IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2012 1774

FINDING INTO DEATH WITH INQUEST

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

Inquest into the Death of: JUSTIN CHRISTOPHER PIOTROWSKI

Delivered On:	16 July 2014
Delivered At:	Coroners Court of Victoria
	Level 11, 222 Exhibition Street
	Melbourne 3000
Hearing Date:	16 July 2014
Finding Of:	AUDREY JAMIESON, CORONER
Police Coronial Support Unit	Leading Senior Constable Stuart Hastings

I, AUDREY JAMIESON, Coroner having investigated the death of **JUSTIN CHRISTOPHER PIOTROWSKI**

AND having held an inquest in relation to this death on 16 July 2014

at MELBOURNE

find that the identity of the deceased was **JUSTIN CHRISTOPHER PIOTROWSKI**

born on 1 July 1974

and the death occurred on 17 May 2012

at the Western Hospital, 148 Gordon Street, Footscray 3011

from:

1 (a) HYPOXIC BRAIN INJURY

1 (b) CARDIAC ARREST

1 (c) BOWEL VOLVULUS

in the following circumstances:

1. On 16 July 2014, a mandatory inquest under section 52(2)(b) of the *Coroners Act 2008* (Vic) (the Act) was held into the death of Mr Justin Christopher Piotrowski, because immediately before his death, Mr Piotrowski was "a person placed in....care" as it is defined in the Act. Mr Piotrowski had an intellectual disability and had been a client of the Department of Human Services Disability Services.

BACKGROUND AND CIRCUMSTANCES

2. Mr Piotrowski was 37 years of age at the time of his death. He lived at a Community Residential Unit operated by the Department of Human Services for people with intellectual disabilities located at 85 Killarney Drive, Melton (the residence). Mr Piotrowski had lived at the residence for approximately seven years. His mother, Mrs Anna Piotrowski, had previously cared for him until he reached 30 years of age.

3. Mr Piotrowski had a past medical history that included autism, congenital hydrocephalus with ventricular shunt, Hirschsprung's disease, constipation and a fractured right femur (2010).

4. On 27 April 2012, Mr Piotrowski was taken to his General Practitioner (GP), who referred him to the Sunshine Hospital Emergency Department (ED) with a suspected intestinal obstruction. On presentation to the ED, it was reported that he had been experiencing abdominal pain for two days and that he had not opened his bowels for three days. Objective examination noted that his abdomen was distended. Plain abdominal films revealed distended loop of large bowel and faecal loading around the ascending colon, representing a partial bowel obstruction. He was assessed by the Surgical Registrar who performed an examination and rigid sigmoidoscopy. He was admitted to the surgical ward for observation and intravenous fluid therapy and was discharged to his mother's care on 29 April 2012 after he demonstrated clinical improvement. He returned to the residence on 30 April 2012.

5. On Friday, 11 May 2012, Mr Piotrowski was picked up by his sister, Nicole to stay with her over the weekend. On 13 May 2012, residence staff picked him up from Nicole's house to attend a day trip.

6. On the morning of 14 May 2012, residence staff had noticed that Mr Piotrowski's abdomen was again distended. He was observed walking around the residence just before 10.00am. Staff discussed his need for medical review at approximately 10.00am. Mr Piotrowski was located unconscious by residence staff at approximately 10.05am. Emergency Services were contacted and staff commenced cardiopulmonary resuscitation. Paramedics attended within 10 minutes and continued resuscitation attempts. Approximately 40 minutes later, upon return of spontaneous circulation, Mr Piotrowski was transported via ambulance to the Western Hospital ED in Footscray, arriving at approximately 12.00pm. He as assessed as having suffered a cardiac arrest.

7. Mr Piotrowski remained hypoxic and hypotensive in the ED despite manual ventilation, due to a grossly dilated abdomen.[1] Western Health Intensive Care Physician Dr Forbes McGain called for the assistance of General Surgeon Mr Rod Jacobs to insert a colonoscope to disimpact his dilated large bowel, which occurred at approximately 1.30pm, at which time there was an obvious reduction in abdominal distension and a corresponding marked

[1] Dr McGain explained that abdominal distension can impede venous return to the heart, causing a shocked, hypotensive state, and can "cramp" the lungs, making ventilation difficult.

improvement in ventilation and oxygenation. Dr McGain concluded that Mr Piotrowski had experienced a pseudo-obstruction.[2]

8. At approximately 5.00pm, Mr Piotrowski was transferred to the Western Hospital Intensive Care Unit (ICU) in a medically stable state. Mr Piotrowski's family were informed that he was likely to have suffered a severe neurological insult.

9. On 15 May 2012, Mr Piotrowski was assessed as having sustained a severe neurological injury. Symptoms of bowel obstruction returned on 16 May 2012, and treating physicians were unable to effectively relieve the obstruction. After several family meetings, a decision was made to provide Mr Piotrowski with palliative care. Treatment was withdrawn on 17 May 2012 and Mr Piotrowski died shortly after. Mr Piotrowski became an organ donor.

FORENSIC PATHOLOGIST EXAMINATION AND EVIDENCE

10. Dr Michael Burke, Forensic Pathologist at the Victorian Institute of Forensic Medicine, performed an external examination upon the body of Mr Piotrowski, reviewed a post mortem CT scan and reviewed the Victorian Police Report of Death, Form 83. Anatomical findings were consistent with Mr Piotrowski having been an organ donor. Dr Burke ascribed the cause of Mr Piotrowski's death to a hypoxic brain injury secondary to cardiac arrest as a result of a bowel volvulus.

POLICE INVESTIGATION

11. The circumstances of Mr Piotrowski's death have been the subject of investigation by Victoria Police. Police obtained statements from Mr Piotrowski's GPs Dr Steven Zebic and Dr Thien Nguyen, a residence staff member, Western Health Coordinator of Safety and Quality (Division of Surgery) Dr Graeme Thompson and Dr McGain.

FURTHER INVESTIGATIONS

12. Mrs Anna Piotrowski contacted the Court in January 2014 requesting an adjournment of a Summary Inquest originally listed for 3 February 2014. An adjournment was granted in order for Mrs Piotrowski to obtain and peruse the coronial brief and medical examination report.

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[2] Dr McGain explained that the rapid relief of Mr Piotrowski's abdominal distension was not due to obstruction from adhesions, a malignancy, or other surgical pathology. Dr McGain also noted that people with severe constipation/poor bowel motility are at risk of developing pseudo-obstructions.

13. In letters dated 25 February 2014 and 2 July 2014, Mrs Piotrowski expressed concerns relating to her son having received Caltrate (and its relationship to the development of a bowel volvulus) after she instructed residence staff to cease providing it to her son.

14. The Coroners Prevention Unit (CPU)[3] was asked to review Mr Piotrowski's medical records on the Coroner's behalf.

15. The medical records reflect that Mr Piotrowski was prescribed Caltrate by Western Hospital Endocrinologist Dr Dutta on or around 18 April 2012, and that Caltrate was provided to him on 20 April 2012. The drug chart indicates that Mr Piotrowski received Caltrate for four days. It is unclear whether Caltrate remained in his Webster pack upon his discharge from Sunshine Hospital on 29 April 2012.

16. The records also reflect that the dose of Caltrate provided to Mr Piotrowski was within an acceptable therapeutic range.

17. The CPU identified two reports to the United States of America Food and Drug Administration (FDA) between 2004 and 2012 of bowel obstruction in patients taking Caltrate, however on inspection of these reports, the treating Physicians did not believe that Caltrate was responsible for the development of bowel obstruction.

18. The MIMS Full Prescribing Information handbook used by Australian Medical Practitioners similarly does not identify bowel obstruction/volvulus as a known complication of taking Caltrate.

19. As no evidence was identified that established a connection between the administration of therapeutic doses of Caltrate and the side effect of bowel obstruction/volvulus, no further investigation was undertaken.

FACTORS CAUSING OR CONTRIBUTING TO DEATH

20. The evidence supports a conclusion that Mr Piotrowski died on 17 May 2012 and that the cause of his death was a hypoxic brain injury secondary to cardiac arrest as a result of a bowel volvulus. The circumstances under which Mr Piotrowski died were, according to the

[3] The Coroners Prevention Unit (CPU) was established in 2008 to strengthen the prevention role of the coroner. The unit assists the coroner with research in matters related to public health and safety and in relation to the formulation of prevention recommendations, as well as assisting in monitoring and evaluating the effectiveness of the recommendations. The CPU comprises a team with training in medicine, nursing, law, public health and the social sciences.

forensic pathologist, consistent with Mr Piotrowski's relevant past medical history. There was no evidence to suggest any other cause or contribution to his death. Mr Piotrowski died from natural causes related to his development of a bowel volvulus.

COMMENTS

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

In all the circumstances, I am satisfied that there would be no benefit from conducting a full inquest into Mr Piotrowski's death or obtaining any further medical or other evidence, as neither would assist me to further understand the medical issues before me or the cause of Mr Piotrowski's death which resulted from natural causes in the context of the development of a bowel volvulus.

FINDINGS

I accept and adopt the medical cause of death as ascribed by Dr Michael Burke and I find that Justin Christopher Piotrowski died from natural causes being a hypoxic brain injury secondary to cardiac arrest as a result of a bowel volvulus.

AND I find that there is no relationship between the cause of Mr Piotrowski's death and the fact that he was "a person placed in care".

AND I further find that there has been no relationship identified between the administration of Caltrate and the medical cause of death.

Pursuant to section 73(1) of the **Coroners Act 2008**, I order that the following be published on the internet.

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

Mrs Anna Piotrowski

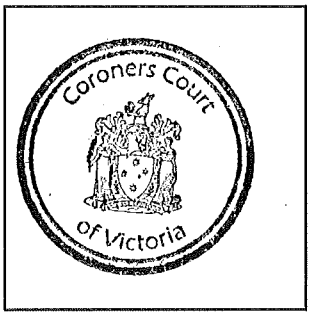
Mr Shane Beaumont, Department of Human Services – Disability Service

Dr Graeme Thompson, Coordinator of Safety and Quality (Division of Surgery), Western Health

Dr Steven Zebic and Dr Thien Nguyen, Medical One, Taylors Lakes

Constable M J Ong

Signature:



AUDREY JAMIESON
CORONER
Date: **16 July 2014**