



# MAGISTRATES COURT *of* TASMANIA

## CORONIAL DIVISION



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## **Record of Investigation into Death (Without Inquest)**

*Coroners Act 1995  
Coroners Rules 2006  
Rule 11*

I, Rod Chandler, Coroner, having investigated the death of Betty Irene Ball

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

- a) The identity of the deceased is Betty Irene Ball;
- b) Mrs Ball was born on 13 April 1948 and was aged 67 years;
- c) Mrs Ball died on 2 February 2016 at Calvary St Luke's Hospital (Calvary) in Launceston; and
- d) The cause of Mrs Ball's death was a perforated sigmoid volvulus with peritonitis upon a background of spinocerebellar ataxia.

### **Background**

For almost 47 years Mrs Ball had been married to David John Ball. They had three children. Mr Ball was employed as a farm manager up to 2003 when he and his wife purchased a farm property at Winkleigh, which they operated together. Although symptoms had begun to present some years earlier, it was not until February 2009 that Mrs Ball was diagnosed with hereditary spinocerebellar ataxia, a disorder which occurs when the cerebellum becomes inflamed or damaged and which causes loss of co-ordination, often involving impaired use of the arms and legs, impaired gait and difficulties performing fine motor skills. Not long after the formal diagnosis Mr Ball became his wife's full-time carer. In June 2009 Mrs Ball was admitted to the Launceston General Hospital (LGH) for treatment following a fall. She was not discharged home but instead, on discharge, took up residence in an aged-care facility operated by Presbyterian Care Tasmania (the Home). This was on 24 September 2009 and she was categorised as a 'high care' resident.

By the time Mrs Ball had moved to the Home, the farm at Winkleigh had been sold and a residence purchased at Legana. The Home is also sited at Legana and it was Mr Ball's practice to visit his wife at the Home on a near daily basis. He would also take her home at weekends when he cared for her himself.

### **Circumstances Surrounding the Death**

On 27 January 2016 Mr Ball visited his wife at the Home. He had not seen her over the previous week as he had been hospitalised for hernia surgery. At this visit his wife was a

grey colour and appeared ill. Her stomach was distended. She said that she was constipated and had not had a bowel movement for over a week. Mr Ball spoke to staff at the Home and expressed concern about his wife. He was told that she had been unable to use her bowels for eleven days and that the general practitioner who attended the Home had been trying to resolve her constipation without success.

Mr Ball requested that his wife be taken to hospital and the Home staff agreed. In his affidavit for the investigation, Mr Ball stated that an ambulance was called at 11.30am but did not attend until after 5.00pm. It seems the ambulance was requested on a non-urgent basis and because of demand for its services was unable to attend earlier.

At the LGH, investigations in its Emergency Department indicated Mrs Ball had a bowel obstruction. She was taken to theatre for a colonoscopic decompression of the bowel. However, at the beginning of the procedure the bowel appeared ischaemic and the procedure was converted to an open laparotomy. With pressure release the bowel perforated resulting in widespread contamination of the abdominal cavity. The sigmoid colon was then resected and a stoma made. Mrs Ball was then taken to the Intensive Care Unit (ICU).

After initial improvement Mrs Ball's condition deteriorated and after family consultation it was decided to implement palliative care. She was then transferred to Calvary on 1 February 2016 and died the following day.

Initially Mrs Ball's death was not reported to the coroner and hence a post-mortem examination was not undertaken. A death certificate was written and states the cause of death to be a perforated sigmoid volvulus with peritonitis upon a background of spinocerebellar ataxia.

## **Investigation**

This has been informed by:

1. A Police Report of Death.
2. An affidavit from Mr Ball.
3. Ambulance Tasmania Patient Care Report.
4. A report from Dr Cas Stewart.
5. A report from Dr Muhammed Iqbal.
6. A report from solicitors, Dobson Mitchell Allport, provided on behalf of the Home.
7. A review of Mrs Ball's records at the Home, the LGH and Calvary carried out by research nurse, Ms L K Newman.
8. A report provided by Dr A J Bell, medical adviser to the coroner.

A focus of the investigation has been upon Mrs Ball's care at the Home in the days prior to her admission to the LGH, most particularly with respect to the management of her constipation. It has revealed the following:

- Dr Stewart and Dr Iqbal are medical practitioners attached to the Legana Medical Centre. That Centre has 40 to 50 patients resident at the Home, including Mrs Ball. It was Dr Stewart's practice to review each of the patients at the Home each Tuesday. Each Thursday evening Dr Iqbal would attend the Home to review any urgent cases and to attend to any residents who preferred his care to that of Dr Stewart.
- Dr Bell advises that constipation is a common complaint for older adults with a prevalence of 26% for women aged 65 years or older.
- Mrs Ball had a known history of constipation and since November 2009 her medication standing orders at the Home included medication for that condition. However, normally Mrs Ball self-managed her constipation with a teaspoon of Nulax, a fruit laxative.
- The Home maintained a bowel chart for Mrs Ball. It shows that the last occasion her bowels had been opened prior to her admission to the LGH was on 15 January 2016.
- The evidence indicates this chronology of events post 15 January:
  - On Sunday 17 January Mrs Ball was febrile and complained of feeling 'yuk.' She was given Panadol with good effect. A note was made to follow up with the general practitioner the following day if required.
  - On 18 January Mrs Ball stated that she felt a little better. Nevertheless, it was suggested that she be reviewed by a general practitioner. However, Mrs Ball declined a review by Dr Stewart and requested that she only be seen by Dr Iqbal.
  - On 21 January Mrs Ball refused an aperient. She saw Dr Iqbal who terminated her order for Trimethoprim which she had been taking for a bladder infection. It seems that at this consultation the subject of Mrs Ball's constipation was not discussed.
  - On 23 January Mrs Ball was given Nulax.
  - On 24 January Mrs Ball was given a large dose of Nulax along with 2 suppositories.
  - On 25 January Mrs Ball was administered a Shaw's cocktail, an oral laxative comprising senna, agarol and milk.
  - At around 10.30am on 26 January Dr Stewart was contacted and advised of Mrs Ball's ongoing constipation. She ordered a fleet enema and the order was sent by facsimile to the Legana pharmacy. However, as it was Australia Day the pharmacy was closed and the order could not be filled until the following day. That evening Mrs Ball was given a Microlax enema but without effect.
  - Mrs Ball remained constipated on 27 January. This was the twelfth consecutive day that she had not opened her bowels despite use of a range of aids. As has been already stated, later that day Mrs Ball was transported by ambulance to the LGH after Mr Ball had expressed concerns regarding his wife's state of health.

Information provided by the Home shows that it had in place a protocol entitled 'Continence management' which was part of its accreditation framework. The protocol sets out the governing guidelines for the assessment and oversight of residents' continence and bowel management. That management was aided by a programme known as iCare which required each resident's bowel history to be recorded each shift on an individual chart. In Mrs Ball's case, her chart confirmed that she had a history of constipation with periods of 3 to 4 days without opening her bowels to be relatively common. There were also periods of 5 to 6 days recorded but the Home acknowledges constipation extending over 8 days to be unusual. Further, the Home says that it was its practice to contact the patient's general practitioner if there had not been a bowel movement for three days. On this same issue Dr Stewart says that she would expect to be informed if a patient had not opened their bowels before one week had elapsed. In such an instance she says her usual treatment would be *"to first increase or add an aperient, or to change the timing (e.g. move the usual aperient from as required to regular on the drug chart). If the problem persists, I would usually add in a small bowel irritant (microlax enema or glycerol suppository) on an as required basis; however this usually only works if there is faecal matter in the rectum (and hence the need of an examination by a nurse). If there is an ongoing problem after this, then usually I would examine the resident myself by abdominal palpitation and auscultation, and PR examination. If the resident was well, I would also be sending them for an x-ray of abdomen, looking for constipation. If the resident was unwell, in pain, or deteriorating (as was the case with Mrs Ball), I would be sending the resident to the Emergency Department for assessment of potential bowel obstruction (of which a volvulus is one cause)."*

### **Findings, Comments and Recommendations**

In Dr Bell's opinion the cause of Mrs Ball's death as expressed on the certificate, is correct. I accept this opinion and find accordingly.

The evidence shows that it was not until 26 January that medical advice was sought concerning Mrs Ball's constipation. By this time 11 days had elapsed since she had last opened her bowels. I acknowledge that Mrs Ball had a history of constipation with previous episodes extending over 5 to 6 days followed by a return to normalcy. This may explain why the Home did not follow its own practice and seek medical advice after 3 days had passed. However, it was a further 8 days before Dr Stewart was contacted and this, in my view, was regrettable. Rather, it would have been more appropriate and consistent with the doctor's own expectations if she had been informed of Mrs Ball's constipation around 7 days after it began; that is by 22 January 2016.

It is not possible for me to positively find that Mrs Ball's death would have been prevented if Dr Stewart had received earlier notice of the ongoing constipation. Nevertheless it is, in my view, likely that Dr Stewart would have initiated her usual treatment regime which I have set out above at an earlier time. If this failed to resolve the constipation it is likely that Mrs Ball's presentation at the LGH would have occurred earlier and this in turn may have increased her prospects of survival.

I am advised by the Home that it now has in place a continence management programme known as Lee Care which has replaced iCare. It is described as a more proactive system in

that it automatically provides alerts to staff when a resident's bowels have been inactive for a number of days. The alerts appear on the home page so that they are seen by staff when they log on at the start of each shift. This appears to be a desirable development which should better equip the Home to manage its residents' continence difficulties.

I have decided not to hold a public inquest into this death because my investigation has sufficiently disclosed the identity of the deceased, the date, place, cause of death, relevant circumstances concerning how her death occurred and the particulars needed to register her death under the *Births, Deaths and Marriages Registration Act 1999*. I do not consider that the holding of a public inquest would elicit any significant information further to that disclosed by the investigation conducted by me. The circumstances of the death do not require me to make any further comment or to make any recommendations.

I convey my sincere condolences to Mrs Ball's family and loved ones.

**Dated:** 29 January 2018 at Hobart in the State of Tasmania.

**Rod Chandler**  
**Coroner**