Coroner's Column

We have recently been sent reports of two findings from the Wellington Coroner and a brief summary of the relevant messages for GPs from each of these is outlined for consideration.

THE FIRST involves a 38-year-old psychiatric patient who died suddenly in hospital. The Coroner's finding was that he most likely died of a cardiac arrhythmia induced by thioridazine. The patient was taking a low dose of thioridazine but expert opinion was that the addition of fluoxetine to his regime delayed the metabolism of thioridazine, which in turn increased the chances of an arrhythmia occurring. Cardiac arrhythmia may occur with normal therapeutic doses of thioridazine. (Decision No. 11/03)

THE SECOND concerns a four-year-old boy who died of Rotavirus gastro-enteritis and dehydration about seven hours after he was assessed and sent home by a general practitioner. The Coroner commented on the inadequacy of the history, the underestimation of the degree of dehydration and failure of clear communication about management and follow-up. He stated: *'It is easy to criticise the acts and omissions of health professionals through the eyes made wise by a complete knowledge of facts and events. Doctors' bags contain no retrospectoscopes. All that can reasonably be expected of them is that they should act at all times within those parameters of clinical practice generally accepted by their peers as being appropriate in the circumstances. It goes without saying that they must act in a practical and commonsense way and, before diagnosis and treatment, should have in their possession a proper clinical history and carry out a proper clinical examination.'* He quoted from practice guidelines relative to the management of gastro-enteritis in young children and directed that his findings be sent to the Editor of the *NZFP*. (Decision No. 32/03)