



MAGISTRATES COURT of TASMANIA

CORONIAL DIVISION



Record of Investigation into Death (Without Inquest)

*Coroners Act 1995
Coroners Rules 2006
Rule 11*

I, Rod Chandler, Coroner, having investigated the death of Phillip John Hill

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

- a) The identity of the deceased is Phillip John Hill;
- b) Mr Hill was born in Hobart on 9 April 1935 and was aged 82 years;
- c) Mr Hill died on 23 April 2017 at the Royal Hobart Hospital (RHH) in Hobart; and
- d) The cause of Mr Hill's death was sepsis due to faecal peritonitis due to suture failure of bowel anastomosis following right hemi-colectomy due to carcinoma of the colon.

Background

Mr Hill had an extensive medical history including a myocardial infarction in 1998, polycythaemia, chronic obstructive pulmonary disease, sleep apnoea, prostate cancer and Type II diabetes.

In February 2017 Mr Hill was admitted to hospital with rectal bleeding. He was diagnosed with colonic cancer in the right colon. There was not any evidence of metastatic disease. Following cardiac assessment and lung function testing Mr Hill was reviewed by an anaesthetist. He was considered fit to undergo a laparoscopic hemicolectomy and he gave his consent for the procedure to take place.

Circumstances Surrounding the Death

Mr Hill was admitted to the Hobart Private Hospital (the Private) on 12 April 2017 and his surgery took place that day. The surgeon was Mr Srinivasa Yellapu. The surgery proceeded without incident and Mr Hill was returned to the High Dependency Unit at around 7.30pm. Mr Hill was reviewed on 13 April and his recovery was proceeding normally. The following day he was seen by Mr Yellapu who was happy with his progress. Mr Yellapu was going to be away from 14 April and he arranged for general surgeon, Mr Milan Djeric to take over Mr Hill's care.

On 15 April Mr Hill developed atrial fibrillation. He was seen by a cardiologist and treated with amiodarone. The next day he began to experience hiccupping which interfered with his sleep. His abdomen was noted to be very firm and distended. That evening he was

nauseated and vomited twice. He vomited again in the early hours of the next morning and a naso-gastric tube was inserted. 2.5 litres of fluid was drained over the next 3 hours. He was reviewed by Mr Djeric who diagnosed an ileus. That evening Mr Hill was agitated and

confused. In the morning of 18 April he became faecally incontinent and the naso-gastric tube was draining faecal fluid. Later that day Mr Hill again developed atrial fibrillation which was again treated with amiodarone. His C-reactive protein (CRP) was significantly elevated at 401 mg/L but the white cell count was normal. Mr Djeric had the naso-gastric tube removed and a light ward diet was commenced.

On 19 April Mr Hill's vital signs were stable and he was afebrile. The CRP was 310 mg/L and the neutrophil count had risen to 9.2 nL. Later that evening, nursing staff became concerned because Mr Hill was confused, had scant bowel sounds and a tight distended abdomen. Mr Djeric requested a CT scan of the abdomen which revealed a right paracolic collection containing gas consistent with a 'small contained leak.' A drain was placed under ultrasound control. The following day contents were noted to be draining from the bowel. A further CT scan of the abdomen was carried out. At this point general surgeon, Mr Stephen Wilkinson became involved. He considered that Mr Hill was septic and required an urgent laparotomy. At 4.40pm on 21 April 2017, Mr Hill was taken to theatre where Mr Wilkinson performed a laparotomy with aspiration and lavage of a faecal collection. The original wound was opened and was contaminated with faecal material. It was noted that the anastomosis had largely broken down.

Following his surgery Mr Hill was transferred from the Private to the Intensive Care Unit of the RHH. He had septic shock. Despite intensive support Mr Hill continued to deteriorate. He developed multiple organ failure and died at 2.30pm on 23 April 2017.

Post-Mortem Report

This was carried out by forensic pathologist, Dr Donald Ritchey. In his opinion the cause of Mr Hill's death was sepsis due to faecal peritonitis due to suture failure of bowel anastomosis following right hemi-colectomy due to carcinoma of the colon. I accept this opinion.

Investigation

This has been informed by:

1. A Police Report of Death.
2. RHH Death Report to Coroner.
3. An affidavit of Mr Hill's daughter, Beverley Challenger.
4. A review of Mr Hill's records at the Private and at the RHH carried out by clinical nurse, Ms L K Newman.
5. A report of Dr A J Bell as medical adviser to the coroner.

In his report Dr Bell offers these opinions:

- That Mr Hill's pre-operative assessment was comprehensive and the conclusion that the hemicolectomy could be performed safely was correct.

- That without the surgery Mr Hill's cancer was incurable.
- Anastomotic leakage is the most serious complication specific to intestinal surgery and its early diagnosis is essential.
- That there was probably a delay in the diagnosis of Mr Hill's anastomotic leak with its first symptoms presenting about 5 days post-surgery. It was around this time that Mr Djeric diagnosed an ileus.
- That Mr Hill did not demonstrate some of the typical clinical signs of sepsis. Notably there was not a typical elevation in his neutrophil or white blood cell count. Also he remained afebrile. This made diagnosis difficult.
- That polycythaemia is a condition characterised by the production of too many red blood cells in the bone marrow.
- That it's likely the anastomotic leak evolved because Mr Hill's capacity to heal from his surgery was compromised by his age and his bone marrow disorder.

Findings, Comments and Recommendations

It is evident that it was necessary for Mr Hill to undergo the hemicolectomy to treat his colon cancer and I accept that his pre-operative management was appropriate in all respects. The evidence clearly shows that Mr Hill subsequently suffered a breakdown in the anastomosis which led to leakage from his bowel and the ensuing sepsis. I accept the opinion of Dr Bell that Mr Hill's age coupled with his bone marrow disorder were factors which likely contributed to the anastomotic breakdown. I also accept the opinion of Dr Bell that Mr Hill did not demonstrate some of the typical signs of a bowel leakage with sepsis making its diagnosis difficult. I therefore do not make any criticism of the delay in diagnosis. Of course an earlier diagnosis and treatment would have increased Mr Hill's prospects of survival. However, it needs to be noted that those prospects were in all likelihood lessened by Mr Hill's compromised capacity to heal as identified by Dr Bell.

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 his death occurred and the particulars needed to register his 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 Mr Hill's family and loved ones.

Dated: 16th day of April 2019 at Hobart in the State of Tasmania.

Rod Chandler
Coroner