IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2023 001947

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

Section 67 of the ***Coroners Act 2008***

Findings of:	Coroner Ingrid Giles
Deceased:	Trevor Lindsay Jones
Date of birth:	16 February 1948
Date of death:	13 April 2023
Cause of death:	1(a) Ruptured abdominal aortic aneurysm
Place of death:	Bairnsdale Regional Health Service, 122 Day Street, Bairnsdale, Victoria, 3875
Keywords:	RUPTURED ABDOMINAL AORTIC ANEURYSM; GROIN PAIN; BACK PAIN, NAUSEA; VOMITING; HYPERTENSION; DIABETES; BAIRNSDALE REGIONAL HEALTH SERVICE; VICTORIAN HEALTH INCIDENT MANAGEMENT SYSTEM; MISDIAGNOSIS; MISSED OPPORTUNITY; CLINICAL RED FLAGS

INTRODUCTION

1. Trevor Lindsay Jones (**Mr Jones**) was 75 years old when he died on 13 April 2023. At the time of his death, Mr Jones lived with his wife, Margaret Jones (**Mrs Jones**) in Paynesville. Mr and Mrs Jones had three children together, Suzie, Andrew, and Shelley.

2. Mr Jones spent a lot of his time outside working on the family sheep farm and playing cricket. He enjoyed hunting and fishing with his friends.

3. Mr Jones had an extensive medical history, including hypertension, type 2 diabetes mellitus, left inguinal hernia repair, gout, and hyperlipidaemia. Mr Jones was a smoker up until the age of 40.

4. Mr Jones' father passed away from heart failure, and his mother passed away from a ruptured aortic aneurysm.

THE CORONIAL INVESTIGATION

5. Mr Jones's death was reported to the coroner as it fell within the definition of a reportable death in the *Coroners Act 2008* (**the Act**). Reportable deaths include deaths that are unexpected, unnatural or violent or result from accident or injury.

6. The role of a coroner is to independently investigate reportable deaths to establish, if possible, identity, medical cause of death, and surrounding circumstances. Surrounding circumstances are limited to events which are sufficiently proximate and causally related to the death. The purpose of a coronial investigation is to establish the facts, not to cast blame or determine criminal or civil liability.

7. Under the Act, coroners also have the important functions of helping to prevent deaths and promoting public health and safety and the administration of justice through the making of comments or recommendations in appropriate cases about any matter connected to the death under investigation.

8. Victoria Police assigned an officer to be the Coroner's Investigator for the investigation of Mr Jones' death. The Coroner's Investigator conducted inquiries on the Court's behalf, including taking statements from witnesses – such as family, the forensic pathologist, treating clinicians and investigating officers – and submitted a coronial brief of evidence.

9. Coroner Paul Lawrie (**Coroner Lawrie**) initially held carriage of the investigation into Mr Jones' death. I assumed carriage in July 2023 for the purposes of conducting discrete additional investigations and making findings.

10. Upon receipt of the coronial brief, the Coroners Prevention Unit[1] (**CPU**) conducted a review of the material to determine whether Mr Jones' death was preventable, and whether there was a missed diagnosis at the hospital. I have considered the CPU findings below.

11. This finding draws on the totality of the coronial investigation into the death of Trevor Lindsay Jones including evidence contained in the coronial brief. Whilst I have reviewed all the material, I will only refer to that which is directly relevant to my findings or necessary for narrative clarity. In the coronial jurisdiction, facts must be established on the balance of probabilities.[2]

CIRCUMSTANCES IN WHICH THE DEATH OCCURRED

12. On 13 April 2023, Mr Jones attended the Metung Skin Clinic for an appointment in relation to a skin cancer on his forehead. He was reportedly feeling agitated in the lead-up to the appointment.

13. Mr Jones arrived home at about 3pm. Upon returning home, he complained to his wife Margaret that he felt sick and had had to pull over on the way home to vomit on the side of the road. Mr Jones also complained on pain in his groin.

14. At approximately 5pm on 13 April 2023, Mrs Jones drove Mr Jones to the Bairnsdale Regional Health Service Emergency Department. A triage nurse spoke to him at approximately 5:19pm and the emergency physician saw him at approximately 6:45pm. Mr Jones reported experiencing right lower quadrant abdominal pain, on a background of back and groin pain for a few weeks. The pain was constant, and was causing nausea and vomiting.

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[1] The CPU was established in 2008 to strengthen the prevention role of the coroner. The CPU assists the coroner with research in matters related to public health and safety and in relation to the formulation of prevention recommendations. CPU staff include health professionals with training in a range of areas including medicine, nursing, and mental health; as well as staff who support coroners through research, data and policy analysis.

[2] 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.

15. Mr Jones noted he had recently been lifting heavy firewood, and was diagnosed with musculoskeletal pain. He was advised to return to the emergency department if the pain worsened, and was discharged at approximately 7:38pm.

16. Mrs Jones returned to the Emergency Department with Mr Jones at 7:45pm after he became unresponsive on the drive home. At approximately 7:47pm, hospital staff loaded Mr Jones onto a hospital stretcher and extensive resuscitation was attempted.

17. After approximately 30 minutes, following consultation with Mrs Jones and Shelley, doctors ceased resuscitation efforts.

18. Mr Jones was confirmed to be deceased at approximately 8:23pm.

19. The medical deposition to the coroner filled in by staff at the Emergency Department noted *'??Myocardial infarction vs abdominal aortic aneurysm'* as possible causes of death.

IDENTITY OF THE DECEASED

20. On 13 April 2023, Trevor Lindsay Jones, born 16 February 1948, was visually identified by his daughter, Shelley Wirken, who signed a formal statement of identification to this effect.

21. Identity is not in dispute and requires no further investigation.

MEDICAL CAUSE OF DEATH

22. On 17 April 2023, Forensic Pathologist Dr Gregory Young **(Dr Young**) from the Victorian Institute of Forensic Medicine (**VIFM**), conducted an external examination of Mr Jones' body. Dr Young reviewed the Victoria Police Report of Death Form 83, medical deposition form, medical records from Bairnsdale Hospital, post-mortem CT scan, and VIFM contact log and provided a written report of his findings.

23. The examination showed a partly-healed incision on the right side of the forehead (consistent with recent skin cancer removal) and no unexpected signs of trauma. An internal examination was not performed.

24. A post-mortem CT scan was reviewed by Dr Chris O'Donnell, a radiologist at the VIFM. This showed extensive predominantly right-sided retroperitoneal haemorrhage due to a ruptured abdominal aortic aneurysm. The heart showed focal coronary artery calcification. Previous

surgery to the right hip was noted. There was no intracranial haemorrhage. Bilateral anterolateral rib fractures were attributable to CPR.

25. An aneurysm is an abnormal outpouching of a blood vessel, which in this case was the aorta. The mechanism of death is bleeding due to a rupture of the aneurysm. When rupture occurs, there is often severe sudden back or loin pain and shock, or sudden collapse. Hypertension, smoking, and atherosclerosis are major risk factors for the development of aneurysms.

26. Dr Young provided an opinion that the medical cause of death was 1 (a) ruptured abdominal aortic aneurysm.

27. I accept Dr Young's opinion.

FAMILY CONCERNS

28. Mrs Jones provided a set of concerns regarding the medical management of her husband for my consideration. She stated that she understood Mr Jones' death may not have been preventable, but questioned how the diagnosis was missed when he deteriorated so quickly upon leaving the hospital. These concerns are addressed below.

CPU REVIEW

Statements from Bairnsdale Regional Health Service

29. Dr Navin Singh (**Dr Singh**), the emergency physician who saw Mr Jones on 13 April 2023, provided a statement for the coronial brief. A statement was also provided to the Court from Kathy Kinrade, Executive Quality and Education at Bairnsdale Regional Health (**Ms Kinrade**). Ms Kinrade stated that Mr Jones' death was not reported to Safer Care Victoria nor as a serious adverse event at the time.

30. Mr Jones' case was informally internally reviewed by the Deputy Director of Medical Services and noted at the organisational Mortality and Morbidity review. This review did not identify any systems issues in the absence of a confirmed cause of death, "*with the assumption that the cause of death was highly likely to be ruptured aortic aneurysm*".

31. The CPU noted that it is unclear whether this finding means the review did not identify misdiagnoses or whether it considered a misdiagnosis to be an individual issue, and not a systems issue. Open disclosure was not performed.

32. Bairnsdale Regional Health Services further stated that the Executive and Quality team will implement an in-depth death review in future similar cases, in order to assist in identifying whether any system issues are present.

Assessment of care provided

33. The CPU noted that Dr Singh's retrospective medical note in the electronic medical record was *'?Msk[3] pain. No sinister features'*. The documented notes by the resident and triage nurse provided that the pain was sudden onset, not precipitated by movement, and was associated with repeated vomiting. The CPU considered that these symptoms are outliers to the working diagnosis of musculoskeletal pain and 'clinical red flags' for either aortic pathology (especially for a man over 50 years of age with hypertension, diabetes, and ex-smoker) or renal colic.

34. In his statement to the Court, Dr Singh stated, *"In light of the collateral history and resident note, I acknowledge the patient gave me a very different clinical picture".* The CPU found there was a missed opportunity to consider the diagnosis of ruptured aortic aneurysm.

35. However, Mr Jones's death was unlikely to have been preventable. CPU opined this to be due to the fact that such diagnosis would have required a CT aortogram, which can take up to two hours. Further, the surgical correction of the aorta requires a vascular surgical team, which Bairnsdale Regional Health Service does not have.

36. When a diagnosis is made in a regional centre, Adult Retrieval Victoria (**ARV**) is contacted to locate an appropriate service to accept the patient and arrange the transfer to a tertiary centre or a secondary centre with a vascular surgery team. Transfer times are variable, but it could be up to four hours before a patient arrives in surgery.

37. Given that the time between Mr Jones's presentation and his arrest was approximately one hour from the time he was examined by Dr Singh, even if the diagnosis of abdominal aneurysm had been considered, there may not have been time to confirm the diagnosis, and almost certainly there was not sufficient time to arrange transfer to a vascular centre before he arrested.

38. Notwithstanding, in the opinion of CPU, the 'red flags' in Mr Jones's clinical history were not recognised by the treating doctor and the appropriate diagnosis was missed.

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[3] Musculoskeletal.

FINDINGS AND CONCLUSION

39. Pursuant to section 67(1) of the *Coroners Act 2008* I make the following findings:

    a) the identity of the deceased was Trevor Lindsay Jones, born 16 February 1948;

    b) the death occurred on 13 April 2023 at Bairnsdale Regional Health Service, 122 Day Street, Bairnsdale, Victoria, 3875, from ruptured abdominal aortic aneurysm; and

    c) the death occurred in the circumstances described above.

40. I agree with the opinion of the CPU that while Mr Jones' death cannot be said to have been preventable, there was a missed opportunity by Bairnsdale Regional Health Service to consider the diagnosis of a ruptured aortic aneurysm and to take action to treat Mr Jones in accordance with that diagnosis. In so finding, I acknowledge the challenges faced by emergency departments in regional areas, noting Dr Singh's observation that Mr Jones presented to an '*extremely busy emergency unit*'.

41. I note for completeness that Bairnsdale Regional Health Service was provided with an opportunity to provide any comments or submissions in relation to my intended findings in relation to Mr Jones' death, and did not provide further information. However, the Court was assisted by the two statements provided in the course of the investigation, which included an undertaking to '*review this case along with the findings of the coroner to identify further learnings and opportunities*'.

RECOMMENDATIONS

While it cannot be said that Mr Jones' passing was preventable, it is my view that, given the outcome, the potential for systemic improvement should be identified, considered, and pursued. Pursuant to section 72(2) of the Act, and following advice of the CPU, I make the following recommendations:

(i) **To Bairnsdale Regional Health Service:** I recommend that Mr Jones' case be used for educational purposes as a case study for Emergency Department staff.

(ii) **To Safer Care Victoria**: I recommend that Safer Care Victoria consider whether further guidance is required to clarify the types of events (such as misdiagnosis leading to patient harm) that should be reported as adverse patient safety events, and which should be registered with the Victorian Health Incident Management System and formally investigated.

I convey my sincere condolences to Mr Jones's family for their loss and thank them for engaging with the coronial investigation.

DIRECTIONS

Pursuant to section 73(1A) of the Act, I order that this finding be published on the Coroners Court of Victoria website in accordance with the rules.

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

Margaret Jones, Senior Next of Kin

Caitlin Adams, Bairnsdale Regional Health Service

Safer Care Victoria

First Constable Charlie Dickinson, Coroner's Investigator

Signature:

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Coroner Ingrid Giles

Date: 28 May 2024

NOTE: Under section 83 of the ***Coroners Act 2008*** ('the Act'), a person with sufficient interest in an investigation may appeal to the Trial Division of the Supreme Court against the findings of a coroner in respect of a death after an investigation. An appeal must be made within 6 months after the day on which the determination is made, unless the Supreme Court grants leave to appeal out of time under section 86 of the Act.