IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2018 005904

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Coroner Paul Lawrie
Deceased:	Paul Desmond Smith
Date of birth:	30 September 1960
Date of death:	23 November 2018
Cause of death:	1(a) COMPLICATIONS OF LARGE BOWEL PSEUDO-OBSTRUCTION
Place of death:	58 Ford Street, Newport, Victoria, 3015
Keywords:	Western Health, bowel pseudo-obstruction, medical record keeping

INTRODUCTION

1. On 23 November 2018, Paul Desmond Smith was 58 years old when he was found deceased at his home. At the time of his death, Mr Smith lived at 58 Ford Street, Newport with his mother, Lorraine Smith.

THE CORONIAL INVESTIGATION

2. Mr Smith'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.

3. 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.

4. 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.

5. Coroner John Olle originally had carriage of this investigation. Victoria Police assigned an officer to be the Coroner's Investigator for the investigation of Mr Smith's death. The Coroner's Investigator conducted inquiries on Coroner Olle's behalf, including obtaining records and statements from witnesses – such as the forensic pathologist and the treating clinician.

6. In October 2022 I took over carriage of this matter for the purposes of finalising the finding.

7. This finding draws on the totality of the coronial investigation into the death of Paul Desmond Smith 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.[1]

BACKGROUND

8. Mr Smith lived with his mother. He was single, unemployed and had no children. He had no regular general practitioner and took no regular medications.

9. On 18 November 2017, twelve months prior to his death, Mr Smith presented to the Western Hospital with an advanced and critical large bowel pseudo-obstruction.[2] He was admitted to intensive care where a very large faecal bolus was determined to be causing an abdominal compartment syndrome, hydronephrosis[3] and vascular compromise to the arteries supplying his right lower limb.

10. Mr Smith received intensive care treatment and manual disimpaction of faeces in the operating theatre. He spent three weeks in hospital and recovered.

11. During this admission, nursing and allied health documentation indicated that Mr Smith was 'vague' and inconsistent in his mental state, and in reporting his bowel symptoms. These notes indicate that he may also have had difficulty understanding instructions. It was also noted that Mr Smith declined safety recommendations made by the occupational therapist and 'self-discharged'.

12. Mr Smith was then scheduled for a colonoscopy on 12 January 2018 however the procedure was abandoned because of faecal loading – the procedure requires a completely empty bowel. This is usually achieved after several days of medication to induce diarrhoea. The failure of Mr Smith's bowel preparation may have been due to non-compliance with the recommended medication regime, or due to the regime being ineffective due to the degree of faecal loading.

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[1] 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.

[2] Dilation of the bowel without evidence of a mechanical obstruction beyond faecal loading, hence not amenable to surgical treatment beyond decompression. If dilation is unchecked, this can lead to thinning of the bowel wall, sepsis, and rupture. Causes may include chronic constipation or a bowel motility problem.

[3] Swelling in one or both kidneys due to the accumulation of urine when drainage from the kidney to the bladder is impaired.

13. The endoscopists recommended that Mr Smith be rebooked urgently for a further colonoscopy and be admitted so that nursing staff could ensure the bowel preparation was adequate prior to further colonoscopy attempts. However, Mr Smith declined this procedure.

14. On 1 June 2018, Mr Smith attended Western Health's renal outpatient clinic in Newport. He reported to the doctor that he 'has had no significant issue over the past few months with no symptoms of constipation'. Mr Smith reported that he opened his bowel regularly. Following this appointment, he was discharged from the clinic.

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

Circumstances in which the death occurred

15. At 6.46pm on 21 November 2018, Mr Smith presented to the Footscray Hospital Emergency Department (ED) with lower abdominal pain and reported that his bowels had not opened for four days. The ED staff noted Mr Smith's past admission a year prior and flagged him as a 'high risk'. An abdominal X-ray again demonstrated marked faecal loading with a maximal bowel dilation diameter of 19cm. The surgical registrar was contacted who suggested a fleet enema.[4]

16. Mr Smith was admitted to the Emergency Observation Unit (EOU) and the plan documented by the ED staff was for Mr Smith to have nil oral intake, receive intravenous fluids and be reassessed in the morning to consider a manual disimpaction in the operating theatre.

17. The only other documentation available from this admission was the discharge summary. This summary stated that Mr Smith had overflow diarrhoea after the fleet enema and Movicol. He was advised to continue taking Movicol and see his General Practitioner in three days if he had a poor response to the Movicol.

18. Mr Smith was discharged at 5.29pm on 22 November 2018 and returned home.

19. On 23 November 2018 Mr Smith had trouble consuming food and water. He reportedly did not appear well and spent most of the day sitting in a reclining chair. At approximately 5.30pm Mr Smith ate dinner before returning to the recliner.

20. At approximately 7.00pm, Mr Smith's mother discovered him slumped in the recliner. She contacted emergency services. Ambulance Victoria paramedics attended and attempted to

[4] A medication inserted per rectum to induce rectal emptying.

resuscitate Mr Smith. However, these attempts were unsuccessful, and he was declared deceased at the scene.

Identity of the deceased

21. On 23 November 2018, Paul Desmond Smith, born 30 September 1960, was visually identified by his mother, Lorraine Smith.

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

Medical cause of death

23. Forensic Pathologist, Dr Gregory Young from the Victorian Institute of Forensic Medicine (VIFM), conducted an autopsy on 29 November 2018 and provided a written report of his findings on 14 January 2019.

24. The post-mortem examination revealed that:

    a) Mr Smith had a large bowel pseudo-obstruction due to constipation, with 6.22kg of faeces within the large bowel. There was patchy mucosal ischaemic in the large bowel, but no evidence of perforation or peritonitis. The urinary bladder was dilated, as were the right ureter and right renal pelvis. Aspirated material (likely stomach contents) was seen in the right lung.

    b) Vitreous humour biochemistry showed elevated urea and creatinine (24 mmol/L and 133 µmol/L, respectively), consistent with renal impairment. Other results were non-contributory.

    c) There was no post-mortem evidence of any injuries which may have caused or contributed to Mr Smith's death.

25. Toxicological analysis of post-mortem samples did not identify the presence of any alcohol or any common drugs or poisons.

26. Dr Young noted that a large bowel pseudo-obstruction occurs when there is an apparent blockage of the affected segment of large bowel for which no anatomical cause is apparent. Constipation is commonly noted. Other causes include some medications, previous abdominal surgery, infection, or muscle or nerve diseases. Complications include metabolic and fluid imbalances, pressure effects on the diaphragm (leading to aspiration of gastric contents),

ischaemia of affected segments of bowel, and blockage of other structures (such as ureters, leading to renal impairment).

27. Dr Young provided an opinion that the medical cause of death was 1 (a) COMPLICATIONS OF LARGE BOWEL PSEUDO-OBSTRUCTION.

28. I accept Dr Young's opinion.

FURTHER INVESTIGATIONS AND CPU REVIEW

29. This matter was referred to the Coroners Prevention Unit (CPU)[5] Health and Medical Investigations Team (HMIT) for a review of the medical management provided to Mr Smith on 21 and 22 November 2018 by the Upper Gastrointestinal and General Surgery (UGIG) Unit at Western Health.

30. The HMIT noted that although Mr Smith did not volunteer a medical history of chronic constipation, it was highly unlikely that either of his presentations with large bowel pseudo-obstruction were new conditions and more likely represented an acute decompensation of a chronic untreated condition. They also noted that Mr Smith's limited health literacy and non-compliance with appointments may have been a barrier to the proactive management of his chronic bowel motility impairment.

31. Minimal documentation was recorded by Western Health during the course of Mr Smith's treatment on 21 and 22 November 2018. Consequently, a statement was requested from the Consultant at the UGIG Unit ('the Consultant') to provide detail of Mr Smith's care at Footscray Hospital.

Statement from the UGIG Consultant

32. The Consultant acknowledged that the surgical notes from Mr Smith's admission were brief. For the purposes of the statement, he relied on the notes and telephone conversations with the night surgical registrar and surgical fellow who attended to Mr Smith during his admission.

[5] 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.

33. The Consultant stated that Mr Smith was examined on admission by the night surgical registrar who subsequently admitted Mr Smith to the Short Stay Unit. An abdominal X-ray demonstrated marked faecal loading with a maximal bowel dilation diameter of 19cm and a rectal examination showed Mr Smith had hard stools with no blood. Mr Smith was flagged as 'high risk' due to previous complications arising from his previous admission in November 2017 and was treated with laxatives and fleet enema to induce bowel actions. The documented plan included reassessing Mr Smith during the morning ward round, with the possibility of manual disimpaction in the operating theatre if the treatment did not provide relief.

34. The notes from the morning ward round indicate the plan for Mr Smith to be treated with bowel preparation however the Consultant stated 'no other documentation was found regarding the diagnosis, likely complication and further investigations'.

35. No further surgical notes were made prior to Mr Smith's discharge. The Consultant stated it was not clear whether Mr Smith was seen by a doctor working within the UGIG prior to discharge, or who made the decision to send Mr Smith home after the morning ward round.

36. The discharge summary stated that Mr Smith had overflow diarrhoea following the use of fleet enema. In providing an explanation for the decision to discharge Mr Smith, the Consultant stated he 'appeared to have responded reasonably well to the fleet enema prescribed' and 'it appears from the discharge summary that the surgical team were happy with the patient progress'.

37. The discharge summary included a recommendation for further laxatives to be used with an increase of dosage if there were no further bowel actions in the day after discharge. It was also recommended that Mr Smith see a GP three days after discharge if the results from the laxatives were poor, and for a gastroenterology follow-up to take place.

38. Mr Smith had a dilated bladder, ureter, and kidney due to pressure on the draining organs from the faecal bolus. This was also present in the November 2017 admission. In response to a question of whether there was an opportunity for earlier diagnosis of urinary retention considering it was present in the November 2017 admission, the Consultant stated, 'it is not clear from the documentation whether there was appreciation of possible urinary retention'.

39. The Consultant acknowledged that Mr Smith suffered from acute on chronic constipation that failed to be addressed by any surgical follow up. He identified Mr Smith's presumed health literacy issues, non-compliance with appointments, and cancellation from the colonoscopy as

factors that contributed to his inadequate follow-up and poor ongoing bowel management. The Consultant stated that Mr Smith would have been referred to the surgical team had the colonoscopy been completed, and that this may have avoided Mr Smith returning to the ED on 21 November 2018 with a complicated pseudo-obstruction.

40. The Consultant further stated that Mr Smith's care would have been better managed by a prescribed bowel management program coordinated by the colorectal service. However, Mr Smith was never referred to the colorectal team.

Western Health weekly surgical audit

41. Mr Smith's care was discussed at Western Health's weekly surgical audit ('the Audit') on 28 June 2019. It was noted that while Mr Smith had a common condition, the lack of follow up after the November 2017 admission meant it was not clear how Mr Smith was managing his constipation.

42. The following points were highlighted by the Audit as 'Key Learnings':

    a) While Mr Smith may have been discharged based on the fact that his bowel had opened after laxatives and a fleet enema, the significance of the November 2017 admission and lack of specialist outpatient follow up should have alerted the surgical team to Mr Smith's clinical complexity and the need for longer inpatient management.

    b) The failure of Mr Smith to attend appointments and accept the repeat colonoscopy with inpatient bowel preparation prevented the opportunity to manage his care more effectively.

    c) There was minimal documentation of the management plan during Mr Smith's admission in November 2018, including no documentation related to diagnosis or discharge plans. The importance of in-patient documentation and communication was highlighted as a key learning.

FINDINGS AND CONCLUSION

43. The standard of proof for coronial findings of fact is the civil standard of proof on the balance of probabilities, with the caution required by *Briginshaw*.[6] Adverse findings or comments

[6] *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

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.

44. While constipation is a common and usually benign condition, in this case there was an apparent lack of appreciation that Mr Smith represented a high risk of complications due to his previous admission in November 2017 and poor self-management.

45. The surgical assessment conducted during the morning ward round on 22 November 2018 suggests that only a cursory review took place. It appears unlikely that this review took into account the significance of Mr Smith's medical history, the radiological finding of a dilated bowel, the potential for urinary obstruction and Mr Smith's poor compliance with follow-up after the November 2017 admission (during which he was critically unwell). In this context, Mr Smith should not have been discharged without a further surgical examination.

46. Mr Smith's discharge represents a missed opportunity to provide appropriate treatment to manage the obstructing faecal bolus by continued use of enemas, repeat X-rays to confirm decrease in the bowel dilation, or the manual disimpaction in an operating theatre as identified by the admitting ED doctor upon Mr Smith's admission.

47. Having considered all the evidence, I agree with the conclusion reached by the Audit that Mr Smith's medical history was not adequately considered in the management of his care, and that his previous lack of follow-up should have alerted the surgical team to treat him longer under inpatient management.

48. Additionally, the quality of the surgical assessments were inadequate due to minimal documentation regarding Mr Smith's management plan, including the absence of documentation in the decision to discharge Mr Smith. I welcome the Audit recognising the lack of documentation as a key learning and I encourage steps being taken by Western Health to improve the quality of documentation of assessments, clinical findings, and discharge plans.

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

    a) the identity of the deceased was Paul Desmond Smith, born 30 September 1960;

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…'.

b) the death occurred on 23 November 2018 at 58 Ford Street, Newport, Victoria, 3015, from COMPLICATIONS OF LARGE BOWEL PSEUDO-OBSTRUCTION; and

c) the death occurred in the circumstances described above.

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

Pursuant to section 73(1B) 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:

Gary Smith

Western Health

Safer Care Victoria

Senior Constable Gretta Lanyon, Coroner's Investigator

Signature:

Coroner Paul Lawrie

Date : 29 November 2022

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.