



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 Julianne Fulham

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

- a) The identity of the deceased is Julianne Fulham;
- b) Mrs Fulham was born in Smithton on 18 October 1958 and was aged 58 years;
- c) Mrs Fulham died on 28 November 2016 at Forest; and
- d) The cause of Mrs Fulham's death was an ischaemic small bowel due to a bowel obstruction most likely due to a combination of adhesions from previous surgery and recurrent Crohn's disease.

Background

Mrs Fulham was married to Ronald Keith Fulham. They resided at Forest and had four children, now all adults. She was employed as a process worker. Mrs Fulham's medical history included Crohn's disease (CD) diagnosed in 1992, bowel resections, a cholecystectomy and a hysterectomy.

Circumstances Surrounding the Death

Mr Fulham reports that for about two weeks from mid-November 2016 his wife had been suffering with diarrhoea and episodes of vomiting. He says that *"she stated that she had this awful taste in her mouth and that she mentioned that she may be getting another blockage."* On 22 November she attended Dr Darren Briggs at the Smithton Medical Centre (SMC). This was her first visit to a general practitioner for two years. She reported having CD and requested a referral to gastroenterologist, Dr Brent Mitchell who had treated her previously. Mrs Fulham gave a history of mild nausea with no fevers. She reported intermittent cramping and abdominal pain for a couple of months with watery diarrhoea and no blood. She also reported feeling bloated. There was no weight loss. Her vital signs were satisfactory. Dr Briggs noted club fingers. Her abdomen was distended, and soft with mild upper discomfort. Dr Briggs had a concern regarding an evolving bowel obstruction. Chest and abdominal x-rays were ordered from Regional Imaging. Full blood tests were performed. Dr Briggs has since advised that Mrs Fulham denied recent vomiting but acknowledges that this was not recorded in his notes. He says that his response may well have been different if there had been a

history of vomiting. Instead he provided a non-urgent referral for Mrs Fulham to see Dr Mitchell. The plan was for a review once the radiology and blood results were known and a follow-up appointment was made for 29 November. In the meantime, Mrs Fulham was advised to attend hospital if she deteriorated.

Mrs Fulham's white cell count was elevated as was the platelet count. The vitamin B12 level was low as were the potassium and albumin levels. The C-reactive protein was slightly elevated. The x-ray report provided by Regional Imaging states; *"Abdomen: Both hip joints appear normal. Moderate degenerative change in the symphysis pubis. Mild degenerative change in both sacro-iliac joints."* The report did not comment upon the bowel or bowel gas distribution.

Mr Fulham further reports that in the early morning of 28 November his wife complained of severe stomach pain. He took her to the Smithton District Hospital (SDH). Its records show that she presented at 6.45am with *"spasms of pain in abdomen. Bloating upper abdo, experiencing DV also. Normally has diarrhoea due to Crohn's, but pain is significantly worse in the past week. Saw GP on Tuesday (22/11/16). Vomiting today-bringing up bile, not eating much."*

Nursing staff at SDH contacted Dr Thiru Thirukkumaran, a general practitioner who was also attached to SMC and was the doctor-on-call. He advised that Mrs Fulham be given analgesia with a plan for her to be reviewed at his surgery that morning. Mrs Fulham was then administered paracetamol and discharged at 7.30am with advice to call SMC at 8.30am to obtain an appointment.

After Mrs Fulham returned home she went to bed. Her husband periodically checked on her during the course of the morning: *"she was still sick but no sicker or better than when I took her to the Hospital."* At around noon Mr Fulham left home to go to work and returned at about 7.00pm. When he went to the bedroom he found his wife on the edge of the bed with her feet on the ground. When he touched her he realised that she was deceased. Emergency Services were called and officers from Ambulance Tasmania and Tasmania Police attended. Police were satisfied that no suspicious circumstances were attached to the death.

In his affidavit Mr Fulham says: *"I have a number of complaints about the way Julianne was handled the morning of the death. Julianne should not have been allowed to leave that Hospital without seeing a doctor and given her known history 2 Panamax tablets were not going to resolve what was wrong with her. It is my opinion that had she been kept in, placed on a drip and seen by a Doctor that the issue she was suffering from would have been identified and she would still be alive today. Julianne should never have been turned away. I can't even drive past that hospital now as it just makes me so angry what happened."*

Post-Mortem Examination

This was carried out by pathologist, Dr Rosanne Devadas. In her opinion the cause of Mrs Fulham's death was an ischaemic small bowel due to a bowel obstruction most likely due to a combination of adhesions from previous surgery and recurrent CD. I accept this opinion.

Investigation

This has been informed by:

1. A Police Report of Death.
2. An affidavit from Mr Fulham.
3. A review of Mrs Fulham's medical and hospital records carried out by clinical nurse, Ms L K Newman.
4. A report from Dr Thirukkumaran.
5. A report from HWL Ebsworth Lawyers on behalf of Dr Thirukkumaran.
6. A statement from Dr Briggs dated 19.02.18.
7. A statement from Dr Briggs dated 04.12.18.
8. A statement from Dr Julian Walter.
9. An email of Regional Imaging dated 06.11 2018.
10. A report from Dr Pip Taplin of Radiology Tasmania.
11. Reports provided by Dr A J Bell as medical adviser to the coroner. In those reports Dr Bell advises:
 - a. CD is a disorder of uncertain aetiology that is characterised by full bowel wall inflammation of the gastrointestinal tract. Surgery does not cure CD. Although clinical remission is often achieved most patients eventually relapse. Clinical recurrence rates range from 20% to 37% at one year and from 34% to 86% at three years. Because of the recurrent nature of the disease close medical supervision is required.
 - b. The clinical history obtained on 22 November along with the clinical findings and pathology, notably white cell and platelet counts, along with low potassium and albumin levels clearly show that Mrs Fulham was suffering from active CD which had been present for weeks.
 - c. The absence or presence of vomiting is important. If it was not reported at the consultation on 22 November it was reasonable for Mrs Fulham to be treated in the community and for her to be provided with a specialist referral.
 - d. Nursing staff at SDH could not, on 28 November, have been expected to have understood the seriousness of Mrs Fulham's condition arising from her CD. However, it is apparent that they informed Dr Thirukkumaran of her CD history, with recent nausea, vomiting, and diarrhoea, spasms of abdominal pain and abdominal bloating. This information should have alerted Dr Thirukkumaran to the likelihood that she was suffering a small bowel obstruction until proven otherwise. It should have led him to either attend to examine Mrs Fulham himself or to ensure that she was reviewed by Dr Briggs that morning.
 - e. A medical review, if carried out in the morning of 28 November should have led to the realisation that Mrs Fulham was suffering a small bowel obstruction and that she required immediate admission to the North West Regional Hospital (NWRH) where CT scanning and a surgical review would have been required to settle on a treatment plan.
 - f. CD is a treatable condition and there is a strong likelihood that Mrs Fulham would have survived this recurrence if a prompt diagnosis had been made and hospital treatment initiated.
 - g. Mrs Fulham was suffering a serious, long-term disease. It required continuous regular review and medical management. An interval of two

years between doctor visits was not an appropriate way to manage the condition.

- h. In recent times new therapies have evolved which have greatly improved the management of CD and its symptoms.

The investigation has given rise to several aspects of the evidence which require expansion.

The first relates to Mrs Fulham's history of vomiting in the period preceding her death. In his affidavit Mr Fulham states; *"For the two weeks prior to Julianne's death she had diarrhoea and she had been vomiting bile and her condition was gradually worsening."* Mr Fulham accompanied his wife to her consultation with Dr Briggs on 22 November where he says she *"explained to (Dr Briggs) what was happening with her bowel and the pain she was in."* Notably Mr Fulham does not say whether or not Dr Briggs was told that Mrs Fulham had been vomiting. For his part, as I have stated, Dr Briggs advises that Mrs Fulham denied that she had been vomiting although this was not recorded in the notes. He further says; *"If I had received a history of ongoing vomiting, I would have been very unlikely to have proceeded with her management in the community as I did, as this would have been a likely indication of a serious sequelae namely bowel obstruction."*

The second area that I need to address relates to management of Mrs Fulham following her presentation at the SDH in the morning of 28 November. As I have already noted Mrs Fulham was discharged that morning at around 7.30am after Dr Thirukkumaran had been consulted by phone and a plan settled for Mrs Fulham to obtain an appointment at SMC to be seen by Dr Briggs sometime that day. Dr Thirukkumaran further says that it was the practice for all SMC practitioners working on any given day to attend at SDH at around 8.30am for the morning handover where the care and continuing management of all admitted patients and others who may be admitted were discussed. He says that at the handover on 28 November Dr Briggs was present and he advised him of Mrs Fulham's presentation at SDH and for the need for him to review her that morning. Further he says that at morning tea time that day he reiterated to Dr Briggs the need for Mrs Fulham to be reviewed.

However, Dr Briggs' account of events on the morning of 28 November differs from that of Dr Thirukkumaran. He says that whilst he did call at the hospital that morning and that he may have seen Dr Thirukkumaran he contends that he has no recollection of either *"receiving a formal handover or any advice needing further action by myself on that morning specifically concerning Mrs Fulham."* He further says; *"I may have been told a patient would come in to review results, but I certainly do not recall being handed patient details to ensure an appointment was made."*

Findings, Comments and Recommendations

It is apparent, and I find, that there had been a worsening of Mrs Fulham's CD when she presented at the SDH in the morning of 28 November. I accept the opinion of Dr Bell that at this time she required a medical review. Unfortunately this did not occur because:

1. Dr Thirukkumaran took the view that it was best for Mrs Fulham to be promptly reviewed by Dr Briggs as he was the practitioner who was managing her CD;
2. Mrs Fulham did not act upon the advice of SDH nursing staff and seek an appointment with Dr Briggs on 28 November; and
3. There was a breakdown in communication between Dr Thirukkumaran and Dr Briggs so that either the latter was not made aware of Mrs Fulham's presentation at the SDH or if he was that he failed to take active steps to ensure that she was immediately reviewed by him.

A medical review of Mrs Fulham in the morning of 28 November should have led to the diagnosis of a possible small bowel obstruction with Mrs Fulham's urgent transfer to the North West Regional Hospital where the diagnosis could have been confirmed and the condition surgically treated. I am unable to find that Mrs Fulham's death would have been avoided if this course had been taken but it would have provided her with the best prospect of survival.

I have referred above to the apparent breakdown in communication between Drs Thirukkumaran and Briggs. I am unable to make a finding upon which practitioner's account is correct. It leads me to make the observation that a finding upon the true situation would have been enhanced if a written entry had been made in Mrs Fulham's records of any advice provided to Dr Briggs.

The evidence shows that Mrs Fulham's visit to Dr Briggs on 22 November 2016 was her first contact with a medical practitioner for two years. I note and accept Dr Bell's opinion that CD is a condition which requires regular review, and this is particularly worthwhile given the continuing evolution of new therapies which are enhancing the better management of the disease. This case should serve as a reminder to other sufferers of CD to ensure that their condition is regularly monitored to better ensure management of the symptoms and minimising the risk of recurrence.

I have decided not to hold a public inquest into this death because my investigation has been sufficient to disclose 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 Fulham's family and loved ones.

Dated: 18th day of April 2019 at Hobart in the State of Tasmania.

Rod Chandler
Coroner