IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2015 1538

FINDING INTO DEATH WITHOUT INQUEST

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

I, JACQUI HAWKINS, Coroner having investigated the death of Ross Albert Butler without holding an inquest:
find that the identity of the deceased was Ross Albert Butler
born on 1 June 1947
and the death occurred on 29 March 2015
at Monash Medical Centre, 246 Clayton Road, Clayton, Victoria 3168
from:

1 (a) FAECULENT PERITONITIS
1 (b) PERFORATION OF A SIGMOID VOLVUS
CONTRIBUTING FACTORS – ALZHEIMERS DISEASE (MEDICAL HISTORY)

Pursuant to section 67(1) of the **Coroners Act 2008**, I make findings with respect to **the following circumstances**:

1. Ross Butler was 67 years of age at the time of his death. He had been a resident at the Cumberland View Residential Aged Care facility in Wheelers Hill, since June 2014.
2. Mr Butler's past medical history included Parkinson's disease, dementia and type II diabetes mellitus. He suffered multiple falls.
3. On 27 March 2015, Mr Butler was reviewed by General Practitioner, Dr Lackner after he had a decreased appetite and left lower abdomen and groin pain for three days. Dr Lackner noted Mr Butler's abdomen was 'not generally distended but tight'. He recommended Mr Butler be transferred to the Monash Medical Centre (MMC) Emergency Department for investigation and management of a possible small bowel obstruction.
4. On arrival at the Emergency Department, Mr Butler was noted to be alert with a mild tachycardia and moderate hypertension. Abdominal and chest x-rays revealed that 'an enormously distended loop of colon almost fills the abdomen, ascending superiorly and to the

right' which caused the diaphragm to be markedly elevated. It was suggested Mr Butler had a sigmoid volvulus, which is a twisting of a segment of the lower bowel and can often lead to a bowel obstruction.

5. On-call surgical registrar, Dr Alex Pun reviewed Mr Butler and noted he had a soft abdomen which was tender on the left side, no palpable masses and no evidence of peritonism. Dr Pun discussed Mr Butler's presentation with consultant surgeon, Dr Dean Spilias and a plan was made for intravenous (IV) fluids, no oral intake, analgesia and a rigid sigmoidoscopy for insertion of a rectal tube. Dr Pun performed the sigmoidoscopy and rectal tube insertion. A significant amount of gas successfully passed through the tube once it was inserted and was left in place to enable further decompression. At 5.03pm, the post procedure x-ray revealed that the rectal tube was inserted correctly, but that 'the greatly distended loop of colon superiorly and on the right remains almost unaltered.'
6. Mr Butler was admitted to the general surgical ward for observation and re-hydration. IV fluids and clear oral fluids were ordered. The overnight nursing entry recorded that Mr Butler did not complain of pain and had stable vital signs with slight persistent tachycardia. This assessment was reiterated at 8.20am on 28 March 2014 during the morning ward round, conducted by surgical registrar Dr Boris Ruggiero. Mr Butler's abdomen remained soft on palpation and Dr Ruggiero decided Mr Butler should have no oral intake again until a management plan was confirmed with the surgical consultant.
7. At 11.30am, Mr Butler was noted to have a temperature of 38 degrees Celsius. Around this time, he also required low-dose supplemental oxygen therapy for a short period. At approximately 12pm, surgical resident Dr Haran was paged to review Mr Butler. A medical management plan was still pending. Dr Haran prescribed a single low dose of IV morphine which was effective in relieving Mr Butler's increasing agitation and discomfort. It was noted that no gas or fecal matter had filled the collection bag.
8. Overnight, Mr Butler became unsettled again and complained of arm pain, possibly caused by his IV cannula. On 29 March 2015 at 3.15am, he was administered oral endone. At 7.35am, he was noted to be comfortable and responding to voice. At 8.15am, a code blue was initiated after Mr Butler was found to be unresponsive. Cardiopulmonary resuscitation (CPR) was commenced and Mr Butler was intubated. Mr Butler's daughter and medical power of attorney, Kerri-Anne Butler was contacted and advised that she did not wish CPR to be performed. Mr Butler was declared deceased at 8.30am.

CORONIAL INVESTIGATION

9. The role of a coroner is to independently investigate reportable deaths to establish, if possible, identity, medical cause of death and with some exceptions, surrounding circumstances. Surrounding circumstances are limited to events which are sufficiently proximate and causally related to the death. The broader purpose of coronial investigations is to contribute to a reduction in the number of preventable deaths, the promotion of public health and safety and the administration of justice.

10. The law is clear that coroners establish facts; they do not lay blame, or determine criminal or civil liability.[1]

11. A coroner may comment on any matter connected with the death, may report to the Attorney-General and may make recommendations to any Minister, public statutory authority or entity, on any matter connected with the death, including recommendations relating to public health and safety and the administration of justice.[2]

12. Victoria Police conducted an investigation on behalf of the Coroner into the circumstances of Mr Butler's death. A coronial brief was provided to the Coroner which included a statement obtained from Mrs Butler.

Forensic Medical Investigation

13. On 7 April 2015, Professor Stephen Cordner, Forensic Pathologist at the Victorian Institute of Forensic Medicine performed an autopsy on the body of Mr Butler and reviewed the post mortem computed tomography (CT) scan, the Form 83 Victoria Police Report of Death and the medical records.

14. Professor Cordner reported the autopsy confirmed the on-going existence of the sigmoid volvulus, with incipient infarction and perforation at the apex of the volvulus. There was faeculent peritonitis. Precisely when this occurred is beyond the resolution of the autopsy alone. However, Professor Cordner commented that given the volvulus was still present and markedly distended following the insertion of the tube, as seen radiologically, it is perhaps less likely that the perforation occurred at this point.

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[1] In the coronial jurisdiction facts must be established on the balance of probabilities subject to the principles enunciated in *Briginshaw* v *Briginshaw* (1938) 60 CLR 336. The effect of this and similar authorities is that coroners should not make adverse findings against, or comments about, individuals unless the evidence provides a comfortable level of satisfaction as to those matters taking into account the consequences of such findings or comments.

[2] Section 72(1) and (2) *Coroners Act 2008* (Vic).

15. Professor Cordner provided an opinion as to the medical cause of death being 1 (a) FAECULENT PERITONITIS 1 (b) PERFORATION OF A SIGMOID VOLVUS, CONTRIBUTING FACTORS – ALZHEIMERS DISEASE (MEDICAL HISTORY).

Family Concerns

16. Mrs Butler expressed some concerns in her statement regarding the care and management of Mr Butler. The main issues raised by Mrs Butler was that there was poor communication from MMC staff to Mr Butler's family regarding his diagnosis and treatment and that there was insufficient and delayed treatment.
17. I referred the matter to the Coroners Prevention Unit (CPU)[3] to review whether the medical care was appropriate and reasonable in the circumstances.

Coroners Prevention Unit Investigation

18. The CPU reviewed Mr Butler's medical records, the medical examiner's report, coronial brief, Form 83 Victoria Police Report of Death and additional statements requested of Mr Butler's treating team including Dr Scott Josey, Dr Pun and Dr Ruggiero.
19. Dr Pun reported that following a normal rectal examination, the rigid sigmoidoscopy and rectal tube insertion proceeded successfully. At no point did he suspect that he may have caused a tear or perforation to the bowel during the procedure.
20. Following the procedure, Mr Butler commented that his pain had moderately decreased. Dr Pun handed over to Dr Ruggiero, who was the surgical registrar for the evening of 27 March 2015. At the time, Dr Ruggiero was in the operating theatre. Dr Pun continued to work as the on call surgical registrar despite his shift finishing to cover while Dr Ruggiero was in theatre. They met again at approximately 9pm and handed over surgical patients. Later that night Dr Pun sent a text message to night shift surgical registrar Dr Dane Holden, requesting that he check the result of Mr Butler's follow up x-ray. Dr Holden replied with details of the x-ray and explained that the rectal tube could not be further inserted and advised he would hand over to Dr Ruggiero, who was the morning surgical registrar on 28 March 2015.

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[3] The role of the Coroners Prevention Unit (CPU) is to assist the Coroner's investigation into the nature and extent of deaths which occurred during the provision of healthcare, and identify potential system factors in healthcare related deaths. CPU personnel comprise of practising Physicians and Clinical Research Nurses who draw on their medical, nursing and research experiences, skills and knowledge to independently evaluate clinical evidence for the investigation of reportable healthcare deaths and to assist in identifying remediable factors that may assist in prevention and risk management in health services settings.

21. Dr Ruggiero reported that when he received the initial handover he was told by Dr Pun that Mr Butler was clinically improving following insertion of the rectal tube and he was not asked to review Mr Butler or follow up the x-ray. On the morning of 28 March 2015, when he received handover from Dr Holden, he was not informed of any deterioration in Mr Butler's condition. Dr Ruggiero assessed Mr Butler noting that he was clinically stable and had a mildly distended abdomen that was not tender or painful on palpation. Beyond advising that Mr Butler was not to have any oral intake (except for his usual medications), no medical management plan was documented on 28 March 2015, despite Dr Ruggiero's explanation in his statement that the conservative plan also included IV fluids and gentle mobilisation to aid with the resolution of the volvulus.

22. No assessment was recorded in the progress notes by Dr Haran when he prescribed a single low dose of morphine to Mr Butler on the afternoon of 28 March 2015. Similarly there is no information documenting any features of abdominal assessments, other than noting the presence of the rectal tube, performed by nursing staff following Mr Butler's admission to the surgical ward due to his bowel obstruction. As such, it is difficult to provide even an approximate time line regarding if and when Mr Butler may have been exhibiting worsening abdominal symptoms that warranted urgent medical review. Additionally, no vital signs were recorded between 8pm on 28 March 2015 and 5am on 29 March 2015. While these vital signs remained unchanged, the omission of this routine basic assessment at approximately 12am reduced the opportunity for nursing staff to identify any acute clinical changes.

23. The CPU reported that the pain associated with a sigmoid volvulus is usually continuous and severe, which does not appear to be the case for Mr Butler, who received minimal analgesia during his MMC admission. Symptoms of perforation and or peritonitis include fever, tachycardia, hypotension as well as abdominal guarding, rigidity and rebound tenderness. With the exception of mild tachycardia and a transiently elevated temperature, Mr Butler did not display further symptoms of bowel perforation or peritonitis.

24. It is unclear whether Mr Butler's bowel perforation was caused by an accidental penetrating trauma from the rectal tube insertion or from pressure-related trauma due to sustained or increasing distension of the bowel caused by trapped gas. Dr Pun reported he had experience with rectal tube insertion procedures and was confident performing it unsupervised. Professor Cordner commented that Mr Butler's marked bowel distension remained following the tube insertion and it is unlikely the insertion caused the perforation.

25. Dr Ruggiero reported that it appeared neither Dr Pun nor Dr Holden reviewed Mr Butler's post-rectal tube insertion abdominal x-ray. Mr Butler's clinical condition improved after the

rectal tube insertion and a conservative management plan was implemented for the subsequent 24 hour period, unless there were any rapid changes in his condition. Dr Ruggiero noted a further abdominal x-ray was planned for 29 March 2015 and if Mr Butler had displayed signs of clinical deterioration, the plan was to further discuss his case with the surgical consultant.

26. It is noted that Dr Pun reported Dr Holden reviewed the x-ray. It remains unclear whether Dr Holden communicated the results to Dr Ruggiero on the morning of 28 March 2015. Nonetheless, the rectal tube was successfully inserted and Mr Butler reported improved comfort following insertion, as well as an absence of significant or sustained signs and symptoms that suggested further investigation or intervention was required, the ongoing medical management plan of IV fluids, gentle mobilisation and for the rectal tube to remain to aid further bowel decompression was appropriate.

27. Dr Ruggiero also addressed the concern raised by Mrs Butler regarding poor communication by MMC staff. Dr Ruggiero noted that the family were promptly contacted during the code blue on the morning of 29 March 2015 and following Mr Butler's death, a family meeting was arranged. The family attending the meeting were in a very distressed state and while a brief explanation of events was provided, Dr Ruggiero explained that further conversation proved difficult and a detailed debrief was deemed inappropriate due to the Butler family's distress. Plans were made to meet with the Butler family again, though Dr Ruggiero acknowledged that unfortunately no further arrangements were made. The reason for this is unclear.

CPU conclusions

28. Following review of the statements and medical records, the CPU concluded that Mr Butler was reasonably referred for a surgical assessment following the rapid identification of his sigmoid volvulus upon his ED presentation on 27 March 2015. An appropriate invasive procedure to attempt to resolve the volvulus was expedited later that afternoon and Mr Butler appeared to clinically improve. Conservative ongoing management of Mr Butler's seemingly resolving sigmoid volvulus was reasonably continued on 28 March 2015, however Mr Butler died on the morning of 29 March 2015, before further abdominal x-ray monitoring could be undertaken to review the degree of success of the conservative approach. The resuscitation attempt was appropriately and adequately undertaken.

29. Dr Ruggiero reported that Mr Butler's death was reviewed at a fortnightly Upper Gastrointestinal and Hepatobiliary Unit audit meeting in the week following his death. The audit meeting determined that whilst "visualisation of the post decompression plain abdominal and chest x-ray would have raised the level of concern... [the almost unaltered image of the

distended colon] was unlikely to have changed the course of action undertaken up to that point nor beyond." Dr Ruggiero added that identification and appreciation of the post-rectal tube insertion x-ray findings would have allowed early and appropriate end of life discussion with Mr Butler and his family, suggesting that the definitive management for an unsuccessful resolution of a sigmoid volvulus following sigmoidoscopy, a laparotomy, would not have been undertaken in light of Mr Butler's significant comorbidities.

30. Dr Ruggiero further reported that as a result of Mr Butler's death, the MMC audit meeting reinforced the need for staff to adhere to the strict protocols outlined in the MMC surgical unit handbook. Additionally, communication of all outstanding investigations and the need to check these results was also reinforced as per the MMC protocols. The method of how these protocols were reinforced to MMC staff is unclear.

31. The CPU concurred with Mrs Butler's identified issue of poor communication from MMC staff to Mr Butler's family regarding his diagnosis and treatment. The CPU identified several areas of poor communication and documentation by MMC staff:

    a. Dr Pun did not communicate the need for Dr Ruggiero to review Mr Butler's post-rectal tube insertion x-ray on the evening of 27 March 2015. The initial handover took place in the less than ideal setting of an operating theatre during a procedure, however a second handover also took place later that evening. Dr Pun sent a text message to Dr Holden to follow up on the x-ray result and this suggests that he did not communicate this information to Dr Ruggiero during either of the handovers.

    b. It appears Dr Holden did not communicate the follow-up x-ray results to Dr Ruggiero on the morning of 28 March 2015. The lack of awareness by the medical team regarding the nature of the follow-up x-ray images resulted in both a lack of understanding of the gravity of Mr Butler's predicament, as well as the inadequate provision of information to Mr Butler and his family.

    c. Dr Ruggiero and the general surgical team did not effectively document the medical management plan, nor communicate the plan to nursing staff or the Butler family.

    d. Dr Haran did not document his assessment of Mr Butler at around midday on 28 March 2015 when he prescribed morphine for agitation and discomfort. It is unclear if an assessment was performed.

    e. Surgical ward nursing staff did not adequately document their assessments of Mr Butler's abdomen throughout his hospital admission. It is unclear if appropriate abdominal nursing assessments were performed.

32. I provided Monash Health the opportunity to address these specific concerns and to advise if any improvements had been made or whether any training has been provided to staff about these issues. On 6 June 2016, Monash Health advised they had no further comment to make.

FINDINGS

33. I accept and adopt the cause of death as provided by Professor Cordner and therefore find that Mr Ross Butler died on 29 March 2015 and his cause of death was 1 (a) FAECULENT PERITONITIS 1 (b) PERFORATION OF A SIGMOID VOLVUS, CONTRIBUTING FACTORS – ALZHEIMERS DISEASE (MEDICAL HISTORY).
34. I find that once a sigmoid volvulus was identified, Mr Butler was referred promptly for surgical assessment and an appropriate procedure was performed in a timely manner, followed by a conservative management approach. I am satisfied Mr Butler appeared to clinically improve following intervention.
35. I find that there was poor documentation and communication by Mr Butler's treating team during his admission to Monash Medical Centre from 27 to 29 March 2015. Due to the insufficient medical and nursing documentation of clinical assessments, it is impossible to comment whether there was a lack of recognition of clinical deterioration in this case. All nursing entries during Mr Butler's stay on the surgical ward were deficient in documenting a comprehensive abdominal assessment. It is therefore unclear whether adequate nursing or medical assessments occurred. It is possible that Mr Butler did not exhibit significant signs of clinical deterioration prior to his sudden unexpected arrest, however normal assessment findings should therefore have been documented.

COMMENTS

36. Pursuant to section 67(3) of the **Coroners Act 2008**, I make the following comment(s) connected with the death:

    The importance of effective communication and documentation in health care cannot be overstated, and health care staff should be reminded of this frequently. Communication enables the essential collaboration and continuation of various specialty medical, allied health and nursing services in order to appropriately treat the unwell patient. Effective communication also allows patients and their families to comprehend the diagnoses, prognoses and treatment.

The Monash Medical Centre internal audit meeting concluded even if medical staff had adequately communicated and followed up Mr Butler's x-ray results, the medical management would unlikely have changed. However, if the persistent extensive sigmoid volvulus had been identified and communicated to the Butler family in a timely manner, a discussion between surgeons and the Butler family regarding the feasibility of surgical repair of the volvulus could have occurred. Such a discussion at the very least, would have allowed the opportunity for the Butler family to comprehend Mr Butler's increased mortality risk, if not advocate for proceeding with the surgery.

RECOMMENDATION

37. Pursuant to section 72(2) of the Coroners Act 2008, I make the following recommendation connected with the death:

This case has highlighted a broader issue of adequate communication and documentation by health care professionals. I RECOMMEND THAT Monash Medical Centre use this case as a training example to remind nursing staff of the importance of adequate nursing assessment and documentation and for surgical staff to remind them of the importance of adequate communication not just within the surgical team, but to nursing staff as well as patients and their families.

Pursuant to Rule 64(3) of the Coroners Court Rules 2009, I order that the finding be published on the internet.

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

The family of Mr Ross Butler;
Information recipients; and
Coroner's Investigator, Victoria Police

Signature:

Jacqui Hawkins
Coroner
Date: 14 July 2016