IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2021 001876

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Coroner Simon McGregor
Deceased:	Reginald William Griggs
Date of birth:	26 July 1936
Date of death:	12 April 2021
Cause of death:	1(a) Respiratory failure complicating hospital acquired pneumonia following surgical treatment of recurrent nasal squamous cell carcinoma
Place of death:	Peter MacCallum Cancer Centre, 305 Grattan Street, Melbourne, Victoria, 3000
Keywords:	Peter MacCallum Cancer Centre, squamous cell carcinoma, tracheostomy, pneumonia, hospital acquired pneumonia, Advanced Care Plan, Advanced Care Directive

INTRODUCTION

1. On 12 April 2021, Reginald William Griggs was 84 years old when he died at the Peter MacCallum Cancer Centre (**PMCC**) following surgery for cancer of his jaw. At the time of his death, Reginald lived at 3 Heathfield Road, Brighton East.

2. Reginald's medical history included coronary artery disease requiring stenting, cardiac arrythmias, asthma, chronic pain, ischaemic heart disease, anaemia, and rheumatoid arthritis.[1]

3. In 2017, Reginald was diagnosed with a squamous cell carcinoma (**SCC**) of the left nasal cavity which was removed and treated with radiotherapy in March 2018.[2]

4. In late 2020, Reginald suffered from persistent swelling of the left mandible which led to the removal of several teeth by the dental team at PMCC. After continuing to suffer from pain and swelling, a scan was organised which diagnosed a further SCC of the left mandible.[3]

THE CORONIAL INVESTIGATION

5. Reginald'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.

[1] PMCC Medical records.
[2] PMCC Medical records.
[3] PMCC Medical records.

8. This finding draws on the totality of the coronial investigation into the death of Reginald William Griggs 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.[4]

9. In considering the issues associated with this finding, I have been mindful of Reginald's basic human rights to dignity and wellbeing, as espoused in the *Charter of Human Rights and Responsibilities Act 2006*, in particular sections 8, 9 and 10.

MATTERS IN RELATION TO WHICH A FINDING MUST, IF POSSIBLE, BE MADE

Circumstances in which the death occurred

10. On 22 March 2021, Reginald underwent surgery to remove the SCC which commenced with a tracheostomy[5] and a mandibulectomy[6] followed by a right ALT free flap to the excised area[7] and a removal of a basal cell carcinoma.[8]

Pneumonia

11. Reginald's post-operative course, whilst well-documented by PMCC, was not straightforward. He was noted to suffer from pneumonia which was diagnosed as either aspiration pneumonia or hospital-acquired pneumonia. During Reginald's pre-operative assessments, it was noted that he had swallowing difficulties since his surgery in 2017-18 which had led him to limit his diet.[9]

12. Chest X-rays and CT scans appeared to have never revealed more than minor changes, however, and the infectious diseases team was involved from early in his course and appropriately escalated Reginald's antibiotics when he failed to improve.[10]

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[4] 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.

[5] A tracheostomy is performed by making a hole in the trachea to allow access to the mouth for surgery and to protect the airway. This also facilitates a slow and controlled return to patient breathing and swallowing.

[6] A mandibulectomy is a partial removal of the jaw.

[7] The removal of a section of tissue from the thigh which is then transplanted to the area where the tumour was removed.

[8] PMCC Medical records.

[9] PMCC Medical records.

[10] PMCC Medical records.

Delirium

13. Reginald was noted to suffer from mental state changes throughout his post-operative phase which were noted from early on and described as a "hypoactive delirium." He was frequently described as more confused and impulsive overnight and "pleasantly confused" during the day, with significant lucid periods.[11]

14. Early in his post-operative course Reginald described his condition as "horrendous" and he repeatedly expressed his wish to die. This appears to have been variously attributed to his delirium or a reactive depression. Psychiatric services were involved in his care.[12]

Troponin rises

15. On 26 March 2021, an assessment of Reginald's troponin levels was conducted as part of the investigation of his confusion the night before. Whilst it was found to be mildly elevated, Reginald denied any chest pain and there were no changes on his electrocardiogram (**ECG**).[13]

16. Reginald was reviewed by the cardiology team who felt it was a Type II myocardial infarction which is generally considered to reflect 'strain' on the heart causing a 'leak' of troponin, rather than the blockage of a coronary artery.[14]

Slow tracheostomy wean

17. Before removing the tracheostomy, it was necessary to assess whether Reginald was likely to be able to survive without it. The two major concerns were ensuring he could clear (cough up) secretions from his lungs and that, after the surgery, he had sufficient function in his throat for saliva or food to be directed down the oesophagus rather that trachea.[15]

18. A tracheostomy 'wean' involves gradually increasing the amount of time that the tracheostomy tube's inflatable cuff is deflated, and repeatedly assessing how patient the finds breathing, clearing secretions, comfort, and, eventually, swallowing.

[11] PMCC Medical records.
[12] PMCC Medical records.
[13] PMCC Medical records.
[14] PMCC Medical records.
[15] PMCC Medical records.

19. Clinical staff noted that there were many factors in Reginald's case that suggested that this would not be easy, including multiple surgeries, pre-operative swallowing difficulties, evidence of chest infection or poor ability to clear secretions from the start, frailty, delirium, and, with time, deconditioning.[16]

20. On 8 April 2021 at 11.00am, Reginald had his tracheostomy removed. His swallowing was still impaired but there had been no evidence of aspiration with the cuff down for 48 hours. Reginald was judged to be sufficiently strong to clear his secretions but at some risk of fatiguing. It appears that Reginald's surgeons, medical team, speech pathology, physiotherapy, and nursing staff were all involved in the decision.[17]

MET calls

21. On 9 April 2021, a Medical Emergency Team (**MET**) call was activated after Reginald was found to have low oxygen saturations, increased secretions, and "gurgly upper airway sounds". He was managed with suction and supportive care and his tracheostomy was re-inserted with a plan to monitor and consider admission to the Intensive Care Unit (**ICU**) if there were any further problems.[18]

22. At 4.30pm, a second MET call was made after Reginald was observed to have a high respiratory rate and low oxygen saturations. His case was discussed with the ICU team however it appears that a decision was made to decline admission based on his "advanced age, multiple comorbidities, and inpatient medical issues".[19]

23. Following "multiple discussions with [his] family", staff became aware of Reginald's Advanced Care Plan (**ACP**). A copy of the ACP was obtained which specified that Reginald had refused "CPR – prolonging life without quality or dignity. Ventilators." A decision was made that if he deteriorated over night, Reginald would not be for resuscitative measures.[20]

24. Over the subsequent days, Reginald became delirious and appeared to be in at least moderate distress consistent with aspiration pneumonia.[21]

[16] PMCC Medical records.
[17] PMCC Medical records.
[18] PMCC Medical records.
[19] PMCC Medical records.
[20] PMCC Medical records.
[21] PMCC Medical records.

25. On 11 April 2021, Reginald was referred to the Palliative Care team who commence hydromorphone, midazolam, and haloperidol to manage his symptoms, with the nursing team noting ongoing restless and agitation.

26. On 12 April 2021, Reginald's condition deteriorated further and, at 4.01pm, he passed away.[22]

Identity of the deceased

27. On 12 April 2021, Reginald William Griggs, born 26 July 1936, was visually identified by his daughter, Sarah Griggs.

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

Medical cause of death

29. Senior Forensic Pathologist Dr Matthew Lynch from the Victorian Institute of Forensic Medicine (**VIFM**) conducted an examination on 13 April 2021 and provided a written report of his findings dated 14 April 2021.

30. The post-mortem examination revealed evidence of recent left mandibulectomy and skin grafting, calcific coronary artery disease, and left basal consolidation. Other findings were consistent with the history given.

31. Toxicological analysis was not indicated and was not performed.

32. Dr Lynch provided an opinion that the medical cause of death was 1 (a) *respiratory failure complicating hospital acquired pneumonia following surgical treatment of recurrent nasal squamous cell carcinoma*.

33. On the basis of the available evidence, Dr Lynch opined that the death was due to natural causes.

34. I accept Dr Lynch's opinion.

[22] PMCC Medical records.

FAMILY CONCERNS

35. On 19 April 2021, Reginald's daughter, Sarah Griggs, wrote to the court and expressed concerns regarding the care that her father received, as well as pertaining to the communication between PMCC and Reginald's family.

CPU REVIEW

36. To assist with my investigation into Reginald's death, I requested that the CPU undertake a review of the care that Reginald received during his time at PMCC in the context of the concerns received from Sarah in her correspondence dated 19 April 2021.

37. The CPU considered sources of evidence including Reginald's court file, his medical records, the letter of concern received from Sarah, and a response to statement questions sent to Dr David Speakman, Chief Medical Officer at PMCC.

Causal links between the removal of the tracheostomy and Reginald's pneumonia

38. The CPU noted that Reginald had been suffering from pneumonia throughout his post-operative course, and that a removal of the tracheostomy had the potential to result in more severe aspiration events, however the process of assessing and removing the tracheostomy was standard and reasonable.

39. The assessment revealed numerous risk factors, but these appeared to have been accepted as part of the decision to remove the tracheostomy, as the only alternative would have been to leave it in-situ. This is not generally considered to be a long-term option, however.

40. The CPU concluded that the assessment of suitability for the removal is, essentially, a trial of less and less protection from the tracheostomy to the point where it is removed completely. The CPU considered that Reginald's decannulation was at the riskier end of the acceptable range but not unreasonable, and was the result of an informed, multidisciplinary decision.

41. The CPU also noted that although medical staff differed somewhat in their description of the pneumonia (aspiration pneumonia or hospital acquired pneumonia) the diagnosis of pneumonia was mentioned in almost every medical note, investigated, and appropriately treated. It is not clear from the notes how often the family were updated, and the contents of such conversations are not recorded.

Reginald's Advanced Care Plan

42. Following a review of Reginald's care and subsequent death, the CPU noted that, despite his advanced age and comorbidities, there appeared to be little evidence of appropriate consideration of his possible deterioration or death following the surgery.

43. In particular, medical staff at PMCC were not aware of his ACP until the MET call on 9 April 2021 that heralded his ultimate deterioration. This was after more than two weeks' hospitalisation that was characterised by complications and slow progress.

44. On 16 March 2021, Reginald completed an ACP with his general practitioner, Dr David Fox. It is reasonable to conclude that Reginald was aware of the risks of the surgery, and he was taking steps to prepare for every eventuality.

45. Reginald's ACP included both an Instructional Directive and a relatively detailed Values Directive. His comments in the values directive started with the comment, "Quality of life matters most to me" which included comments relating to his fear that he would not be able to take care of himself.

46. On 22 March, Reginal was admitted for surgery with his Goals of Care being documented as "A – No treatment limitation". This did not appear to have been changed until 11 April when it was updated to include a refusal of CPR, intubation, or Code Blue medical emergency calls.

47. Reginald's documented Goals of Care were initially inconsistent with his ACP. Section 50 of the *Medical Treatment Planning and Decisions Act 2016* requires that, should a patient lose the capacity to make decisions regarding their health, health practitioners must make reasonable efforts in the circumstances to locate an advance care directive and medical treatment decision maker. It does not appear that this was actioned until the MET call occurred on 9 April 2021.

48. The CPU also noted that, from the MET call of 9 April, there was a delay in recognising and responding to Reginald's impending death. Certainly, his referral to palliative care (on 11 April) was very late in his clinical trajectory.

Response from PMCC

Lack of awareness of Reginald's ACP

49. The court sent statement questions to Dr David Speakman, Chief Medical Officer at PMCC. On 11 August 2022, Dr Speakman provided a response to these questions; these were then provided to the CPU for further analysis in the context of the issues identified above.

50. The CPU noted that, on 10 March 2021, the PMCC Pre-Anaesthesia Clinic Nurse Consultant asked Reginald whether he had appointed a Medical Treatment Decision Maker or had an ACP. When he responded that he did not, paperwork was sent to Sarah which was completed by Dr Fox on 16 March 2021, however Dr Speakman was unable to confirm whether the completed paperwork was sent or received by PMCC.

51. The CPU posited that issues regarding the transmission and handling of documents may have contributed to a lack of awareness however it is likely that, during the consent process, clinicians did not ask about whether an ACP had been completed or adequately explored Reginald's wishes in the event of complications from his procedure. Even if they had done so, it is certainly clear that such a conversation was not adequately documented.

52. Whilst Dr Speakman was unable to elucidate as to why Reginald's treating clinicians were unaware of the existence of his ACP, he described subsequent improvements in PMCC's policies and procedures regarding ACPs which was led by Dr Sonia Fullerton, Senior Palliative Care Consultant and Deputy Chief Medical Officer. This includes the provision of pre-admission questionnaires that specifically address the issue of ACPs, as well as electronic prompting functionality and further training for administrative and clinical staff in the recording and documentation of ACPs.

53. The improvements and processes described by Dr Speakman following Reginald's death appear to me to be reasonable and appropriate given the circumstances.

Delayed palliative care review

54. With regards to the apparent delay between Reginald's deterioration on 9 April 2021 and the subsequent initiation of palliative care measures on 11 April, Dr Speakman reported that "as needed" (**PRN**) morphine was available immediately after the MET call on 9 April and a referral to the Palliative Care team was made on 10 April, however the team had left the hospital and so the review did not occur until the following day.

55. I am satisfied that the immediate provision of PRN morphine was the most important appropriate response to Reginald's deteriorating condition, and that the reason for the delay between Reginald's deterioration and subsequent palliative care is sufficient, given that he received appropriate symptomatic treatment.

Communication between PMCC and Reginald's family

56. In her correspondence with the court, Sarah expressed concerns regarding communication issues between Reginald's treating clinicians and his family (including a lack of communication regarding the initiation of the MET call on 9 April 2021, the diagnosis of Reginald's pneumonia and subsequent treatment, and a lack of a single point of contact for his family).

57. Whilst concerns regarding communication between treating facilities and patients' families are not traditionally within the remit of the coronial jurisdiction, Dr Speakman was invited to respond to these concerns directly in his response of 11 August 2022.

58. Dr Speakman acknowledged the communication issues between Reginald's treating clinicians and his family and apologised for the lack of timely or effective communication about his pneumonia diagnosis. He also highlighted the difficulties inherent with multiple treating teams and stated that PMCC is working with their Quality unit on addressing this ongoing and complex issue. The CPU agreed with this assessment, noting that communication issues often manifest in when large numbers of highly specialised medical teams are involved in patient care.

59. Dr Speakman also addressed the issue of the MET call and stated that the "records indicate that [Reginald's] family were informed about the MET call by Dr Chia at [1.34pm]" and, with regards to the issue of aspiration pneumonia, that it may occur with or with a tracheostomy in-situ and, correctly, believed it was done appropriately.

60. Following Reginald's death, the Adverse Committee Meeting identified that documentation of the discussion of risks of surgery and communication with the family "could have been better." Dr Speakman attested that these findings were discussed with the lead surgeon and "major recommendations around Mr Griggs' case were for improvements in communication from the surgical team, both written, and verbally for the family and/or carers" were made.

61. I note that it is open to Sarah to address these concerns further with PMCC should she have further questions or make a complaint to the Health Complaints Commissioner.

CPU Conclusion

62. The CPU concluded that Reginald's medical management appeared to have been reasonable, and that the subsequent hospital review appropriately identified issues stemming from the documentation of discussions with family members and handling of ACP documents.

63. Following the review of Reginald's death by PMCC, appropriate recommendations were also made and acted upon however the CPU noted that communication issues are endemic to healthcare and are well-recognised as difficult to cure.

FINDINGS AND CONCLUSION

64. 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 explications.[23] Adverse findings or comments against individuals in their professional capacity, or against institutions, are not to be made with the benefit of hindsight but only on the basis of what was known or should reasonably have been known or done at the time, and only where the evidence supports a finding that they departed materially from the standards of their profession and, in so doing, caused or contributed to the death under investigation.

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

    a) the identity of the deceased was Reginald William Griggs, born 26 July 1936;

    b) the death occurred on 12 April 2021 at Peter MacCallum Cancer Centre, 305 Grattan Street, Melbourne, Victoria, 3000, from *respiratory failure complicating hospital acquired pneumonia following surgical treatment of recurrent nasal squamous cell carcinoma*; and

    c) the death occurred in the circumstances described above.

[23] *Briginshaw v Briginshaw* (1938) 60 CLR 336 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…'.

RECOMMENDATIONS

66. Whilst appropriate internal improvements were made by PMCC following Reginald's death, I do not consider it to be good medical practice that under circumstances such as these (consenting an elderly patient for high risk cancer surgery or, later, managing the subsequent complications) that there was no medical documentation describing a discussion with patient about goals and limitations of therapy that might have discovered the ACP or previously expressed wishes about treatment and acceptable outcomes.

67. It is reasonable to conclude that this is because the questions were not asked (by multiple staff at multiple points in time), rather than simply not documented. I do note, however, that PMCC has improved their policies and procedures regarding the ascertainment of the existence and documentation of ACPs.

68. The above notwithstanding however, I believe that there is scope for the wider medical community to be made aware of the need to clarify the existence of ACPs, especially for vulnerable patients.

69. Therefore, pursuant to my prevention function under section 72(2) of the Act, I make the following recommendation:

    I recommend that the Department of Health works with its relevant stakeholders to raise awareness about the importance of initially ascertaining and properly documenting the existence of an Advanced Care Directive, as well as conducting proper Goals of Care discussions, especially in elderly and vulnerable cohort of patients.

I convey my sincere condolences to Reginald's family for their loss.

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:

Giovanna Griggs, Senior Next of Kin

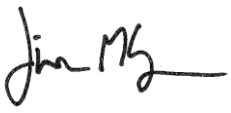
Professor Mike Roberts, Safer Care Victoria

Laura Sparks, Peter McCallum Cancer Centre

The Hon. Mary-Anne Thomas, MP, Minister for Health

Constable G. McLaren, Victoria Police, Reporting Member

Signature:



Coroner Simon McGregor

Date : 16 March 2023

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.