IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2013 003708

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 60(2)
Section 67 of the ***Coroners Act 2008***

I, PARESA ANTONIADIS SPANOS, Coroner,
having investigated the death of JAMES MICHAEL HOCTOR
without holding an inquest:
find that the identity of the deceased was JAMES MICHAEL HOCTOR
born on 10 February 1920
and that the death occurred on 22 August 2013
at St Vincent's Hospital, 41 Victoria Parade, Fitzroy, Victoria 3065
from:

I (a) COMPLICATIONS FOLLOWING COLECTOMY FOR CLOSTRIDIUM DIFFICILE PANCOLITIS IN THE SETTING OF RECENT ANTIBIOTIC THERAPY

Pursuant to section 67(2) of the **Coroners Act 2008**, I make findings with respect to **the following circumstances**:

1. Mr Hoctor was a 93-year-old man who lived with his sister-in-law in Kyneton. He was independent in activities of daily living and had a medical history that included recurrent skin cancers, congestive cardiac failure, gout, and osteoarthritis.

2. Relevantly, Mr Hoctor's recent medical history included right sided neck pain and swollen and enlarged lymph nodes (lymphadenopathy) associated with an underlying collection of fluid which required the long-term administration of antibiotics and daily dressings. District nurses performed the daily dressings for two months, under the supervision of Mr Hoctor's general practitioner, Dr John Turner from Coliban Medical Centre. In July 2013, Dr Turner referred Mr Hoctor to St Vincent's Hospital for review and management of the neck abscess, as he was concerned it might be a squamous cell carcinoma.

3. On <u>8 July 2013</u>, Mr Hoctor was admitted to St Vincent's Hospital [St Vincent's] for investigation and treatment of his right sided chronic neck abscess. No carcinoma was

detected and the abscess responded well to antibiotics following surgical excision and debridement on 17 July 2013. However, Mr Hoctor's admission was complicated by diarrhoea, for which a faecal specimen was collected, although results were not available before he was transferred to Kyneton District Hospital [KDH] on 24 July 2013 for convalescence and discharge planning.

4. On the day of transfer, St Vincent's staff telephoned KDH to advise that Mr Hoctor's pathology results indicated that he had contracted Vancomycin-Resistant Enterococcus [VRE], requiring his isolation from other patients to prevent the spread of the infection. Standard single room isolation precautions were implemented at KDH and the nature and purpose of these measures were explained to Mr Hoctor and his daughter.

5. Nurses documented routine vital sign observations and care notes three times each day in the medical record. Dressings on Mr Hoctor's neck wound were changed daily and the wound was noted to be healing well and showing no signs of infection. Peripheral oedema was observed, consistent with Mr Hoctor's history of heart failure, so his lower limbs were elevated to assist with this and, following medical review, a small dose of frusemide was also initiated with good effect. All other medications were administered in accordance with the St Vincent's discharge medications list.

6. When he was reviewed by Dr Turner on 29 July 2013, in his capacity as a visiting medical officer at KDH, Mr Hoctor was medically stable, with vital observations within normal limits, and so discharge planning was commenced. On 31 July 2013, Dr Turner ceased the oral antibiotics commenced at St Vincent's, which Mr Hoctor had been taking for one week without a fever nor signs of wound infection, and ordered a neck wound swab for culture to confirm the absence of significant infection.

7. When reviewed by Dr Turner on the morning of 2 August 2013, Mr Hoctor complained of three episodes of diarrhoea overnight commenting that he had not told nursing staff because he had not wanted to disturb them. In the absence of other symptoms, Dr Turner treated Mr Hoctor's diarrhoea symptomatically with Gastro-stop.

8. During the morning nursing shift, Mr Hoctor was assisted to shower and complained of 'feeling flat'. His temperature was slightly elevated and rose to 38.3 Celsius by about midday. He was returned to bed with paracetamol. Throughout the afternoon and evening, Mr Hoctor rested in bed, tolerated minimal fluids and diet and continued to feel 'very washed out'. He did not have (or did not report) any further episodes of diarrhoea that day.

9. Dr Turner reviewed Mr Hoctor again on 3 August 2013, noting that he had been afebrile overnight and that Gasto-stop had controlled his diarrhoea. Viral diarrhoea was suspected and so Mr Hoctor was encouraged to rest and take fluids. Dr Turner also noted that results of the neck wound swab showed no signs of infection.

10. Mr Hoctor continued to feel weak but reported that he was comfortable, experiencing no nausea or vomiting. He had two loose bowel movements during the day and another in the evening with Gastro-stop administered after each episode. His temperature was elevated in the evening and he had tolerated only small amounts of diet and fluid over the course of the day. He did however appear to rest well overnight.

11. On 4 August 2013, Mr Hoctor had one episode of diarrhoea in the morning, afternoon and evening, each treated with Gastro-stop, and remained afebrile. He was ambulant with a walking frame during the day, refused a shower but was assisted to wash, and tolerated diet and fluids. There were no further episodes of diarrhoea overnight.

12. On 5 August 2013, Mr Hoctor's temperature remained elevated at 38 Celsius throughout the day. He experienced loose bowel movements in the morning and afternoon and was administered Gastro-stop. Mr Hoctor complained of back pain and aches on moving and was administered paracetamol in the afternoon and ibuprofen in the evening. His appetite was poor and he tolerated only minimal diet.

13. The following morning, on 6 August 2013, Mr Hoctor was alert and oriented but was slightly febrile, with blood pressure and oxygen saturations below his normal limits. Chest auscultation produced left lower lobe crepitation and bilateral wheezing, more pronounced in the left lung. He also had a moist and unproductive cough and reported a loose bowel movement that morning. Mr Hoctor was encouraged to take fluids and rest in bed with oxygen administered via nasal prongs and Dr Turner was notified.

14. At lunchtime, Dr Turner examined Mr Hoctor, finding signs consistent with a left lower lobe infection. He ordered a chest x-ray, full blood examination, urea, electrolytes and D-Dimer (to screen for venous thrombus or emboli) and commenced intravenous [IV] penicillin and oral roxithromycin for suspected pneumonia.

15. Mr Hoctor appeared pale, lethargic and a little 'vague' during the afternoon nursing shift. His blood pressure remained low and his condition was characterised as 'pre [cardiac] arrest'. KDH nursing staff informed Dr Turner by telephone of the results of investigations: in particular, that the chest x-ray revealed no suggestion of lung consolidation but that blood tests revealed an elevated C-reactive protein of 233 and a white cell count of 33.2 indicative

of a severe infection. Dr Turner considered these results to be consistent with a gram-negative septicaemia and, in view of the gravity of Mr Hoctor's condition, authorised a Not For Resuscitation order. Dr Turner then telephoned Mr Hoctor's daughter who was at KDH, to explain her father's condition and discuss whether he should be transferred back to St Vincent's.

16. After the conclusion of his general practice hours, Dr Turner examined Mr Hoctor and found him to be clinically very unwell: feverish, with low blood pressure, poor oxygen saturation and reduced conscious state. Dr Turner ordered blood cultures and IV fluids and, following Mr Hoctor's family's decision to transfer him to St Vincent's, liaised with the admitting officer with a view to arranging a consultation with an infectious diseases specialist. When Mr Hoctor was transferred by ambulance to St Vincent's at 8.30pm he was afebrile, alert and verbalising with stable vital observations.

17. On arrival at St Vincent's, the admitting medical unit, in consultation with the infectious diseases specialist commenced empirical antibiotic treatment with IV teicoplanin and meropenum. A blood culture isolated E Coli and a faecal specimen identified Clostridium difficile.

18. On 7 August 2013, Mr Hoctor underwent a sub-total bowel resection for a Clostridium difficile infection. After a protracted stay in the St Vincent's Intensive Care Unit, complicated by acute renal failure, ongoing hypotension and infection, Mr Hoctor died on 22 August 2013 with family present.

19. Forensic Pathologist Dr Heinrich Bouwer of the Victorian Institute of Forensic Medicine reviewed the circumstances of Mr Hoctor's death as reported by police to the coroner, post-mortem computerised tomography [PMCT] scanning of the whole body, St Vincent's medical records and deposition and performed an external examination. Dr Bouwer observed possible chronic bilateral subdural haematoma with no mass effect, possible mitral valve calcification, bilateral lower lobe pneumonia and pleural effusions and mild ascitic fluid on PMCT. The external examination was consistent with the reported circumstances with evidence of recent abdominal surgery and a healing ulcer on the neck.

20. Dr Bouwer noted that Mr Hoctor underwent pan-colectomy for Clostridium difficile pancolitis which had been complicated by multi-organ failure, acute kidney injury, hypotension, atrial fibrillation, sepsis, disseminated intravascular coagulopathy, hyperkalaemia, deranged liver function and delirium.

21. In the absence of a full post-mortem examination, Dr Bouwer attributed Mr Hoctor's death to complications following colectomy for Clostridium difficile pancolitis in the setting of recent antibiotic therapy.

22. In a letter to the Court dated 25 October 2013, Reverend Shane Hoctor, raised a number of concerns about the care his father received at KDH which may be summarised as follows:

    a. KDH staff were inadequately informed about VRE infection;

    b. Isolation precautions may have hindered the provision of appropriate care, with staff 'popping' their heads around the corner to check on him rather than putting on gown, mask, gloves and entering the room to perform an adequate assessment and, this in turn, heightened Mr Hoctor's feelings of loneliness.

    c. The frequency with which Mr Hoctor was monitored on 6 August 2013 when his condition acutely deteriorated was inadequate.[1]

23. In light of Reverend Hoctor's concerns, at my request the Coronial Prevention Unit[2] examined all available materials, including further information it obtained from Dr Turner and Ms Hussey, KDH's After Hours Nursing Manager, and provided advice about the adequacy of the clinical management and care Mr Hoctor received at KDH. The CPU advised:

    a. Medical records and the statements of Dr Turner and Ms Hussey provide evidence that both Mr Hoctor's medical and nursing assessment and care were timely and appropriate, but there was no investigation of the colitis.

    b. Neither Dr Turner nor KDH nursing staff considered or investigated the possibility of Clostridium difficile infection as an explanation for several days of diarrhoea and low grade fevers. Given his prolonged use of antibiotics, Mr Hoctor's complaints of diarrhoea and his age and frailty, this diagnosis should have been considered and investigated.

[1] Reverend Hoctor raised other concerns, such as the widely reported political situation existing between local general practitioners and KDH management at the time of Mr Hoctor's admission that he believed may have affected the quality of the care provided to his father but these were not investigated as they are beyond the reasonable scope of a coronial investigation.

[2] The Coroners Prevention Unit [CPU] was established in 2008 to strengthen the prevention role of the Coroner. CPU assists the coroner to formulate prevention-focused recommendations and comments, and monitors and evaluates their effectiveness once published. CPU is staffed by practising physicians and nurses who are independent of the health professionals or institutions involved. They assist the Coroner's investigation of deaths occurring in a healthcare setting by evaluating clinical management and care provided and identifying areas of improvement where appropriate so that similar deaths may be avoided in the future.

c. It is not possible to determine whether Mr Hoctor's clinical course would have been materially different if his Clostridium difficile infection had been diagnosed and treated earlier.

24. KDH's Medical Director, Dr Peter Sloan, and Dr Turner were informed of the CPU's advice and each subsequently provided additional information to the Court in the form of oral[3] and written submissions respectively.

25. Dr Sloan observed that when Mr Hoctor was transferred to KDH, pathology results from St Vincent's indicated he had contracted VRE but not Clostridium difficile. He noted that Clostridium difficile was an extremely rare disease that often went unrecognised and that faecal cultures, the manner through which the infection is detected, are not a particularly common practice.

26. Dr Sloan stated that at KDH, patients are medically reviewed by visiting rural medical officers, ordinarily local general practitioners, on an 'as needs' basis and if a patient was acutely unwell he would anticipate daily medical review. He noted that KDH relied on its advanced nursing staff, particularly the Rural Isolated Practice Endorsed Registered Nurses present each shift during the day, to assess patients and contact a medical officer if necessary. The prevailing culture is that nurses 'do not hesitate' to call in a doctor if this is clinically indicated and medical officers, like Dr Turner, would attend for review.

27. Dr Sloan observed that Dr Turner's initial impression and treatment of Mr Hoctor's diarrhoea with Gastro-stop was not unreasonable. Noting that Mr Hoctor appeared to improve over a period of time, nurses were happy with his progress and so he was not seen by Dr Turner for a couple of days. When Mr Hoctor acutely deteriorated, nurses summoned Dr Turner who attended to review the patient, altering his management plan to include IV antibiotics and then transfer to a tertiary hospital as diagnostic results became available and Mr Hoctor's condition worsened. Dr Sloan endorsed the clinical management and care provided by Dr Turner and KDH nurses.

28. Among those submissions made on Dr Turner's behalf[4] was an expert report prepared by Associate Professor Christopher Pearce, a fellow of the Australian College of Rural and Remote Medicine with extensive clinical experience as a rural general practitioner. A/Prof

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[3] Dr Sloan made oral submissions on behalf of Kyneton Hospital at a mention hearing on 28 May 2015. Not all of the matters he addressed are reflected in this finding but may be found in the Transcript of the Hearing which appears on the Court file.

[4] Written submissions dated 21 May and 24 September 2015 were received by the Court in addition to A/Prof Pearce's report dated 3 September 2015.

Pearce noted that the management of the extremely elderly, like Mr Hoctor, presented particular challenges due to their reduced functional reserve and varied responses to illness. Varied physiological responses and the risk that interventions may have a higher likelihood of causing harm complicated clinical decision-making for the rural general practitioner.

29. A/Prof Pearce observed that the symptoms of Colistridium difficile infection can be non-specific and that faecal testing conducted at St Vincent's had been negative in the preceding week. In light of Mr Hoctor's ongoing diarrhoea following this test and KDH' staff assessments of his symptoms as mild and settling, A/Prof Pearce thought it was reasonable to consider the gastrointestinal symptoms to be consistent with a viral illness.

30. Thus, A/Prof Pearce opined that there was not an opportunity to confirm the diagnosis by faecal examination before 4 or 5 August 2013. It was note that Clostridium difficile is confirmed by sigmoidoscopy or faecal examination and that finalisation of faecal examination results may take over 24 hours. A/Prof Pearce opined that it was not until 4 or 5 August 2013, when Mr Hoctor's gastrointestinal symptoms and fever worsened that he considered it reasonable to perform a faecal examination. Moreover, he observed that earlier diagnosis would have made little or no impact on Mr Hocotr's ultimate outcomes.

31. The standard of proof for coronial findings of fact is the civil standard of proof, on the balance of probabilities, with the *Briginshaw* gloss or explication.[5] The effect of the authorities is that Coroners should not make adverse findings against or comments about individuals, unless the evidence provides a comfortable level of satisfaction that they caused or contributed to the death.

32. Having applied that standard of proof to the available evidene, I find that Mr Hoctor, late of Piper Street, Kyneton, died on 22 August 2013 at St Vincent's Hospital as a result of complications following colectomy for Clostridium difficile pancolitis in the setting of recent antibiotic therapy.

33. The evidence before me does not support a finding that there was any want of clinical management or care on the part of Dr Turner or the nursing staff at Kyneton District Hospital that caused or contributed to Mr Hoctor's death.

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[5] *Briginshaw v Briginshaw (1938) 60 C.L.R. 336 esp at 362-363.* "The seriousness of an allegation made, the inherent unlikelihood of an occurrence of a given description, or the gravity of the consequences flowing from a particular finding, are considerations which must affect the answer to the question whether the issues had been proved to the reasonable satisfaction of the tribunal. In such matters "reasonable satisfaction" should not be produced by inexact proofs, indefinite testimony, or indirect inferences..."

COMMENTS

Pursuant to section 67(3) of the *Coroners Act* 2008, I make the following comment:

1. I note that Kyneton District Hospital's Medical Director and After Hours Nursing Manager acknowledged the difficulty posed by infection control regimes on the social and emotional wellbeing of patients, like Mr Hoctor, subject to them. It is therefore heartening that Kyneton District Hospital has implemented strategies, such as social work and allied health referrals to minimise adverse effects on isolated patients.

RECOMMENDATION

Pursuant to section 62(2) of the *Coroners Act* 2008, I make the following recommendation:

1. I recommend that Mr Hoctor's death be used as a case example for Kyneton District Hospital staff education programs to enhance clinical management and, in particular, ensure that medical practitioners and nursing staff caring for elderly patients on protracted courses of antibiotics are aware of the signs and symptoms of Clostridium difficile infection.

I direct that a copy of this finding be provided to:

Reverend Shane Hoctor

Dr (Edwin) John Turner, Coliban Medical Centre

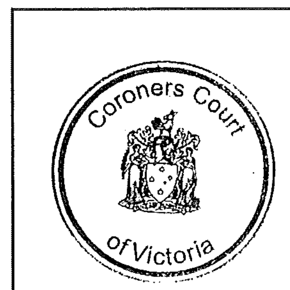
Dr Peter Sloan, Medical Director, Kyneton District Health

Melanie Kyezor, Clinical Risk Manager, St Vincent's Health

Associate Professor Christopher Pearce

Australian College of Rural and Remote Medicine

Signature:



PARESA ANTONIADIS SPANOS
CORONER
Date: 5 April 2015

cc. Manager, Coroners Prevention Unit