

It should never have happened

By Dr David Carter*
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The tragic death of 13-year-old Louis Tate at Frankston Hospital in Victoria made headlines across the country. Tate, who had a well-managed but severe allergy to cow's milk, nuts and eggs, died at Frankston Hospital following a severe anaphylactic reaction caused by food served to him by the hospital. Tate required intubation, and died from a rare complication of anaesthesia, malignant hyperthermia. The findings of a coronial inquest into his death were recently handed down. The inquest raised a range of issues, especially bringing attention to the need

for all hospital services and activities — not only the obviously ‘clinical’ ones — to be an active part of the patient safety agenda, and the need for hospital and health services staff to follow proper procedures for securing evidence for internal investigation and potential coronial cases.

The history

Louis Tate was admitted to Frankston Hospital late one evening for observation and oxygen therapy following an exacerbation of his asthma. Admitted to the paediatric ward, Louis’ mother advised nursing staff of his food allergies and what he was able to eat for breakfast, all of which was documented in Tate’s medical record.

Discharge was arranged the following morning, after approximately eight hours in the hospital, with Louis’ asthma having resolved.

Breakfast was prepared for Louis in the paediatric ward kitchen by a personal care assistant. The Registered Nurse who had admitted Louis gave evidence at the inquest that she advised her colleague that Louis could be served Weet-Bix with soy milk. This conformed with the advice provided by Louis’ mother and Louis’ own meal request given to the personal care assistant. However, nothing about Louis’ allergies was recorded on a whiteboard in the paediatric ward kitchen that was used for this purpose, nor was anything recorded at the bedside to indicate or warn hospital staff of Louis’ allergies.

Minutes after his breakfast was served, Louis walked to the nurses’ station and reported that he was experiencing a ‘tingling’ on his lips. Approximately two-and-a-half hours later, he died.

What went wrong?

After Louis told the nurses about the tingling, he was actively treated for his anaphylactic reaction, necessitating multiple MET calls, summoning of the paediatric retrieval team and eventual intubation. Louis had, however, eventually suffered malignant hyperthermia, a rare reaction to anaesthetic agents used to facilitate his intubation. Following cardiac arrest, he was declared deceased in spite of further, lengthy resuscitation measures.

Following an inquest into his death, Coroner Phillip Byrne concluded that Louis experienced an allergic reaction “virtually immediately after the first mouthful of breakfast”. The Coroner was “comfortably satisfied” that Louis suffered an anaphylactic reaction to the breakfast provided, and whilst all of the medical management of his deterioration was timely and appropriate, Louis suffered a reaction to an anaesthetic agent which resulted in malignant hyperthermia “which could not reasonably have been foreseen”.

Coroner Byrne concluded that the inquest into the death of Louis Tate was “one of the saddest cases I have dealt with over the decades” observing that there was a “cruel irony” attached to the events that led to his death. However, Coroner Byrne made a series of observations that hospitals and health services managers must take note of in light of the death of Louis Tate.



Louis Tate. Image credit: ©Supplied

Findings of the coronial inquest: crucial evidence destroyed?

An initial autopsy report into the death concluded that Louis' death had been asthma related, and not due to an anaphylactic reaction to elements found in the breakfast served to Louis Tate by the hospital. Coroner Byrne noted that "Louis' parents were in furious disagreement" with these initial findings, and this was the cause of engaging in an inquest. Given this conflict, and the importance of the allergy question, it was important to establish precisely what the allergen in the breakfast was.

Coroner Byrne, however, was frustrated in his attempts to establish what the allergen was. The hospital had failed to isolate the food that Louis had been given for the purpose of testing. A carton of milk had been delivered for testing; however, the Coroner was unable to satisfactorily confirm whether this carton of milk delivered for analysis by the hospital was in fact 'the' carton of milk from which Tate's portion had been served. In his findings, Coroner Byrne wrote:

Even without knowledge that Louis would ultimately die, the fact that very shortly after commencing breakfast he suffered symptoms indicative of an allergic reaction...dictated that the foodstuff that may have contained the allergen should

have been retrieved and secured, if for no other reason than for the purpose of internal investigation.

As should be well known, in general, nothing should be done to a body after death if it may become a coroner's case. This includes items of equipment, implanted or otherwise. In the case of Louis Tate, this should have included the entire chain of food and food supply equipment — the actual food served to Louis, the food tray and implements, alongside food supplies located in the paediatric ward kitchen.

Findings of the coronial inquest: the food service regime

The hospital conceded to the coronial inquest that there was no written policy regarding food handling for patients with an allergy on the paediatric ward at the time of Louis Tate's admission. What did exist was an ad hoc process that relied on oral communication between the personal care assistant and nursing staff as to what food a patient could be given. However, the hospital did not concede during the inquest that Louis was given food or drink to which he was known to be allergic.

The coroner referred to these deficiencies in policy and procedure as 'systemic', and the hospital has since revised and strengthened its procedures and training related to food preparation and allergies. It is clear that policies, procedures and training were in place in the larger, centralised food services area. However, these had not been translated and adapted for the myriad of other situations in which food is served by hospital staff.

Dr Deborah Debono, a healthcare quality and safety researcher at UTS, calls this type of misalignment "a disparity between work-as-imagined versus work-as-[actually]-done". A more clear-eyed view of work at the clinical coalface is required, so that those managers and others who are distant from it do not promote policy and procedure that imagines or simply misses situations and practices where work and care is delivered.

The involvement of food service work in the events leading to Louis Tate's death highlights how all hospital services, activities and staff — not only the obviously 'clinical' ones — need to be an active part of the patient safety agenda in a manner attentive to the actual practices and work of health care, rather than those imagined — or forgotten — to be taking place.

Key points:

- The death of Louis Tate reinforces the need for continued improvement of the quality and safety of our health services.
- All hospital services, activities and staff — not only the obviously 'clinical' ones — need to be an active part of the patient safety agenda.
- Hospitals and health services should review their policy, procedure and training for food services activities and allergies — including where food is served outside of centralised food service areas.
- Policies and procedures that guide staff to prepare for potential internal investigation or coronial cases should be revised to include reference to non-medical equipment and materials where appropriate.

Reference:

Inquest into the Death of Louis Oliver Tate (2018) Coroners Court of Victoria COR 2015 5382 (26 February 2018) (Coroner Mr Phillip Byrne) <http://www.coronerscourt.vic.gov.au/home/coroners+written+findings/findings+-+538215+louis+oliver+tate>



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