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 Ian Patrick Summerfeldt

Find that:

(a) The identity of the deceased is Ian Patrick Summerfeldt.

(b) Mr Summerfeldt was born at Brisbane in Queensland on 25 May 1966 and was aged 48 years.

(c) Mr Summerfeldt died at the North West Regional Hospital (NWRH) in Burnie on 23 October 2014;

(d) The cause of Mr Summerfeldt's death was sepsis and renal failure due to a perforated gastric ulcer.

Background

Mr Summerfeldt was single and had lived alone at Queenstown since early September 2014. He had previously lived in Launceston. He had been the partner of Ms Therese Dora Orme and they had a daughter, Millie. Although Mr Summerfeldt and Ms Orme separated in about 1991, they remained close friends and continued to live in close proximity. Mr Summerfeldt's past medical history included hepatitis C, schizo-affective disorder, chronic back pain and chronic obstructive pulmonary disease.

Circumstances Surrounding the Death

On Monday 20 October 2014, Mr Summerfeldt was visiting his daughter and grandson. After lunch he said that he felt sick and that he had worsening stomach pain. He declined her offer to call an ambulance. However, later that day he phoned his daughter and asked that an ambulance be called. He was conveyed to the West Coast District Hospital (WCDH) arriving at about 3.15pm. The hospital records show that Mr Summerfeldt indicated that his pain was located in the right upper quadrant and that he rated it as 8/10. A nurse recorded that Mr Summerfeldt's pain radiated to his right shoulder tip, that his abdomen was tender all

over, especially the upper abdomen, and he described the pain as 'continuous' rather than 'colicky'. This further entry has been made in the nursing notes:

> *"Whilst awaiting review patient left the facility "due to pain". Patient also stated staff here have 'poor bedside manner – why would I want to stay here in pain.' Following having left patient entered the staff dining room and disturbed another patient (inpatient) in the process. Author and nurse unit manager had to convince patient to get into a wheelchair and return to the A & E department so as the doctor could review. Analgesic was given and we continued to monitor patient as per doctor's instructions. Patient later left as he had 'other things to do' and stated to author he could get 'black market medications if he wanted'. Doctor informed and patient left the facility at 17.50. Impression upon discharge was ? Gallstones or ? Drug-seeking."*

Whilst in the WCDH clinical observations were made of Mr Summerfeldt on three occasions and were within normal limits. He had no signs of fever, and was given ketorolac for pain relief.

The following morning Ms Summerfeldt visited her father. She said he *"seemed a bit better"* but *"you could tell that he has (sic) still unwell."* At about 5.00pm she visited him again. This time she said; *"He was in so much pain that he couldn't get up to answer the door. I could hear him crying out in pain."* However, Mr Summerfeldt would not invite his daughter into his home and did not want her to call an ambulance.

At 10.50am on 22 October, Mr Summerfeldt re-presented at the WCDH. He was transported by ambulance having been found lying on the ground outside his home. The ambulance case report indicated that his speech was slurred and he *"had excessive jaw movement."* His skin was described as mottled. He had trouble standing and an abnormal gait. It was recorded that he appeared intoxicated although there was no smell of alcohol. At the WCDH his presentation was recorded as: *"Brought in by ambulance, found lying in path - slurred speech, complaining of pain 10/10."* He was described as pale. Clinical observations were: pulse ~128, respiration ~19, blood pressure 150/100, oxygen saturation 99% and temperature 35.6-36.3º.

Nursing notes indicate that Mr Summerfeldt was reluctant to be admitted but did agree after discussion with family members.

After admission, Nurse Practitioner Arthit Barnes took over Mr Summerfeldt's care. In the afternoon Mr Barnes requested Dr Alastair Currie to assess Mr Summerfeldt. He reports that at that time *"his abdomen was generally mildly tender but was soft with no guarding or rebound. His colon felt to be distended and Mr Summerfeldt stated that he felt constipated. Bowel sounds were present and a per rectum examination was normal. Except for a tachycardia of 125/min, his other vital observations were acceptable. He also appeared quite dehydrated at that time. A working diagnosis of constipation or gallstones was made and he was treated with IV rehydration of 3L of fluid and analgesia along with management for constipation."* Abdominal x-rays showed faecal loading of the colon and small bowel. Blood tests showed a raised urea and creatinine along with an elevated hemoglobin and a

normal white cell count. Dr Currie regarded these results as indicating a moderate level of dehydration.

During the afternoon of 22 October Mr Summerfeldt continued to complain of ongoing and worsening abdominal pain. Dr Currie was kept informed. He was visited by Ms Orme. She gives this description; *"Ian couldn't talk. He was almost unrecognisable. His forehead was all puffed up, he had a massive bruise (blood coming to the surface) on his right hand side stomach and chest."*

Dr Currie re-examined Mr Summerfeldt at 5.25pm, and was content to continue with the diagnosis of constipation with the intention to *"Re-check path in morning."* The nursing notes show that at 8.00pm Mr Summerfeldt was complaining of worsening abdominal pain which was treated with IV morphine. At 9.00pm he was found on the floor. Dr Currie was called. He states that Mr Summerfeldt was *"clearly in shock with a distending abdomen suggestive of a ruptured bowel."* He decided that at that point it was necessary for Mr Summerfeldt to be transferred to the NWRH.

Ambulance Tasmania records show that it received a call for Mr Summerfeldt's transfer at 10.40pm, and that the ambulance actually departed the WCDH at 11.40pm. En route to Burnie Mr Summerfeldt was positioned supine with his legs elevated. A notation was made that he did not have a radial pulse and only a weak brachial pulse.

The ambulance arrived at the NWRH at 1:10am on 23 October. Mr Summerfield was seen immediately. Bloods were taken and a central line inserted into his right groin. Ketamine was administered, an arterial line was inserted, an ECG was taken and he was intubated. He was promptly transferred to the operating theatre for a laparotomy. The surgeon was Mr Alsaffar. He reports; *"…. there was about 3 litres of faecal matter in the peritoneal cavity and a lot of gas. There was a 10 mm perforation in the pyloric area. The distal half of the small bowel and the right colon looked ischaemic but viable. Procedure; …all the faecal matter was suctioned out. The pyloric perforation was closed with an omental patch….."*

Mr Summerfield was transferred to the intensive care unit. At about 7:30am he was reviewed by the Intensive Care Unit registrar, and a Code Blue was called because of heart dysfunction. Mr Summerfeldt required resuscitation but could not be revived. He was declared deceased at 7:45am.

Post-Mortem Examination

This was carried out by State Forensic Pathologist, Dr Christopher Lawrence. He reports:

> *"This 48-year-old man, Ian Patrick Summerfeldt, died as a consequence of sepsis and renal failure due to a perforated gastric ulcer. Other significant contributing factors include emphysema.*
>
> *The decedent…….presented to Queenstown Hospital with a two-day history of abdominal pain. He was taken late in the evening to North-West Regional Hospital where the ulcer was oversewn however he died the next morning. Autopsy reveals an oversewn pyloric ulcer with what appears to be a dehiscence or re-perforation*

adjacent to the ulcer. Some of the pyloric wall appears necrotic and appears to have re-perforated. There is pus in the abdomen. There are changes in the kidneys consistent with acute renal failure."

Investigation

This has included:

1. Consideration of affidavits provided by Ms Orme and Ms Millie Summerfeldt.

2. Consideration of reports provided by Registered Nurses Anu Daniel and Ashley Burgess, Nurse Practitioner Arthit Barnes and Dr Currie.

3. A review of Mr Summerfeldt's records at the WCDH and the NWRH carried out by research nurse, Ms L K Newman.

4. Consideration of a report provided by Dr A J Bell as medical adviser to the coroner.

5. Meetings attended by me, Ms Newman, Dr Bell, forensic pathologist Dr Donald Ritchey, and Dr Lawrence to review the investigation.

Dr Bell expresses these opinions:

- Sudden onset severe abdominal pain, with radiation to the shoulder tip, along with generalised tenderness of the abdomen are signs of concern.

- The first diagnoses that must be considered in patients with acute abdominal pain are those that may require surgical intervention. These include bowel obstruction and peritonitis.

- There was an underestimation of the degree of Mr Summerfeldt's illness when he first presented to the WCDH.

- The history suggests that Mr Summerfeldt was suffering the effects of increasing peritonitis when attended by ambulance officers on 22 October.

- Mr Summerfeldt's presentation at the WCDH on 22 October was strongly suggestive of a patient suffering acute renal failure, as indicated by his elevated creatinine with a proportional rise in urea levels. His relatively normal vital signs were typical of the ability of a relatively young and healthy patient to compensate for severe illness.

- In the morning of 22 October Mr Summerfeldt required immediate treatment with IV fluid, antibiotics, and emergency transfer to the nearest surgical centre.

- Mr Summerfeldt's best chance of surviving his faecal peritonitis required his immediate transfer from the WCDH to the NWRH in the morning of 22 October. However, it has to be recognised that he was suffering a life threatening condition and the prospects of surgical intervention saving his life were no greater than 50%.

Findings, Comments and Recommendations

I accept Dr Lawrence's opinion upon the cause of death. It is apparent, with the benefit of hindsight, that Mr Summerfeldt was suffering from a perforation in the pyloric area of his stomach when symptoms first presented on 20 October 2014. Regrettably, the seriousness of his condition was not appreciated when he first attended the WCDH. However, I acknowledge that, on this occasion, Mr Summerfeldt appears to have been a less than compliant patient and an extended monitoring of his health was frustrated by his self-discharge.

However, I accept the opinion of Dr Bell that when Mr Summerfeldt re-presented to the WCDH on 22 October he had increasing peritonitis after suffering a perforation of a pyloric ulcer, and was in urgent need of surgery to maximise his prospects of survival. Unfortunately this situation was not recognised when he attended at WCDH, and there was a significant delay before his eventual evacuation to the NWRH. I am not able to find that Mr Summerfeldt would have survived his peritonitis if he had been conveyed to the NWRH at the earliest opportunity on 22 October 2014. However, I am satisfied, and so find, that the delay in his evacuation did, to an appreciable extent, reduce his prospects of survival.

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.

I convey my sincere condolences to Mr Summerfeldt's family and loved ones.

Dated: 3 January 2017 at Hobart in the State of Tasmania.

Rod Chandler
Coroner