CORONERS COURT OF THE AUSTRALIAN CAPITAL TERRITORY

Case Title: **AN INQUEST INTO THE DEATH OF JOHN BELL**

Citation: **[2018] ACTCD 8**

Date of Findings: 26 April 2018

Before: Coroner P.J. Morrison

Decision:

1. John Bell died on 16 February 2014 at The Canberra Hospital, 1 Dann Close, Garran, in the Australian Capital Territory;

2. The manner and cause of death of Mr Bell are sufficiently disclosed and a hearing is unnecessary;

3. The manner and cause of Mr Bell's death was cardiac arrest, due to hyperkalemia due to acute on chronic renal failure, with a recent laparotomy for ileostomy reversal being a significant condition that contributed to death; and

4. Pursuant to s 52(4)(a)(i) of the *Coroners Act 1997*, no matter of public safety is found to arise in connection with this inquest.

File Number: CD 38 of 2014

1. John Bell was a 71 year old man with a history of bowel cancer. He received a sigmoid colectomy, cystectomy and ileal conduit formation on 12 April 2013, after which he received 29 cycles of chemotherapy which concluded approximately 5 weeks before his death. He also had a past history of ischaemic heart disease for which he had received coronary bypass surgery performed in 2002, as well as hypertension, hyperlipidaemia, and peripheral vascular disease.

2. Mr Bell sought an elective reversal of his ileostomy and was admitted to The Canberra Hospital ("TCH") for that surgery to be conducted on 14 April 2014. The surgery apparently went well, but on 16 February Mr Bell had an unexpected cardiac arrest. He was transferred to the Intensive Care Unit where he was treated for hyperkalemia and acidosis. Following discussions with Mr Bell's family a decision was made to treat Mr Bell palliatively and he

died later that evening. As Mr Bell died within 72 hours after an operation of a medical or surgical nature, his death was reportable (and reported) to the ACT Coroner: see section 13(1)(e) of the *Coroners Act 1997* as it was in force at the time.

3. The pathologist who conducted Mr Bell's post mortem examination at my direction queried aspects of the post-operative treatment of Mr Bell by TCH, noting that Mr Bell appeared to have been managed in a "routine manner" in a general ward despite his evidence of chronic renal failure on admission. TCH supplied me with an internal case review which was conducted by Dr John Ellingham. That review supported the suggestion that the case be reviewed by an external renal specialist. . Accordingly, I requested a brief of evidence be prepared by the Australian Federal Police and asked Dr Richard Phoon, a consultant nephrologist practicing at the Western Sydney Renal Service, to review the case and provide his opinion for my assistance.

4. Dr Phoon considered that two issues arose in regards to TCH's care of Mr Bell. He identified:

   a. "an unresolved issue of severely impaired kidney function which was not adequately investigated or managed preoperatively"; and

   b. "an unresolved issue of severe metabolic acidosis which was not corrected preoperatively, or optimally investigated or managed postoperatively".

5. Dr Phoon's key opinions were:

   a. It would have been more prudent to have delayed Mr Bell's surgery until after renal consultation had occurred, given that:

      i. The cause of severely impaired kidney function was not clear and was associated with the complication of metabolic acidosis (both of which may have been able to be improved preoperatively);

      ii. Mr Bell's kidney function had recently declined (and may have been potentially reversible); and

      iii. The proposed surgery of reversal of ileostomy was elective in nature.

   b. Mr Bell's cardiac arrest appears to have resulted from his worsening acidosis likely exacerbated by his declining kidney function and probable excessive administration of intravenous normal saline, with possible contributions of hyperkalemia and occult sepsis. Given Mr Bell had a history of cardiac disease and imparted kidney function, it is also possible that Mr Bell had an acute coronary event postoperatively although it is also noted that his cardiac disease was said to be both treated and stable preoperatively.

c. It would have been particularly useful and important postoperatively to have performed arterial blood gas measurement to assess Mr Bell's arterial pH and pCO2, and determine the appropriateness and degree of respiratory compensation.

d. "With respect to Mr Bell's cardiac arrest and cause of death, more timely recognition, assessment and management of Mr Bell's metabolic acidosis and severely impaired kidney function, and perhaps more appropriate fluid management post-operatively, may have altered his clinical course. However, it is not possible to exclude the possible role of an acute coronary event or occult sepsis. I do not believe the operation *per se* caused the metabolic acidosis."

6. I forwarded a copy of Dr Phoon's reports to the Director-General of the ACT Health Directorate to ascertain whether Dr Phoon's opinions were accepted, and whether TCH had undertaken any remedial action in the period since Mr Bell's death. By way of letter dated 9 March 2018 the Acting Director-General advised that TCH's Clinical Directors of Surgery and Renal Medicine agreed with and accepted the opinions of Dr Phoon as accurate. She acknowledged that Mr Bell was not afforded the standard of care that is expected at TCH. In terms of remedial action the letter advised as follows:

> "Like Dr Phoon, the Clinical Review Committee identified issues arising from Mr Bell's pre-operative management. In particular, aspects of pre-admission care which were considered worthy of further investigation based on the review of Mr Bell's case included:
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> - Communications between specialities in a patient with complex management priorities;
> - Clarity around lines of responsibility, supervision and the appropriate model of care used in the pre-admission clinic;
> - Determination of suitability of day of surgery admission; and
> - Criteria for referral to the pre-admission clinic, and thereafter to specific treating teams by the clinic, based on agreed triggers which identify risks for surgery.
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> These issues became the remit of a team of anaesthetists, pre-admission nursing staff, the Clinical Director of Surgical Services and the General Practitioner Advisor who, together, have led significant initiatives to reorganise the pre-admission clinic. The most significant change has been the inception of a dedicated high risk pre-admission clinic exclusively for patients who are identified by surgeons as requiring that level of service. To allow for a more in-depth review of high risk patients, this clinic sees only 8-10 patients on a normal day, as opposed to the

approximately 22 patients seen in the standard pre-admission clinic. This allows the clinic to provide a service entirely focussed on the needs and safety of patients deemed to be at high risk for surgical intervention.

It has been identified that, in a case such as Mr Bell's, up to date examinations and test results are essential for an accurate pre-admission assessment to be made. To facilitate this more efficient lines of communication (such as greater use of email and/or online access to patient information) between surgeons, clinicians and general practitioners as a means of obtaining accurate and timely clinical information are being considered as part of broader considerations about implementing an e-health record system.

The implementation of the high risk pre-admission clinic is part of a broader project currently underway in ACT Health, which is looking at the pre-admission process and clinic as a whole. The Territory Wide Surgical Services Team currently have a Pre-admission Redesign Project underway, which is due to be completed in 2018. The project aims to redesign the complete process for elective surgery patients in order to reduce duplication and to streamline the pre-admission process to ensure patients are assessed earlier during their wait time and to optimise their health prior to surgery. Canberra Hospital and Health Services believe this will ensure all patients who are undergoing elective surgery will have a thorough and coordinated pre-admission planning process."

7. While the aspects of suboptimal care identified by Dr Phoon and ACT Health are generally of concern, I accept the opinion of Dr Phoon that while these may have influenced Mr Bell's clinical course, the evidence does not rise to a level whereby these matters are directly contributory to Mr Bell's death. In those circumstances, I make no comments adverse to TCH, or the medical practitioners who treated Mr Bell, in the sense of any contribution to Mr Bell's death.

8. Were it not for the remedial actions of TCH and the ACT Health Directorate, I would have found a matter of public safety arose in connection with Mr Bell's death. Against the background of the response from the acting Director-General I conclude that no matter of public safety presently exists. On that basis there is no need to make a recommendation on this matter.

9. The manner and cause of Mr Bell's death is clearly evidenced by the post mortem examination report of Dr Sanjiv Jain. I believe I have all the evidence which exists or is likely to exist which could possibly bear on the decisions I must make. Having regard to the conclusion reached that no matter of public safety presently exists, there is no need to hold a hearing nor any apparent benefit in doing so. I therefore dispense with a hearing.

10. I direct that a copy of my findings in this matter be sent to the Minister for Health and the Director-General of the ACT Health Directorate for their information. I acknowledge the willingness of The Canberra Hospital to assist me in this matter.

11. I will publish my findings and comments on the ACT Coroners Court website.

12. I extend my condolences to Mr Bell's family.

P.J. Morrison
Coroner