



# 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, Simon Cooper, Coroner, having investigated the death of Timothy John Fenton

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

- a) The identity of the deceased is Timothy John Fenton;
- b) Mr Fenton died in the circumstances set out further in this finding;
- c) The cause of Mr Fenton's death was sepsis and multiple organ failure; and
- d) Mr Fenton died on 1 October 2017 at the Royal Hobart Hospital, Hobart, Tasmania.

In making the above findings I have had regard to the evidence gained in the comprehensive investigation into Mr Fenton's death. The evidence comprises an opinion of the forensic pathologist who conducted the autopsy, report of death forms completed by both Tasmania Police and the Royal Hobart Hospital, affidavits confirming identification, medical records, and a report from the medical advisor to the Coronial Division.

Timothy John Fenton was 57 years old when he developed an ileus (a functional blockage in his intestine) which led to his death due to aspiration pneumonia.

Mr Fenton was intellectually disabled and cared for by his father. He had a lengthy history of epilepsy for which he was under the care of a neurologist and medicated with sodium valproate, levetiracetam (Keppra), carbamazepine (Tegretol) and topiramate (Topamax).

On 27 August 2017, after Mr Fenton had reportedly suffered three days of vomiting, nausea and diarrhoea, Ambulance Tasmania were called to assist him. Mr Fenton was transported to the Royal Hobart Hospital (RHH) where he was immediately admitted to the Emergency Department. In the Emergency Department his blood pressure was noted to be 130/70 mmHg, his heart rate 130 bpm, his oxygen saturation 96% on room air and he was noted to be afebrile. Peripheral circulatory shutdown was noted as well as lactic

acidosis. Mr Fenton's white cell count was elevated; so was his creatine which, at 157 micromoles/L, indicated a degree of renal failure. Emergency staff ordered an urgent CT scan of Mr Fenton's abdomen. The CT scan showed dilated small bowel loops with no transition point suggesting a small bowel ileus.

As a consequence, an emergency laparotomy was performed the same day. The surgery appears to have proceeded without incident and Mr Fenton was post operatively reviewed later that evening. Intravenous antibiotics were administered.

Just after midnight on 28 August 2017, a medical emergency team (MET) call was made. Mr Fenton was febrile with a temperature of 38.5°C, his heart rate was 115 bpm, his respiratory rate 20 – 24 bpm and blood pressure 135/74 mm/Hg. Staff noted a high nasogastric output which was to be managed by keeping the nasogastric tube on free drainage with four hourly aspirates. During the course of the day Mr Fenton's condition stabilised.

The next day (29 August) medical notes indicate that during the medical ward round Mr Fenton appeared to feel better and his vital signs were stable. However, medical records indicate that his nasogastric tube had been dislodged around midnight but that it was not reinserted. Later the same day another MET call was made as a consequence of a deterioration in Mr Fenton's condition. Specifically, the factors which led to the call being made included that Mr Fenton was suffering from tachycardia (140 – 150 bpm) and hypoxia (oxygen saturation 91%). In addition, Mr Fenton was vomiting and his stomach was noted to be distended but without signs of peritonitis. A chest x-ray was carried out urgently and showed gaseous distension of his stomach. A nasogastric tube was inserted but the records indicate minimal nasogastric output. An x-ray done at 2.42pm on that day showed the nasogastric tube was correctly placed in Mr Fenton's stomach.

Later still the same day, Mr Fenton was transferred to the radiological department of the RHH and a further MET call was made because Mr Fenton had vomited and aspirated, his oxygen saturation was falling to 81%, and problems were identified in relation to his lungs. The nasogastric tube was aspirated and 2000 mL of fluid removed. High flow oxygen was administered. Various diagnostic tests were conducted including a CT scan of his pulmonary artery which showed no pulmonary embolism. However, a CT scan of his abdomen showed small bowel findings consistent with an ileus (I note this finding had been made when the urgent CT scan was performed shortly after his admission two days earlier).

As a result of Mr Fenton's worsening condition he was transferred to the intensive care unit (ICU) where standard ICU support was provided. Significantly, results of a CT scan available at the time of his transfer to ICU showed right lung lower lobe pathology consistent with aspiration.

By 31 August 2017 Mr Fenton's respiratory function had deteriorated to such an extent that he was intubated and mechanically ventilated. Over the course of the rest of the day Mr Fenton stabilised but he had a persistent ileus and right lung aspiration pneumonia.

The remaining 30 days of Mr Fenton's life were spent in the ICU at the RHH. Although he slowly improved, he never recovered, in particular from the aspiration insult. He developed acute respiratory distress syndrome which in turn led to multiple organ dysfunction syndrome. Problems with his organs included encephalopathy (metabolic brain dysfunction), neuromyopathy (a complication involving his muscles and nerves), circulatory impairment, continued respiratory issues and liver dysfunction.

Mr Fenton continued to deteriorate and signs of sepsis persisted although no specific site of infection could be found. On 1 October 2017 he died.

I am satisfied on the evidence that Mr Fenton likely suffered aspiration pneumonia to which he was predisposed by reason of his ileus. The cause of that ileus is difficult to determine but may be related to his antiepileptic medication.

Dr Anthony J Bell (MB, BS, MD, FRACP, FCICM) medical advisor to the Coronial Division reviewed Mr Fenton's treatment at my request. In a report provided to me Dr Bell expressed the opinion that the decision to perform an exploratory laparotomy upon admission to hospital was a reasonable one. I accept Dr Bell's opinion in this respect.

Dr Bell also opined that the decision not to replace the nasogastric tube on the morning ward round on 29 August 2017 was reasonable. However, Dr Bell expressed the opinion that after the x-ray at 2.42pm on that day showed the correct placement of the tube into Mr Fenton's distended stomach, the nasogastric tube ought to have been aspirated.

There is no record of the tube being so aspirated. Within an hour of the x-ray being done and the tube apparently not being aspirated and the stomach not emptied, Mr Fenton suffered a major aspiration that led to his death. I am satisfied that the failure to aspirate the tube and empty the stomach was a departure from reasonable standards of medical care and directly contributed to Mr Fenton's death.

A copy of this finding, in draft, together with a copy of Dr Bell's report, was sent to the Royal Hobart Hospital on 28 August 2018. The Hospital was invited to make any comment that it considered appropriate within 28 days of that date. In particular, the Hospital was asked to identify whether it disputed any of the above finding and if so, why.

No reply has been received from the Hospital.

I am satisfied in all of the circumstances that Mr Fenton's death was the result of inadequate treatment as an inpatient at the RHH.

### **Comments and Recommendations**

The circumstances of Mr Timothy Fenton's death are not such as to require me to make any comments or recommendations pursuant to Section 28 of the *Coroners Act 1995*.

I convey my sincere condolences to the family and loved ones of Mr Fenton.

**Dated** 8 November 2018 at Hobart, Tasmania.

**Simon Cooper**  
**Coroner**