IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2019 7042

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Coroner Katherine Lorenz
Deceased:	John Francis Flynn
Date of birth:	12 December 1950
Date of death:	24 December 2019
Cause of death:	1(a) Hypoxic ischaemic brain injury 1(b) Right facial artery pseudoaneurysm rupture and haemorrhage
Place of death:	Peter MacCallum Cancer Institute, 305 Grattan Street, Melbourne, Victoria, 3000

INTRODUCTION

1. On 24 December 2019, John Francis Flynn (**Mr Flynn**) was 69 years of age when he died at the Peter MacCallum Cancer Institute (**PMCI**).

2. Mr Flynn was diagnosed with tonsillar squamous cell carcinoma which had been treated at the PMCI with chemotherapy and radiotherapy. His treatment was completed in August 2019.

3. On 12 December 2019, Mr Flynn had a Positron Emission Tomography (**PET**) scan which suggested that there was no metabolic evidence of residual treatment.

4. On 17 December 2019, during a routine follow-up, Mr Flynn complained of right-side throat pain which he reported had been increasing over months since surgery. Medical examination found that he was experiencing trismus[1]. He was prescribed Panadeine Forte and referred to the chronic pain team for out-patient treatment.

THE CORONIAL INVESTIGATION

5. Mr Flynn'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. I took carriage of this investigation in February 2021 from Coroner Bracken when I was appointed as a Coroner.

7. 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.

8. 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] Reduced ability to open the jaw caused by pain or spasm in the muscles used to chew some of which are located near the tonsillar bed.

9. This finding draws on the totality of the coronial investigation into the death of John Francis Flynn. Whilst I have reviewed all the available material obtained during the course of the investigation, 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.[2]

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

Circumstances in which the death occurred

10. On 18 December 2019, at approximately 1:00pm, Mr Flynn presented to the Royal Melbourne Hospital emergency department complaining of ongoing pain and bleeding from the throat.

11. An emergency department clinician reviewed Mr Flynn and consulted with the oncology team. His analgesia was increased, and a plan was made for discharge and outpatient follow-up.

12. At about 4:45pm, while Mr Flynn was waiting for his discharge medication, he coughed up a significant amount of blood. He was transferred to the high-acuity area of the emergency department and medication was given to stop the bleeding.

13. The Ear, Nose and Throat (**ENT**) team reviewed Mr Flynn and performed a nasoendoscopy which showed a large clot in the area of where the right tonsil used to be. There was no active bleeding at this time.

14. The ENT team planned to obtain a computed tomography (**CT**) angiogram to ascertain whether the bleeding vessel could be identified and embolized by interventional radiology. While Mr Flynn's airway was not considered to be at imminent risk at this time, it was noted that if the bleeding was to start again, Mr Flynn's airway would be at significant risk and intubation would be difficult.

15. At about 7:00pm, a CT angiogram was performed and Mr Flynn was subsequently transferred to the High Dependency Unit for observation and to await embolisation.

16. At about 8:00pm, Mr Flynn began coughing up blood again and his blood pressured dropped. By 8:50pm, he arrested and cardio-pulmonary resuscitation was commenced. He was revived

[2] 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.

about 10 minutes later. An ENT registrar and consultant performed a cricothyrotomy and packed his upper throat with gauze to stem the bleeding.

17. The final CT angiogram report was completed as he was being resuscitated and identified a right facial artery pseudoaneurysm and a residual tumour in the tonsillar bed. The scan also revealed a vessel that could be embolized but given the expected time to mobilise the interventional radiology team was going to be over 30 minutes, the decision was made by the ENT team to convey Mr Flynn to theatre where the external carotid was tied-off, a tracheostomy was placed and the cricothyroidotomy was removed.

18. Following the procedure, Mr Flynn was admitted to the Intensive Care Uni where he showed signs of brain damage. This was confirmed by a CT scan performed on 24 December 2019 which showed extensive ischaemic changes.

19. Mr Flynn's prognosis was assessed as poor and, following discussions with family, he was palliated and transferred to the PMCI where he died at 11:28pm, 24 December 2019.

Identity of the deceased

20. On 24 December 2019, John Francis Flynn, born 12 December 1950, was visually identified by his friend, Andrew Murnane, who signed a statement of identification.

21. Identity was not in dispute and required no further investigation.

Medical cause of death

22. Forensic Pathologist Dr Michael Burke from the Victorian Institute of Forensic Medicine (**VIFM**) conducted an external examination on 27 December 2019 and provided a written report of his findings dated 30 December 2019

23. External examination revealed signs of medical intervention but was otherwise unremarkable.

24. A routine post-mortem computed tomography (**CT**) scan showed focal coronary calcification.

25. In considering the reported clinical history, Dr Burke provided an opinion that the medical cause of death was:

> *1 (a) Hypoxic ischaemic brain injury.*
> *1(b) Right facial artery pseudoaneurysm rupture and haemorrhage*

26. I accept Dr Burke's opinion.

MELBOURNE HEALTH IN-DEPTH CASE REVIEW

27. In response to a request made by this Court, Dr Cate Kelly, Executive Director, Clinical Governance and Medical Services and Chief Medical Officer, provided a statement dated 25 September 2020 on behalf of the Royal Melbourne Hospital.

28. Dr Kelly reported that following Mr Flynn's death, Melbourne Health conducted an internal In-Depth Case Review (**IDCR**).

29. She reported that the IDCR identified the following missed opportunities:

    a) Under-recognition of threat to Mr Flynn's airway and a missed opportunity to secure the airway in a controlled environment.

    b) Delay in contacting all relevant teams for initial review.

    c) Missed opportunity for earlier consultant notification by ENT registrar and attendance on site to direct the management plan.

    d) Transfer from Royal Melbourne Hospital ICU to PMCI Institute was not optimal for palliative care.

30. The IDCR made the following recommendations:

    a) Implementation of a 'Best Practice Advisory" in the Electronic Medical Record (EMR) where clinical flags will be shown if a risk is identified. A more targeted approach would also be implemented with clinicians having the ability to add into the comments section that a patient is at high risk and attach alerts to patients deemed to be at high risk of airway compression from bleeding.

    b) Implementation of an educational package containing high-risk cases for ENT junior staff.

    c) Share learnings at unit audit meetings.

    d) Implementation of an ENT triage/ escalation process for earlier consultant notification and attendance.

31. Dr Kelly reported that since review of Mr Flynn's presentation, a new clinical paradigm had been implemented by the ENT team whereby there is now a focus to pre-emptively secure a surgical airway (tracheostomy) for patients presenting with post-chemoradiotherapy oropharyngeal bleeds. Dr Kelly noted that this new protocol had been successfully implemented in a similar recent clinical situation.

32. I am satisfied that the IDCR has identified the missed opportunities in this case and that the Royal Melbourne Hospital has put in place measures to address these and reduce the likelihood of a similar event reoccurring.

REVIEW BY THE CORONERS PREVENTION UNIT

33. Coroner Bracken referred this case to the Health and Medical Investigation team (**HMIT**), a part of the Coroners Prevention Unit (**CPU**)[3] for review of Mr Flynn's clinical management and care by the Royal Melbourne Hospital.

34. CPU reviewed the available material[4] and noted that this case may have met the criteria for being a sentinel event but was not reported to Safer Care Victoria.

FINDINGS AND CONCLUSION

35. Pursuant to section 67(1) of the Act, I make the following findings:

    a) the identity of the deceased was John Francis Flynn, born 12 December 1950;

    b) the death occurred on 24 December 2019 at Peter MacCallum Cancer Institute, 305 Grattan Street, Melbourne, Victoria, 3000, from *hypoxic ischaemic brain injury* and *right facial artery pseudoaneurysm rupture and haemorrhage; and,*

    c) the death occurred in the circumstances described above.

RECOMMENDATION

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

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[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. 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.

[4] Court file; Coronial Brief of Evidence; Royal Melbourne Hospital medical records; Peter MacCallum Cancer Institute medical records and statement of Dr Cate Kelly.

a) Melbourne Health consider whether this case constitutes a sentinel event and, if determined to be a sentinel event, make a report to Safer Care Victoria in accordance with its obligations.

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

Alan Flynn, Senior Next of Kin

Christian Mackay, Melbourne Health

Laura Sparks, Peter MacCallum Cancer Institute

Safer Care Victoria

Signature:

Coroner Katherine Lorenz

Date : 26 October 2021

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.