port Macquarie Base Hospital to have cared for Dad properly and humanely if we are not there to request and oversee it.

Arthur let us know at 2.45pm on 26/1 that Dr F and Dr I had visited Dad. Dr F allocated 5 minutes max and Dr I much less. Also many nurses were giving Dad attention including shave, bath, teeth.

We believe this level of care has only taken place due to our complaint and advising the person we saw in the morning acting head of unit that we had documented all conversations and taken photos and video of Dad's condition.

Evening of 26th January 2021

On the night prior to the morning Dad died 26th January, a nurse we hadn't seen before walked into room 9 and announced 'oh you've got a bump on the head'. Again, the minimising narrative used by hospital staff to reduce this incident rather than own up to the horrendous head trauma and brain Injury, a result of their negligence. Caroline immediately said, no, this is brain damage and wouldn't have happened if the hospital had done their job. Christina asked her to stop this minimising narrative and told her we wouldn't listen to it again. This person continued to try and absolve the staff and hospital of any blame by saying the person on duty was very upset and they couldn't put the rails up because there would have been a risk that he would have tried to climb out. We know this can't be true as Dad was very weak due to cancer treatment and medication including Ordine and MS Contin. This uninvited interaction was distressing and offensive to us as we expected this was the night Dad would die. We are angry that Dad was not cared for properly, Hospital staff used this excuse to explain away their negligence for not raising the rails on Dad's bed, meaning he got out of bed and fell over and had brain damage and died as a result.

Wednesday 27th January 2021

2.20 am Dad died.

At the time of arranging Dad's funeral we were asked if we wanted an open coffin. This devastated us as Dad looks like he was hit by a truck thanks to the staff and doctors at the Port Macquarie Base Hospital. None of these injuries seem to have been treated. Dad has a broken nose, two black eyes, a massive head wound and broken teeth. We are overwhelmed with anger and sadness at Dad's final days at the hands of Port Macquarie Base Hospital. We were advised by the funeral home that it would be impossible for them to cover these injuries with make-up so we are unable to have an open coffin meaning that our family cannot see Dad one final time and they would be shocked and haunted by his appearance if we allowed it.

Over many years Dad endured a lot of treatment and treatment side-effects to try and stay alive. We realise he wasn't going to be around for much longer but the doctors and staff at Port Macquarie Base Hospital wiped him out in two days leaving him blind due to bruised swollen eyes, brain damaged, unable to speak and seemingly in great pain. We feel like we have ptsd just dealing with all the things that the Port Macquarie Base Hospital did to Dad and the events that we witnessed will permanently be with us. They have overshadowed Dad's final days and our thoughts of him when making his funeral arrangements.

At 12.10pm we received a call from Dr I at the Port Macquarie Base Hospital saying that Dad's death certificate would list the cause of death as "fall head strike bleed into the brain" and that there would be no need for an autopsy.

We have photos and video of our father's condition while at the Port Macquarie Base Hospital. Its staff, especially doctors should be ashamed of their cruelty, lack of medical care and intervention for a vulnerable patient in need, and suffering immensely. Their inaction sent us a clear message that they thought he was old and cognitively disabled, not a priority and not worth their time.

We want a copy of the hospital notes. We hope there is an edit log in them as we do not trust the Port Macquarie Base Hospital and its staff to be honest about what went on over the two days they took to maim and kill our father. After Dad's fall it was inhumane to withhold treatment and that seems to be exactly what happened. They ensured he had maximum pain and suffering over that day waiting for Dr F to come and see him. He granted us just five minutes at 4.45pm and attempted to maintain the do nothing course of action/inaction.

Christina Coulston

Caroline Coulston

Dated: 28th January 2021

We have since received a report (after a six month plus wait) from NSW Health patient safety regarding Dad's death and had a teams meeting with the hospital reps. They were very apologetic, but we are concerned that the report sees their errors as "missed opportunities" and that because there was a "do not resuscitate" plan in place they saw that as justification for ignoring Dad and letting him suffer terribly from injuries sustained while in their care. They did not adhere to their policies or keep accurate records but seem to claim that this had no impact on any outcome. It's like they didn't refer to our complaint or the interview we had with them at all when doing the report.

Photos attached represent

(1) my sister Christina and me with Dad in November 2020 to prove his nose wasn't broken before he attended hospital - patient safety asked us if it was,

(2) Dad who normally doesn't use a wheelchair slumped in one for hours at the ED,

(3) Dad with black eye, broken nose and teeth

(4 and 5) Dad with two black eyes, broken nose and teeth and

(6) broken and bloodied teeth.

The hospital reps confirmed on Wednesday 8th December that the dr team in charge that day has not been reprimanded or disciplined after all that has happened. They said they've got new systems in place so it can't happen again, but the patient safety report reveals they don't comply with systems anyway so what is the point.