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Newcastle Private Hospital - Found to be negligent for failing to adhere to post-operative clinical pathway –

Stefanyszyn v Brown; Brown v Newcastle Private Hospital Pty Ltd [2016] NSWSC 826

Key Points

- A hospital's duty of care to a patient is independent of the duty a visiting medical officer (VMO) owes to a patient, and so attendances by the VMO does not discharge the hospital's duty of care.
- Nurses need to ensure that all necessary observations are properly recorded to ensure that medical intervention occurs whenever necessary.
- Nurses are also required to act upon "red flags" in a patient's clinical course, which includes call on the hospital's medical emergency team (MET).
- Any post-operative clinical pathway must be adhered to, and a new pathway created if the original pathway expires.
- If a party does not call its own witnesses to give evidence as to the events giving rise to a claim, then the Court will infer that those witnesses' evidence would have been unhelpful to that party's case.
- Liability was apportioned between the VMO and the hospital on an 80/20 basis in favour of the hospital.

Background

Mrs Colleen Stefanyszyn underwent an elective vaginal hysterectomy on 1 December 2008. The surgery was performed by Dr Brown as a VMO at the Newcastle Private Hospital.

During the operation, a loop of suture material was inadvertently looped around Mrs Stefanyszyn's bowel.

By 3 December, Mrs Stefanyszyn was vomiting faecal matter. Dr Brown diagnosed a post-operative ileus.

By 5 December, Mrs Stefanyszyn continued to vomit faecal matter. Dr Brown prescribed intravenous fluids and nil by mouth.

According to the clinical pathway of Mrs Stefanyszyn, she should have been discharged on 5 December. Despite this significant negative variance in Mrs Stefanyszyn's anticipated

clinical course, no further clinical pathway was implemented as the original clinical pathway required.

No investigations were ordered by Dr Brown, who by that time had apparently become fixated on the diagnosis of post-operative ileus.

By 9.20 pm on 5 December, Mrs Stefanyszyn's oxygen saturation levels were abnormally low at 92%, and she was markedly depleted of fluids and electrolytes.

At 4.00 am on 6 December, Mrs Stefanyszyn had another large vomit. At 5.00 am, she again vomited with significant aspiration of vomit which resulted in her death.

Proceedings

Mrs Stefanyszyn's husband and two daughters sued Dr Brown. Dr Brown admitted liability and those claims were settled. Dr Brown then cross claimed against the hospital claiming contribution from the hospital for on the basis it was negligent to the extent of one third.
The hospital denied liability on a number of grounds:

- It relied on an "Ellis disclaimer" i.e. that Dr Brown was not an employee of the hospital, and that Mrs Stefanyszyn could not pursue the hospital for any negligence on Dr Brown's part.

- Dr Brown was actively involved in Mrs Stefanyszyn's care, and so the hospital's "burden of responsibility" passed to Dr Brown.

- Although there was a failure to properly take and record observations in Mrs Stefanyszyn's chart, those failures were not causative of Mrs Stefanyszyn's death.

Justice Schmidt dealt with the first two issues swiftly by pointing out that the hospital owed Mrs Stefanyszyn a non-delegable duty i.e. it was always required to exercise due care and skill for the safety of Mrs Stefanyszyn, with that obligation of being independent of the duties Dr Brown owed to Mrs Stefanyszyn.

In relation to the hospital's argument that the failures of the nursing staff to follow the clinical pathway and to properly record observations of Mrs Stefanyszyn's condition, the Court rejected that argument because:

- Nursing staff are not only required to properly take and record post-operative observations, but they are required to report concerns about a patient's health.

- The vomiting at 4.00 am on 5 December was a red flag which should have resulted in the medical emergency team being called.

- If the MET had been called at that time, the majority of experts agreed that Mrs Stefanyszyn would not have died.

In reaching these conclusions, Justice Schmidt found that the hospital's failure to call its own staff to give evidence, as well as the failure to provide a policies manual that Dr Brown had subpoenaed, gave rise to the inference that the evidence of the hospital's witnesses and the policies manual would have been unhelpful to the hospital's case.

Conclusion

Justice Schmidt ultimately awarded contribution of 20% from the hospital.

Justice Schmidt rejected the hospital's argument that its contribution should be as low as 5% given the hospital's failures to call evidence from its own witnesses and to produce its own manual.

The assessment of 20% reflected the departure both by Dr Brown and the hospital, from the duty of care they each independently owed Mrs Stefanyszyn, particularly at the crucial times on 5 and 6 December.

Justice Schmidt indicated that costs would be awarded in favour of Dr Brown.

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