

CASE STUDY – Inquest into the death of Nola Jean WALKER

THE PROBLEM

Nola Jean Walker (NJW) was involved in a motor vehicle accident (MVA). Paramedics found no significant injuries but recommended she be taken to hospital. NJW refused, and paramedics decided that her refusal was valid. The problem centres on whether this decision was correct, i.e. whether NJW was competent and autonomous, and therefore able to refuse treatment.

The case gives rise to the questions of whether the paramedics' examination of NJW was adequate and competent so that their duty of care was met; whether the exchange of information between paramedics and police was adequate bearing in mind privacy considerations; whether the police adequately monitored her need for medical care; and whether the police were negligent in failing to commence CPR.

THE FACTS

≈8.00am NJW was involved in a MVA. The previous night she was observed drinking at least 3-4 glasses of wine between 7:00pm and 1:00am.

Paramedics attended NJW while still seated in her vehicle. She was lucid, orientated and answered questions appropriately. Vital signs were twice recorded normal. A paramedic noticed an abrasion consistent with seatbelt injury but NJW denied pain to palpation. She advised paramedics she had undergone heart surgery. She later told police that she had taken Valium the night before and she suffered a liver problem. Paramedics did not notice signs of intoxication.

Paramedics recommended transportation to hospital for further examination but she adamantly refused. NJW agreed to paramedics transporting her home and her dog was placed in the ambulance. Police arrived and advised paramedics that they would transport NJW home.

At 8.35am a police breath test revealed 0.198% BAC. Police assisted NJW from her car. She could walk slowly unassisted. It appears paramedics did not observe her walking. Over the next ≈40 minutes police observed that her condition deteriorated. When she arrived at the police station she needed two officers to support her. Later she was responsive to questions and gave appropriate answers but then "slumped over." Police thought she was being obstructionist.

It is unlikely that the effect of alcohol would become more pronounced seven hours after drinking. I do not believe NJW's deterioration was caused by intoxication.

Police attempted to wake NJW at 10:40am but she was unconscious. They called an ambulance at 10:42am. Resuscitation was commenced at 10:52am when paramedics arrived, with 12 minutes elapsing between NJW being discovered unconscious and CPR commencing. Resuscitation continued for 15 minutes but she had died.

Autopsy showed NJW had BAC of 0.19% and cirrhosis of the liver, commonly caused by long term alcohol abuse. The fact that she did not appear intoxicated when assessed by paramedics suggests a

high alcohol tolerance and possibly alcoholism. This may have affected her decision to refuse transport to hospital.

Autopsy showed presence of diazepam – combined with alcohol she would have been moderately anesthetised, explaining why she made no complaint of pain. In my opinion she was likely to have been suffering class 1 shock, which may also mask pain.

The cause of death was determined to be “blood loss due to the tearing of the spleen and fractured ribs.”

ETHICAL PRINCIPLES

Autonomy

I agree with the Coroner that paramedics had no authority to compel NJW to accompany them to hospital. Paramedics assessed her capacity to understand the nature of her condition and advice given to her. Her lucidity and ability to answer questions appropriately showed she was competent and autonomous. It was reasonable for paramedics to decide that she was entitled to make an informed decision to refuse treatment.

However I feel the paramedics gave unnecessary credit for her ability to remember names of drugs (to be expected from a nurse). The paramedics admitted that if they had been told NJW was very drunk it is unlikely they would have acted differently. Intoxication itself does not negate autonomy. Similarly, a diagnosis of shock does not negate autonomy.

Beneficence

The paramedics did beneficence by offering NJW transport home (which would have enabled continued observation) when she refused further treatment.

When police discovered NJW unconscious they believed she was dead but did not commence CPR. I agree with the Coroner’s finding that police had an ethical responsibility to do beneficence by commencing resuscitation. This obligation is reinforced in the OPM.

Non-maleficence

The police did non-maleficence when they left NJW in the police station waiting area. However they had responsibility to do beneficence because a person in police custody is unable to seek medical treatment for themselves.

Justice

Hospital resources are scarce so justice would not have been done by paramedics taking NJW to hospital against her wishes. NJW received fair and equal treatment by both police and paramedics. The coroner acknowledged that there were “*a number of examples of caring and compassionate treatment of her as one would expect...dealing with a frail and elderly [person].*” Everyone is entitled to compassionate treatment regardless of frailty or age.

Confidentiality and privacy

It was appropriate that paramedics did not make a medical handover to the police as this information is confidential. I do not agree with the coroner proposing “an informal exchange of intelligence” between police and paramedics. Information sharing without the patient’s consent is illegal and breaches the patient’s moral right to privacy.

CONSIDER THE PROBLEM FROM ANOTHER POINT OF VIEW

When paramedics advised police they were taking NJW home, police understood they thought she was fine. I believe this demonstrates lack of insight on the part of the police, knowing from a paramedic point of view that transportation home offers further time for observation.

IDENTIFY THE ETHICAL CONFLICTS

- The Coroner recommended that “*the QPS and the QAS consider ways of ensuring that information relevant to the health and safety of patients/prisoners is passed between the services.*” This highlights the complexity of balancing different parties’ interests. Here beneficence is competing with confidentiality. The Coroner thinks it would have benefited NJW for paramedics to tell police about her medical condition, but the patient’s moral right to privacy cannot be determined on a case by case basis. All patients have this right (except for cases of “public peril” or child abuse/neglect). It is important that people trust medical professionals with confidential information. The Coroner’s recommendation is not appropriate.
- NJW’s autonomy competed with the benefit of being taken to hospital (doing beneficence). The paramedics were correct in their assessment of this ethical conflict (her autonomy outweighs the beneficence).

CONSIDER THE LAW

Negligence

The Coroner stated that the paramedics’ examination of NJW was adequate. However, I believe the paramedics’ primary survey was inadequate and therefore they were negligent in failing to suspect that NJW’s injuries were serious. If paramedics advised her about the potential for life threatening injuries, she may have accepted their advice.

Under the law of negligence “the standard of reasonable care and skill required is that of the ordinary skilled person exercising and professing to have that special skill.”¹ Therefore a paramedic would be expected to have the skill of the ordinary paramedic. Paramedic training teaches what injuries are likely depending on the mechanism of injury. The severe damage to the motor vehicle including to the driver’s seat should have indicated serious injuries. They did not recognise that NJW was probably suffering at least class 1 shock, and failed to consider masked pain. They didn’t need to know she was affected by alcohol to consider the possibility of masked pain.

I believe the police were negligent in not following basic training when they failed to recognise the danger when NJW’s condition deteriorated rapidly. The standard of care for police is similar to that

¹ *Rogers v Whitaker* (1992) 175 CLR 479 at 483.

of ordinary first aiders – their manual says “if a prisoner does not appear to be sobering up this could be a result of a head injury or other serious medical condition.” In *Cattley v St John Ambulance Brigade*,² the skills required by a member of the St John Ambulance Brigade to meet the standard of care were deemed to be the skills referred to in the relevant First Aid manual. Therefore the police manual was crucial and I believe police failed to meet the standard of care.

Police could not be found negligent for failing to commence CPR because autopsy showed CPR would have been fruitless. Damage is a necessary part of a negligence action and in this case the neglect of the police in failing to commence CPR did not cause NJW damage.

The patient’s right to refuse medical treatment is clarified under the *Medical Treatment Act 1988 (Vic)*. The Act creates an offence of medical trespass where a medical practitioner carries out or continues any procedure or treatment that a competent person refuses. As NJW was autonomous, if paramedics had continued to treat her against her wishes this would have been medical trespass as well as assault.

MAKING THE ETHICAL DECISION

NJW’s refusal to go to hospital was valid. However, the paramedics’ examination of NJW was inadequate in light of the obvious vehicle damage. They failed to meet their duty of care. If they had performed a more detailed primary survey and informed her that she may have had life threatening internal injuries she would have been more likely to consent to further treatment. Although she was informed to the best of paramedics’ knowledge at the time, she was not informed with a reasonable standard of information about her condition. The recommendation to go to hospital should have been given after a more extensive examination at the scene.

It would have been unethical for paramedics to provide confidential information to police. The police were negligent in that they did not adequately monitor NJW’s need for medical care, since they should have considered that she was not merely intoxicated but suffering a hidden injury.

² *Cattley v St John Ambulance Brigade* (Unreported, Queen’s Branch Division, Prosser J, 25 November 1988).