IN THE CORONERS COURT
OF VICTORIA
AT SHEPPARTON

Court Reference: COR 2010 000376

FINDING INTO DEATH WITH INQUEST

Form 37 Rule 60(1)
*Section 67 of the **Coroners Act 2008***

Inquest into the Death of GEORGE A HUTTON

Delivered On:	Monday 26th November 2012
Delivered At:	Shepparton Coroners Court
Hearing Dates:	20 August to 22 August 2012
Findings of:	Ms Stella Maria Stuthridge, Coroner
Representation:	Mr P. Halley – Family Mr D. Wallis – Benalla Health and Dr A. Knight
Coroners Assistant	L/S/C C. Cole

I, Stella Maria Stuthridge, Coroner, having investigated the death of GEORGE ALBERT JOHN HUTTON

AND having held an inquest in relation to this death on 20 August to 22 August 2012

at Shepparton Coroners Court

find that the identity of the deceased was GEORGE ALBERT JOHN HUTTON

born on 13 October 1936

and the death occurred On 26 January 2010

at 225 Castle Hill Road, Moorngag Victoria 3673

from:

1a RUPTURED ABDOMINAL AORTIC ANEURYSM

in the following circumstances:

Introduction

The *Coroners Act* 2008 (Vic) prescribes my functions. The primary purpose of the coronial investigation of a reportable death[1] is to ascertain, the identity of the deceased person, the cause of death and the circumstances in which the death occurred.[2]

My secondary role is to comment or make recommendations on any other matter connected with a death including public health, safety or the administration of justice.[3] As a Coroner I am not permitted to include in a finding any statement that a person is or may be guilty of an offence. Similarly, it is not my role to make any specific finding on whether there has been any negligence, giving rise to the death. As Justice Nathan noted in the matter of *Harmsworth v State Coroner* [1989] VR 989, a Coroner's power of investigation is not `free-ranging`.

A coroner is not bound by the normal rules of evidence.[4] Where findings of fact are to be made, the test is whether there is sufficient evidence to be satisfied of a particular fact on a balance of probabilities. When a coroner is considering issues of causation, in relation to individuals or entities, acting in their professional capacity, a higher standard of proof applies.[5] I have applied this higher standard in relation to the medical evidence in these proceedings.

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[1] *Coroners Act*, 2008 (Vic) s. 4
[2] *Coroners Act*, 2008 (Vic) s. 67
[3] *Coroners Act*, 2008 (Vic) s. 72(1),72(2) and 67(3)
[4] *Coroners Act*, 2008 (Vic) s. 62
[5] *Coroner's Case No 2912/01*, Coroner Byrne; *Briginshaw v Briginshaw* (1938) CLR 336

Inquests can be difficult for families. Often they do not resolve the many issues that have arisen because of the death of a loved one. Nevertheless, it is an opportunity to question and to enquire if the circumstances could have been different.

Initial Investigation

In the initial stages of this investigation, errors were made in the preparation of the Preliminary Examination Report and with the Courts communication with Ms Jill Baker, Mr Hutton's partner. These errors added unnecessarily to the distress experienced by Ms Baker. The Victorian Institute of Forensic Medicine and the State Coroner have reviewed those issues. On behalf of the Coroners Court of Victoria, I extend my apologies.

The Circumstances

Mr George Albert John Hutton was 73 years old. He was retired and lived on a farm in Moorngag, Victoria. He had been married to Ms Jill Baker for approximately 23 years. The couple lived together, with Ms Baker working in Melbourne, Monday to Friday.

Dr De Crespigny was Mr Hutton's usual doctor. Mr Hutton was taking Coversyl Plus and aspirin for high blood pressure and had an episode of atrial fibrillation approximately 6 or 7 years before his death. Mr Hutton had recently lost weight, on the advice of his doctor.

On Monday the 25th January 2010, Ms Baker woke at 5 am and Mr Hutton at about 5.30 am. There was nothing unusual about their morning routine.

At lunchtime on Monday, Mr Hutton did not answer a telephone call from Ms Baker. At approximately 5.30pm, Ms Baker telephoned again and spoke with Mr Hutton. Mr Hutton told her that when he was cleaning his teeth that morning, he heard a noise outside and turned sideways to look. At that moment he said he felt a sharp pain in his abdomen. He described the pain as agonising and he thought he was going to faint. He told Ms Baker he had to hold onto the bath to stay upright. He then returned to bed where he appeared to have remained for the day. Ms Baker recalled Mr Hutton had said to her that he had been sweaty and feverish during the day.

Ms Baker discussed with Mr Hutton about attending a Doctor.

She then telephoned the Church Street Clinic. They advised that Mr Hutton should attend the Casualty Department at Benalla Hospital. Ms Baker was under the impression that a Doctor from the

clinic would attend to see Mr Hutton at the Benalla Hospital. Ms Baker called Mr Hutton and he drove himself to Benalla Hospital.

Mr Hutton arrived at Benalla Hospital at 6.30pm on the 25th January 2010. The hospital records indicate Mr Hutton described the onset of the pain on twisting and that the pain was across the lower abdomen. In the medical notes, Mr Hutton is recorded as feeling discomfort and vaguely unwell. He is recorded as having no pain on urination (dysuria). Nursing staff took Mr Hutton's pulse, blood pressure, temperature, oxygen saturations, respiratory rate and a urine sample.

The triage Nurse observed Mr Hutton did not appear in pain to her, but he was telling her he was in significant pain. She did not observe him to be sweaty or dizzy. She said Mr Hutton said he did not have pain at the time she palpitated his abdomen. This occurred when Mr Hutton was lying down. When she took his vital signs, she obtained a blood pressure of 110/65. It was put to her in cross examination that this was low in a man with high blood pressure. She answered she felt the blood pressure was within the normal range. At approximately 5.40 pm the urine sample results showed nitrates, blood and protein were present. This was suggestive of a urinary tract infection.

Mr Hutton was seen by Dr Knight, the on call doctor, at 7.24 pm. Dr Knight examined Mr Hutton, who had available to him the observations taken by the nursing staff, and noted he was not visibly distressed. Mr Hutton described his pain to Dr Knight as mild whilst lying down. He confirmed he had not taken any analgesic tablets. On examination, Dr Knight found moderate tenderness in the left kidney area and suprapubic area. Dr Knight felt it was likely Mr Hutton had a urinary tract infection and prescribed Ibilex, an antibiotic. Mr Hutton was discharged and advised to return to casualty if he became increasingly unwell.

At around 7.30 pm, Ms Baker called Mr Hutton who said he was in casualty at Benalla Hospital. Mr Hutton told Ms Baker that he was still in pain and that if he lay in one position the pain stopped but returned with any movement or standing. Shortly after this call, Mr Hutton was discharged from the Hospital. Ms Baker again spoke to Mr Hutton when he was leaving the Hospital and getting into his car. Ms Baker was surprised Mr Hutton was being sent home. He was not someone who normally complained. He sounded to her as if he was very sick. He described himself to her, as feeling awful. Ms Baker was very concerned.

At around 10 pm, Ms Baker called Mr Hutton again. Ms Baker offered to drive home. Mr Hutton said he was going to bed as he felt unwell and needed to lie down.

On Tuesday 26th January 2010, at 6.45am, Ms Baker telephoned Mr Hutton and there was no answer. She continued to phone both the home and mobile phone without success. At 8am she was so worried she drove home. When she arrived, she found Mr Hutton had passed away. She telephoned '000'. Ambulance and police attended.

A preliminary examination was undertaken of Mr Hutton by Dr Marian Wang, forensic pathologist. The examination included a CT Scan of Mr Hutton, which revealed a ruptured abdominal aortic aneurysm.

Concerns about the failure to diagnose Mr Hutton's abdominal aortic aneurysm.

A central concern of the Inquest was whether Dr Knight should have diagnosed Mr Hutton's abdominal aortic aneurysm, thus allowing timely and possibly life saving medical intervention. At the Inquest, I heard evidence from Dr Knight who treated Mr Hutton. I also heard evidence from Dr Eddy, an emergency medicine specialist who provided an expert opinion for the Court and, Dr Moynihan who provided an expert opinion for the family. Ultimately, all three doctors agreed with the contents of Dr Eddy's report.[6] Dr Eddy's report provided a comprehensive explanation of abdominal aortic aneurysms and their diagnosis and treatment as follows:

> "The aorta is the main artery leaving the heart, branching to supply all parts of the body and ending in the abdomen when it divides into the common iliac arteries that supply the pelvis and lower limbs. The whole of the cardiac output enters the aorta. The abdominal aorta is referred to as a retroperitoneal structure, in that it is not within the abdominal cavity, but runs on the back wall of the abdomen.
> An abdominal aortic aneurysm (AAA) is a localised dilation or 'ballooning' of the aorta in the abdomen. This dilation involves stretching of all three layers of the vessel wall. … Most AAA's involve the aorta below the renal arteries and although some are due to trauma, infection or inflammation, most are due to atherosclerosis and 'degeneration' as age progresses. There is some familial associations, but they are associated with hypertension (high blood pressure) and atherosclerotic vascular disease. These are rare at less than 50 years of age and are commoner in men. The natural history of an AAA is that it will progressively enlarge, eventually resulting in rupture. The rate of expansion is variable and not predictable but the risk of rupture increases with increasing size. Due to its location on the back wall of the abdomen, rupture can occur in two ways. Rupture directly into the abdominal cavity would generally lead to rapid loss of blood volume, shock and death if not treated. Rupture may also occur into the tissues around the aneurysm and this may lead to a process called tamponade where the pressure of the blood in the tissues seals off the rupture, at least for a period. This would commonly progress to further loss of blood into these tissues and or subsequent rupture into the abdomen, with death from hypovolemic (loss of blood volume) shock.
> Rupture into the tissues at the back of the abdomen, or even into the abdomen itself may not be catastrophic in the short term, as the rupture may be small, it may seal itself off and may only bleed

slowly or intermittently. This would be commonly referred to as a 'leaking AAA'. These would ultimately rupture.

The leakage of blood into these tissues forms what is referred to as a retroperitoneal hematoma. The symptoms of a sudden rupture and leak of blood into the retroperitoneum would be the sudden, acute onset of significant pain in the flank or back. It may radiate into the chest, low abdomen, groin and even the scrotum and testis in a male.

Because of the nature of this pain, it is a differential diagnosis for conditions affecting other structures in the retroperitoneum, in particular the kidney and ureters, but also back pain. Pain from an aortic aneurysm masquerading as renal colic or renal pain in the older patient is one of the classic 'red flags' in emergency medicine. Standard text books in Emergency Medicine and General Practice specialities would include AAA as a differential diagnosis of abdominal or flank pain, particularly in an older patient.

At the time of rupture the patient may collapse due to acute loss of blood pressure. Consciousness may then be regained as compensatory mechanisms are activated. If the amount of blood loss is insufficient to cause collapse or low blood pressure, pain may be the only symptom. It is not uncommon for patients with ruptured or leaking AAA's to have normal observations in the short term, if there has been insufficient blood loss to produce signs of shock. Even in patients with significant blood loss there may be relatively slow heart rate due to stimulation of the parasympathetic nervous system.

Abdominal examination of a patient with a 'leaking' or ruptured AAA may reveal a pulsatile mass in the abdomen and tenderness over this mass, as well as in the abdomen, flank, loin or back if ruptured. AAA's can be difficult or impossible to detect by abdominal examination in patients of large or obese body habitus, and so the absence of this clinical examination finding in such a patient should not be taken as excluding the possibility of an AAA.

It is …important to diagnose (AAA's) early, as the only effective treatment is operative intervention. The patient with a classic presentation of a ruptured AAA (a combination of low blood pressure, back or flank pain and a palpable pulsating mass in the abdomen) is relatively straightforward to diagnose. These patients need an operation immediately and if this is not available on site, then transfer to a centre that can perform surgery is urgent. Some patients may die before they get to an operating theatre, regardless of resuscitation attempts, but unless a decision is made to 'palliate' a patient with a ruptured AAA, attempts at transfer are <u>not</u> futile, even if transfer may take hours. However delays in operation increase morbidity and mortality. Depending on the rate of bleeding and other factors, patients who are not operated on for whatever reason may die very quickly or may not succumb for many hours.

The patient with a leaking, but contained AAA rupture is a different proposition, and although they may acutely deteriorate at any time, this may not happen for hours and in patients in whom operative intervention is warranted urgent attempts at transfer to a centre with the appropriate surgical service are warranted."

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[6] Transcript pg 31-49

In evidence Dr Knight conceded that once he considered an AAA as a possibility he should have undertaken the necessary investigations to exclude it with a CT Scan. It was noted in evidence by both Dr Eddy and Dr Moynihan that in a rural setting AAA are relatively uncommon but not rare. They also noted there were aspects of Mr Hutton's presentation that supported the diagnosis of a urinary tract infection. Dr Knight agreed with the evidence of the other doctors, that if Mr Hutton had been correctly diagnosed and transferred there was a reasonable prospect that he would have survived. Dr Knight noted he regretted not having Mr Hutton transferred for a CT scan.
In all the circumstances, once the diagnosis of a AAA was considered the failure to exclude it with a CT scan was a missed opportunity to indentify a life threatening condition and initiate urgent treatment.
Since the conclusion of the Inquest I have received correspondence from Ms Baker. In her letter, she makes the following comment:

> "My family and I admire Dr Knight for being so honest and open in his evidence. We are very grateful to him for that. He asked to meet me after the Inquest to offer his condolences. I think it took great strength of character to do that.
> My family and I have received much of our medical care over the years from rural Doctors – and where necessary from rural hospitals. A number of rural Doctors over the years have given us excellent, caring medical treatment. The medical staff who operate in the country do so without many of the bells and whistles of their city counterparts which makes what they do all the more remarkable. I am confident that Dr Knight is one of that group of rural doctors."

Education

During the Inquest, it became clear there was a need to encourage extra training for rural doctors in emergency medicine. In particular, identifying and managing conditions that are less common, such as AAA's. Dr Eddy gave evidence about the active outreach-training program that operates in Geelong, where he practises. Dr Moynihan provided written submissions in his role as President of the Rural Doctors Association of Victoria. The capacity of rural hospitals to offer emergency services is varied, and is largely dependant on the capabilities of responding doctors. It is important that rural hospitals actively source relevant continuing education for their doctors, including their on call general practitioners.

Rural doctors have been lobbying for many decades for a program of systematic workforce training and provision. In Victoria, the Department of Health provide training opportunities for rural doctors through subsidised continuing professional development, and there is also a similar Federal subsidy. There are presently regional general practitioner training programs in Bendigo, Wodonga and Warrnambool. The Royal Australian College of General Practice has recently upgraded its diploma in rural medicine to a Fellowship by the addition of one year's advanced training. However, Dr Moynihan has noted

> "Overall it is substantially left to individual practitioners to reflect upon and acquaint themselves with the differential diagnosis of different patterns of presentation and to work out from literature and education how to eliminate the more serious ones, especially when sophisticated imaging is not available. Not every [rural] location can afford a CT scanner, still less the 24/7 roster of radiographers."

COMMENTS

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

Since Mr Hutton passed away Benalla Hospital has obtained, staffed and now operates a CT scanner. The service is available 7 days a week, 24 hours a day. This facility is invaluable in diagnosing life-threatening conditions such at abdominal aortic aneurysms.

RECOMMENDATIONS

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

Government funded continuing education in emergency medicine should be available to rural general practitioners who regularly staff rural hospital emergency and urgent care facilities. Such training should not be confined to emergency life saving measures but include the identification and management of differential diagnosis (particularly in potentially life-threatening conditions) in rural settings.

The Department of Health should consider providing fully funded regular specialist training in emergency medicine to general practitioners who staff emergency departments or urgent care centres in rural hospitals.

Conclusion

Mr Hutton died during the night of the 25th January or the morning of the 26th January 2010. I am satisfied he died as a result of a ruptured abdominal aortic aneurysm.

Signature:

Stella Maria Stuthridge
Coroner
Date: 26 November 2012

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

This finding and recommendation to the Rural Doctors Association of Victoria and the Minister for Health.
Dr David Eddy
Dr Michael Moynihan