

IN THE CORONERS COURT  
OF VICTORIA  
AT MELBOURNE

Court Reference: COR 2019 4427

**FINDING INTO DEATH WITHOUT INQUEST**

*Form 38 Rule 63(2)*

*Section 67 of the Coroners Act 2008*

Findings of:	Caitlin English, Deputy State Coroner
Deceased:	Robert Gerard Dimattina
Date of birth:	26 December 1960
Date of death:	20 August 2019
Cause of death:	1(a) Aspiration pneumonia complicating small bowel obstruction in the setting of recent elective subtotal colectomy for the treatment of colorectal adenocarcinoma
Place of death:	Epworth Eastern Hospital, 1 Arnold Street, Box Hill, Victoria

## INTRODUCTION

1. On 20 August 2019, Robert Gerard Dimattina was 58 years old when he died at Epworth Eastern Hospital (EEH), after undergoing a laparoscopic subtotal colectomy<sup>1</sup> for colon cancer on 14 August 2019.
2. In July 2019, Mr Dimattina underwent a biopsy, the results of which confirmed moderately differentiated (intermediate grade)<sup>2</sup> transverse colon cancer.<sup>3</sup>

## THE CORONIAL INVESTIGATION

3. Mr Dimattina'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.
4. 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.
5. 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.
6. I requested the assistance of the Coroners Prevention Unit (CPU)<sup>4</sup> to review the appropriateness or otherwise of the medical care Mr Dimattina received from Epworth Eastern Hospital in the period immediately prior to his death. In the course of the review, the CPU obtained statements from Ms Lisa Edwards, Director of Clinical Services, and Mr Vinna An, the colorectal surgeon.

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<sup>1</sup> A procedure to remove part of the large bowel, minimally invasive via telescope.

<sup>2</sup> The grade or 'differentiation' of cancer refers to the microscopic appearance of cancer cells. Cancers of a higher grade or 'poorly differentiated' are likely to grow or spread more quickly.

<sup>3</sup> The transverse colon is part of the large bowel.

<sup>4</sup> 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. The CPU also reviews medical care and treatment in cases referred by the coroner. The CPU is comprised of health professionals with training in a range of areas including medicine, nursing, public health and mental health.

7. This finding draws on the totality of the coronial investigation into the death of Mr Dimattina, including the evidence obtained during the course of the CPU review. 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.<sup>5</sup>

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

### **Identity of the deceased**

8. On 20 August 2019, Robert Gerard Dimattina, born 26 December 1960, was visually identified by his wife, Silvana Dimattina.
9. Identity is not in dispute and requires no further investigation.

### **Medical cause of death**

10. Forensic Pathologist, Dr Gregory Young, from the Victorian Institute of Forensic Medicine (VIFM), conducted an examination on 26 August 2019 and provided a written report of his findings dated 1 October 2019.
11. The post-mortem examination did not reveal any evidence of obvious bowel perforation, ischaemia,<sup>6</sup> infarction,<sup>7</sup> or pulmonary thromboembolism.<sup>8</sup>
12. Dr Young identified bronchopneumonia in the lungs associated with aspirated gastric contents.<sup>9</sup> Dr Young was of the opinion that the presence of pneumonia in the lungs indicated that aspiration occurred prior to death due to the amount of inflammation observed. The examination also revealed a kinked segment of small bowel extending through a defect in the omentum,<sup>10</sup> associated with proximal dilatation.

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<sup>5</sup> 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.

<sup>6</sup> An inadequate blood supply to tissues.

<sup>7</sup> The death of tissues due to ischaemia.

<sup>8</sup> A blockage of a pulmonary artery in the lungs.

<sup>9</sup> Contents from the stomach are inhaled into the lungs, which causes inflammation of the lungs (pneumonia).

<sup>10</sup> A curtain of fatty tissue in the abdomen which attaches to the bowel.

13. Dr Young provided an opinion that the medical cause of death was *“1(a) Aspiration pneumonia complicating small bowel obstruction in the setting of recent elective subtotal colectomy for the treatment of colorectal adenocarcinoma”*.
14. I accept Dr Young’s opinion.

#### **Circumstances in which the death occurred**

15. Mr Dimattina was diagnosed with colon cancer following a colonoscopy for investigation of iron deficiency anaemia. He did not have any other significant health conditions and was not taking regular medications.
16. On 14 August 2019, Mr Dimattina was admitted to EEH for a laparoscopic subtotal colectomy performed by Mr An. According to Mr An, the adenocarcinoma of the transverse colon was deemed resectable and potentially curable by surgical resection.
17. There were no complications during surgery and Mr Dimattina was returned to the ward for routine post-operative care.
18. On 19 August 2019, Mr An examined Mr Dimattina and noted that his abdomen was mildly distended but soft. His vital signs were normal and he had opened his bowels. In light of slow post-operative progress, Mr Dimattina was continued on a light ward diet and received slow intravenous therapy.
19. At approximately 11.00am on 20 August 2019, Mr An was notified that Mr Dimattina had become tachycardiac<sup>11</sup> at 128 beats per minute and hypoxic<sup>12</sup> with oxygen saturations of 89 per cent. He received oxygen and intravenous fluids, and arrangements were made for him to undergo a computed tomography (CT) scan of the abdomen and pelvis and a CT Pulmonary Angiogram (CTPA).<sup>13</sup> Mr An’s immediate concern was that Mr Dimattina was either dehydrated or had suffered a pulmonary embolism.
20. At approximately 12.30pm that day, Mr An reviewed Mr Dimattina and found that his abdomen was significantly distended. He attempted to insert a nasogastric tube (NGT) and his first attempt failed as the tube coiled in the back of the throat due to vomiting. The second attempt similarly failed due to further vomiting and Mr Dimattina lost consciousness.

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<sup>11</sup> An elevated heart rate, normal heart rate is 60 to 100 beats per minute.

<sup>12</sup> A low blood oxygen level. A normal blood oxygen level is greater than 95 per cent.

<sup>13</sup> CT scan with intravenous contrast to look for a pulmonary embolus.

21. At approximately 1.15pm, a code blue was called and Mr Dimattina was managed as per Advanced Life Support (ALS) protocols. He could not be resuscitated and was pronounced deceased at 1.40pm.

#### **CPU REVIEW OF MEDICAL CARE**

22. The Health and Medical Investigation Team (HMIT)<sup>14</sup> of the CPU reviewed the medical care provided by EEH Health to Mr Dimattina in the period immediately prior to his death. In conducting its review, the HMIT had regard to the statements received from Ms Edwards and Mr An.

#### **Statement from Lisa Edwards, Director Clinical Services, Epworth Eastern**

23. In her statement, Ms Edwards advised that Mr Dimattina's case was reviewed by the hospital's Clinical Review Committee, which is made up of specialist Visiting Medical Officers (VMOs) and chaired by an Intensive Care consultant. Further independent reviews were also conducted by the Victorian Audit of Surgical Mortality and by the September Clinical Review Committee meeting, which included an in-depth review by the Medical Director and a general/upper gastrointestinal surgeon. Ms Edwards noted that no specific issues were identified following any of the reviews. Despite this, she noted that during a VMO information night, there were discussions surrounding the indications and contraindications of NGTs.
24. According to Ms Edwards, no similar events have taken place at EEH and following Mr Dimattina's death, several detailed discussions took place with his wife in which the hospital offered her support.

#### **Statement from Vinna An, Colorectal Surgeon**

25. In his statement, Mr An detailed the informed consent process with Mr Dimattina and his wife that occurred in Mr An's consulting rooms on 31 July 2019. The proposed surgery and post-operative course were described in detail to Mr and Mrs Dimattina, and they were advised of several possible complications. Mr An recalled advising Mr and Mrs Dimattina that some of the complications could be minor and some life-threatening, such as bleeding

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<sup>14</sup> The role of the Health and Medical Investigation Team (HMIT) 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. HMIT 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.

during the procedure, re-bleeding in the recovery period, infection, pneumonia or an intra-abdominal infection, impairment of bowel and gastric motility, and risk of leakage from the bowel join requiring reoperation and stoma.

26. Mr An also provided a detailed overview of the procedure, during which there were no obvious difficulties or complications encountered.
27. Mr An also provided further details of Mr Dimattina's post-operative course, specifically daily reviews completed by either himself or Dr Philip Smart, the rostered weekend surgeon. According to Mr An, he reviewed Mr Dimattina in the afternoon of 19 August 2019 and observed that his abdomen was less distended. Mr Dimattina's nausea had settled, his bowels had opened several times and his appetite was returning. Mr An considered this to be positive progress and ordered oral fluids and soft foods if Mr Dimattina was able.
28. Mr An described Mr Dimattina's post-operative course as unremarkable and noted that he had an ileus,<sup>15</sup> but that this was a common complication of abdominal surgery occurring in up to 30 per cent of patients that undergo this operation.
29. At approximately 9.30am on 20 August 2019, Mr An received a call advising that Mr Dimattina had a fever and elevated heart rate. According to Mr An, he ordered a CT scan as he was concerned about a potential pulmonary embolus or other surgical complication such as a leak from the bowel join. At approximately 11.00am, Mr An reviewed Mr Dimattina again and observed that his abdomen was now much more distended than the previous day. Mr An was concerned that Mr Dimattina was at a high risk of vomiting and aspiration and therefore considered an NGT should be inserted as a matter of priority to relieve the distension and pressure, before a CT scan could occur.
30. Mr An then recounted in his statement the failed attempts to pass an NGT and Mr Dimattina's subsequent loss of consciousness.
31. Mr An was asked to comment on Dr Young's examination findings. He noted Dr Young's finding of a defect in the omentum as a portion had been resected with the cancer, and stated that there was no opportunity to detect this earlier as there was no indication that it was present. In particular, Mr Dimattina had opened his bowels several times in the days prior to his death, which suggested no mechanical blockage. Mr An commented that a significant

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<sup>15</sup> An ileus is an obstruction of the bowel due to paralysis.

obstruction would generally result in increasing abdominal pain and tenderness, and neither of these signs were present.

32. In relation to Dr Young's comment that the presence of pneumonia in the lungs is indicative of aspiration having occurred prior, given the amount of inflammation seen, Mr An noted that prior to 20 August 2019, there was no clinical indication that Mr Dimattina had aspirated gastric contents. At approximately 5.30am on 20 August 2019, Mr Dimattina complained of reflux but there were no clinical indications that he had aspirated gastric contents at this time or developed pneumonia. Further, Mr An stated that there was no clinical evidence of aspiration pneumonia, namely Mr Dimattina's vital signs had remained in the normal range and blood tests did not reveal any elevation of inflammatory marker.
33. Mr An described NGT insertion as an uncomfortable experience which often results in stimulating the gag reflex as the tube hits the back of the throat. He noted that vomiting is not uncommon during the procedure, but the risk is felt to be low in a patient who is alert and cooperative. Mr An stated that it was appropriate that NGT insertion was performed on the surgical ward and several steps were taken to minimise the risks of vomiting, including sitting Mr Dimattina upright at 90 degrees. Other preventative steps include ensuring the patient is awake and alert, which allows for the cough reflex to expel any fluid from the lungs. He further stated that larger tubes are less likely to coil in the back of the throat and improve the chance of successful insertion.
34. Mr An recounted his considerable experience with inserting NGTs and described himself as often being the "*last point of call for nurses and junior staff*" who experience difficulties in inserting NGTs.
35. According to Mr An, NGTs are not placed routinely in surgical patients undergoing colorectal surgery, but judged on a case by case basis. Due to the inherent risks and complications involved in NGT insertion, they are not routinely used in the management of surgical patients. Mr An explained that vomiting carries the risk of aspiration of gastric contents into the lungs, and an aspiration of a significant volume of gastric fluid could impair oxygenation and lead to loss of consciousness.
36. Mr An stated that Mr Dimattina's loss of consciousness and eventual death was unexpected, but the vomiting during NGT insertion was not unusual. He was unable to proffer any suggestions for preventing this unexpected outcome from occurring in the future.

## **Conclusion**

37. The HMIT ultimately considered the medical care provided to Mr Dimattina by EEH was reasonable and appropriate, and that appropriate consent and pre-operation preparation were performed. There were no immediate complications or difficulties encountered during the procedure, which was indicated and could potentially cure Mr Dimattina's colorectal cancer. He was reviewed by a surgeon daily and on the afternoon prior to his death, Mr An observed that his condition appeared to be improving.
38. The HMIT considered that Dr Young's findings at autopsy in relation to the bowel kinking did not appear to be clinically significant, and there was no prior clinical evidence of aspiration pneumonia or bowel obstruction.
39. There were no indications that NGT insertion was required at an earlier opportunity. The HMIT recognised that NGT insertion carries a risk of vomiting, which can uncommonly result in severe aspiration, and as such did not identify any intervention opportunities.
40. I accept and agree with the conclusions reached by the HMIT and find that no prevention opportunities existed in connection with Mr Dimattina's death.

## **FINDINGS AND CONCLUSION**

41. Pursuant to section 67(1) of the Act I make the following findings:
  - (a) the identity of the deceased was Robert Gerard Dimattina, born 26 December 1960;
  - (b) the death occurred on 20 August 2019 at Epworth Eastern Hospital, 1 Arnold Street, Box Hill, Victoria, from aspiration pneumonia complicating small bowel obstruction in the setting of recent elective subtotal colectomy for the treatment of colorectal adenocarcinoma; and
  - (c) the death occurred in the circumstances described above.

## **RECOMMENDATIONS**

Pursuant to section 72(2) of the Act, I make the following recommendations:

1. That the Royal Australasian College of Surgeons (RACS) use a de-identified version of this case as an educational tool to remind its members of the uncommon and unexpected severe risks associated with NGT insertion.



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

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

Mrs Silvana Dimattina, senior next of kin

Mr Vinna Ann

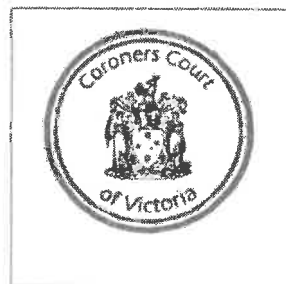
Mrs Allison Friar, Epworth Eastern Hospital

Royal Australasian College of Surgeons

Safer Care Victoria

Senior Constable Shona Valentine, Victoria Police, reporting member

Signature:



**CAITLIN ENGLISH**

**DEPUTY STATE CORONER**

Date: 29 January 2021

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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 six 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.

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