Inquest into death of pregnant woman from ruptured splenic artery aneurysm

THE tragic death of a young woman and her baby at 23 weeks of pregnancy on 15 April 2012 at the Women's and Children's Hospital (WCH) was a poignant reminder that whilst splenic artery aneurysm and ruptured splenic artery aneurysm are rare (statistics from the National Coronial Information System database reveal that since 2000 there have been eight deaths of pregnant women in Australia from ruptured splenic artery aneurysm, and these deaths include this one), it is a catastrophic event in pregnancy, with a maternal mortality of 75% and fetal mortality of 95%.

In his final recommendations as a result of the inquest into this young mother's death, Deputy Coroner Anthony Ernest Schapel emphasised that professional education of medical practitioners and nursing and midwifery staff should ensure that diagnostic indicators of this condition be considered in any pregnant woman presenting with a history of sudden left upper quadrant pain, with or without loss of consciousness. In addition, such patients should be the subject of continual and detailed observation. A medical practitioner at consultant level should supervise such observation. There should be consultations between consultant obstetrician and gynaecologist, emergency, surgical and radiological consultants in the diagnostic process, which should be conducted urgently and at the first available opportunity.

The WCH now has in place the SA Health Rapid Detection and Response (RDR) Chart. It is based on a chart recommended by the Australian Commission on Safety and Quality in Health Care (ACSQHC) that has been through a national pilot and human factors evaluation. Having a standard set of charts ensures a consistent approach within and across healthcare services in order to reduce error associated with variation.

The Abdominal Pain Pathway underpins the diagnostic and treatment escalation of such presentation by a pregnant woman. As recommended, senior clinicians will be engaged early in management decisions of the patients, and especially when patients present with unresolved pain requiring strong analgesics.

Finally, Deputy Coroner Schapel's independent assertion for the existing services at the WCH to be co-located to the Royal Adelaide Hospital (RAH) is a long-held view of the stakeholders within the Women's and Children's Health Network, and has long been advocated by the AMA(SA).

For a full copy of the Coroner's finding, go to www.courts.sa.gov.au > Coroners Findings > All Findings > PALTRIDGE, Mellanie Joanne