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## Record of Investigation into Death (Without Inquest)

*Coroners Act 1995  
Coroners Rules 2006  
Rule 11*

I, Simon Cooper Coroner, having investigated the death of Mr P

**Find, pursuant to Section 28(1) of the Coroners Act 1995, that:**

- (a) The identity of the deceased is Mr P;
- (b) Mr P died in the circumstances set out further in this finding;
- (c) The cause of Mr P's death was a small bowel infarction due to a volvulus owing to adhesions in the small intestine;
- (d) Mr P died in October 2012 at the Royal Hobart Hospital, Liverpool Street, Hobart in Tasmania;
- (e) Mr P was born in Tasmania in 1948 and was aged 64 at the time of his death.

**Introduction:**

Mr P was born in Tasmania in 1948. His parents were GJ and AP. He was raised by his aunt, IP, and had 11 siblings.

Mr P's widow reports that he had a disrupted childhood, and as a teenager liked to play football. He was educated to high school level and gained employment aged 14.

Mrs P met Mr P in November 1971 in Tarraleah where he was working and she was living. A week after they met they commenced going out. A year later they were married. Mrs P describes him as the love of her life. Together they raised four boys; three of whom were Mr P's natural sons, and the fourth, who was eight months old when Mr and Mrs P met, was raised by Mr P as if he was his own child.

Mr P worked for the same company for 32 years.

Self-evidently Mr P was a hard-working man who carted wood on weekends; often being helped by his sons. The whole family would, at Christmas time, pack up and go fishing and camping for a week at a time.

In 1993 Mr P was electrocuted at work and suffered burns to 47% of his body. Mrs P reports that after that time he could not really work.

Mr P's medical history includes suffering from sciatica in about 1980, depression due to his not being able to work, and the removal of his appendix in 2005. He also suffered from a stomach hernia, which was repaired surgically in 2008, and had some minor heart problems.

Mrs P reports that from 2009-2010 Mr P suffered from off and on abdominal pain. He also had cancer of the sinuses which was treated, again by surgery, in about 2007.

### **Circumstances of the Death:**

At the time of Mr P's death he and Mrs P were living together in southern Tasmania, in the family home. On the morning of his death they both got up as Mrs P had two appointments in town and Mr P was intending to go to a social function with a friend. The friend picked Mr P up at 11.00am. At 11.30am Mr P rang Mrs P and asked her to pick him up saying "god I am crook". She did so and took him straight to the Department of Emergency Medicine at the Royal Hobart Hospital.

Emergency Department medical notes, obtained as part of the coronial inquiry, indicate that Mr P presented at 12.46pm on the day in question. He was then suffering from severe central abdominal pain radiating to the right lower abdomen. Mr P was complaining of nausea but had not then vomited.

The notes indicate that vital signs were recorded at 1.30pm as a temperature of 36.5°C, heart rate of 84 bpm (although an electrocardiogram around the time shows a heart rate of 106 bpm), respiratory rate of 14 bpm, blood plate pressure of 179/108mmHg, and a pain score of 8/10. In addition, cheek dustiness was noted.

Mr P was seen by an Emergency Department consultant. The records have no entry with respect to the assessment of neck veins, fluid status or heart recorded. There is a record showing the chest had coarse basal crepitations. The notes indicate that the abdomen was distended and generally tender. The diagnosis was made by the consultant of a bowel obstruction. The consultant ordered x-rays and blood tests and a surgical referral was considered.

Mr P was admitted to a ward at 7.30pm. The notes indicate that he was still indicating a pain score of 8/10 and by now he had vomited twice. The notes record that he was seen by a doctor (although regrettably, no name or designation of that doctor is recorded in those notes). The doctor apparently wrote a formal admission note. The notes have minimal information about pain. The examination (if one was conducted at all) records no vital signs, no chest examination, and no cardiac examination. There was no fluid status assessment. The abdomen is described as grossly distended with percussion tenderness and perionitic. A rectal examination showed faeces. There was no comment in the notes on chest or abdominal x-rays being conducted; though some blood test results are recorded without comment, in particular, the white blood cell count and the presence of the left shift. A high haemoglobin level is recorded but not commented upon.

Nursing notes suggest that Mr P's pain had worsened. Nurses seem to have recalled the surgical senior increasing pain relief.

The notes next record a plan which was to admit Mr P under a general surgeon, and to conduct other treatments. Once again no diagnosis is recorded, no differential diagnosis

is recorded, and there is no consideration of a number of important aspects of the case.

Specifically, there was no attempt to consider the more lethal complications of small bowel obstruction, strangulation of the bowel, perforation, and/or peritonitis. No assessment seems to have been done appropriately (or indeed at all), and if it had, and the conclusion was that Mr P had a complicated bowel obstruction, he may well have survived.

Such a diagnosis is a clinical diagnosis. It requires thought and consideration of the facts. This care was not provided to Mr P.

The Royal Hobart Hospital was afforded the opportunity to respond specifically to the findings made above. The response to that request was unsatisfactory. The consultant was also afforded an opportunity to respond to the findings as indicated above. His response, through the medico legal adviser to the Tasmanian Health Service (and not from him personally), was to advise “that he is currently [sic] not in a position to add anything further to the clinical notes as he is unable to recall any further factual matters”.

The other doctor identified as being involved in Mr P’s treatment, also responded through the medico legal adviser to the Tasmanian Health Service. By letter, dated 17 December 2015, the medico legal adviser stated that she had “been in contact with [that doctor] to discuss this matter and [had] taken the step of forwarding to her all the information relevant to the case“. Ms Dewhurst, the medico legal adviser, went on to request that, “the timeframe for delivery of any response from [that doctor] was left open until the required [sic] deadline of 24 December 2015”. Time was extended accordingly but no response, regrettably, has been received by, or on behalf of, the doctor within that timeframe or at all.

I am satisfied in the circumstances that the assessment in the Department of Emergency Medicine carried out by the consultant on Mr P did not consider the complications of a bowel obstruction. On the ward, the surgical registrar, plainly found signs of complications of small bowel obstruction, but either did not understand or act in relation to what was by then a critical situation.

The standard of care afforded to Mr P by his doctors and the Royal Hobart Hospital generally, was not of an appropriate standard. Mr P was admitted to hospital with a condition that had it been properly diagnosed and treated was eminently survivable.

#### **Comments and Recommendations:**

It should be clear from the foregoing that I am of the view that the treatment afforded to Mr P fell well short of an acceptable standard.

I conclude this matter by conveying my sincere condolences to Mr P’s family.

**Dated:** 27 June 2016 at Hobart in the State of Tasmania.

**Simon Cooper**  
**CORONER**