CITATION: *Inquest into the death of David Colin Fensom* [2018] NTLC 021

TITLE OF COURT:	Coroners Court
JURISDICTION:	Darwin
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FINDING OF:	Judge Greg Cavanagh
CATCHWORDS:	**Delay in diagnosis, unexpected death, poor communication with family, no report to Coroner**

REPRESENTATION:

Counsel Assisting:	Kelvin Currie
Counsel for Dr John Treacy:	Paul Maher
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IN THE CORONERS COURT
AT DARWIN IN THE NORTHERN
TERRITORY OF AUSTRALIA

No. D0057/2017

In the matter of an Inquest into the death of

DAVID COLIN FENSOM
ON 19 OCTOBER 2010
AT ROYAL DARWIN HOSPITAL

FINDINGS

Judge Greg Cavanagh

Introduction

1. David Colin Fensom (the deceased) was born 20 November 1942 in Sydney, NSW. He married twice. The first time was in 1969. He married Lorraine Johnson. Together they had six children.

2. His second marriage was in 1992 when he was 49 years of age. He met Joan Goodwin in May of that year at a "Grab-a-Granny" night at the Seaview Hotel in Townsville. She was nine and a half years his senior. They married in Townsville on 15 November 1992. She said he was the love of her life. They remained inseparable until his death on 19 October 2010. He was 67 years of age.

3. Mr Fensom worked as an Engineering Sales Representative. He and his wife travelled together around the mines. They also had a stall at both Mindil Beach and Parap markets in Darwin selling Skinnyfish music.

4. Mr Fensom died in hospital on 19 October 2010. His death was not reported to the Coroner and did not come to the attention of the Coroner's Office until 22 March 2017. On that date the widow, Mrs Fensom, provided a letter to the Coroner's Office. She was encouraged to seek the Coroner's

assistance after viewing media reports in March 2017 in relation to an inquest into the death of Mrs Magriplis.

5. She wrote:

> *I would be very grateful if you could read my husband's records.*
>
> *His name is David Colin Fensom born 20.11.1942, passed away 19.10.2010.*
>
> *David had a large Hiatus Hernia and although he was always in pain an operation was never mentioned until the Doctor had no option but to operate.*
>
> *His operation was in September 2010 and I think the date was the 23rd.*
>
> *The next day the Registrar saw David before I arrived and told him it may have been better if he hadn't had the operation. David was allowed home that day even though he was still in pain, with an appointment 3 weeks ahead.*
>
> *During this time I wanted to take David back to Hospital but he said he would wait for his appointment.*
>
> *But after 2 weeks & 2 days he was in so much pain I took David back.*
>
> *Later the next day he was taken for a CT scan. Doctor wouldn't let me go with him and I was told he would either go to surgery or ICU. I was just left not knowing.*
>
> *When I did see David again he was in ICU hooked up to so many machines and we never spoke to each other again.*

Five times in the next 11 days David was in surgery and on the 11th day he passed away at 11pm that night.

David's Death Certificate shows he passed away on the 20th that is because his family were on their way so they kept David so his children could say goodbye.

I wanted to get David's records then but his daughter (a nursing sister) said it would just bring us more heartbreak as doctors stick together.

Now I feel I need to do this for David.

Even after 6 and a half years this is still upsetting me.

Yours faithfully

Joan Fensom

6. The medical records indicated that beginning in 1997 Mr Fensom had ongoing problems with bowel obstruction and abdominal pain. In 1997 he had a perforated bowel that required a left hemicolectomy.

7. He was first admitted to Royal Darwin Hospital in 2003 due to bowel obstruction. In 2006 he was once again admitted with abdominal pain. His pain was thought to be due to small bowel obstruction from adhesions constricting the small bowel following the operation in 1997. From 2006 he was also known to have a hiatus hernia, where part of his stomach extended through the hiatus in the diaphragm.

8. His issues with abdominal pain and small bowel obstruction continued. In both 2008 and 2009 he was admitted to Royal Darwin Hospital for subacute small bowel obstruction and attended hospital on two other occasions suffering abdominal pain.

9. Mr Fensom also had worsening gastro-oesophageal reflux disease and recurrent chest infections and pain due to the hiatus hernia. On 21 September 2010 he was admitted for elective surgery. The surgery was performed by Dr Treacy. It involved a laparoscopic 360 degree Nissen fundoplication procedure.

10. By all accounts the surgery went well and Mr Fensom was discharged from hospital on 24 September 2010. However he had considerable abdominal pain. His wife took him back to the hospital in the early hours of 8 October 2010.

11. In the emergency department it was noted that he had epigastric pain. He was assessed at 12.38am on 8 October 2010. He said the pain was similar to when he had a myocardial infarction seven years before. He was slightly nauseous. He described the pain as a grabbing, burning pain, coming in waves. He also had pain in the right shoulder. Fentanyl and Morphine were provided for the pain and GTN spray in case there was a heart related cause. The impression of the Emergency Physician was that Mr Fensom may have been suffering a bout of diverticulitis or a subacute bowel obstruction.

12. By 1.15am the pain was down to 2/10. But by 2.20am the pain was back up to 9/10. It was a burning pain in the right side of his abdomen. He was given two lots of Morphine but the pain did not ease. He was sent for an x-ray of the abdomen. The Radiology report found no evidence of obstruction and found nothing else of note. A CT scan was undertaken and showed that the stomach had migrated upwards, was twisted and had an ischaemic appearance.

13. At 3.05am he was given more Fentanyl as the pain didn’t seem to be dissipating. At 3.15am Mrs Fensom noted that he stopped breathing for 20 seconds. It was decided to withhold further opioids.

14. At 5.51am Mr Fensom was reviewed by the General Surgery Registrar. There was noted tenderness and guarding in the right upper quadrant of the abdomen. In the Registrar's opinion Mr Fensom was suffering post operation pain with adhesive narrowing. He noted that it might be ischaemic bowel, although wrote "(unlikely)" after that note. He suggested transferring Mr Fensom back into Dr Treacy's care.

15. Dr Treacy saw Mr Fensom at 1.00pm. The plan was for a laparoscopy to see what was going on with the possibility of a gastrostomy to hold the stomach in place. Dr Treacy noted, "Aware small possibility of need for laparotomy".

16. Mr Fensom was taken to the operating theatre at 3.30pm that same afternoon. The stomach was put back in place. There was however nothing observed that easily explained the pain levels Mr Fensom had been experiencing. Mr Fensom went to recovery at 5.25pm. He stayed there until 10.15pm with "plentiful" pain relief. He was then returned to the ward. By that time he was said to be pain free. However by 6.00am the next morning he was "constantly complaining about the pain".

17. He was seen by Dr Treacy at 8.00am. The plan was for more pain relief. He was then seen by the pain clinic and was prescribed patient controlled morphine. Two lots of morphine were given. They provided no relief. The patient controlled morphine was put in place. The nursing note indicates that it took some time to become effective.

18. At 1.30pm that day (9 October 2010) Mr Fensom was seen by the surgical cover, Dr Parker, due to increasing pain, reduced blood pressure and an increased heart rate. He was noted as looking distressed. Mr Fensom said he had pain all over but mainly his abdomen and shoulders. The doctor thought he may have been suffering bowel obstruction, bowel perforation, or a myocardial infarction. Blood tests and x-rays were ordered.

19. At 3.30pm he was reviewed by Dr Treacy. A CT scan of his abdomen and chest was ordered. The CT scan did not show any leak or other abnormality from the operation the previous day. Due to that it was noted at 4.40pm, "not for operative intervention at this stage".

20. At 5.45pm due to his continuing deterioration he was admitted to the Intensive Care Unit (ICU). He was in an unstable and critical condition. He was intubated at 11.45pm (9 October).

21. When reviewed the following morning (10 October) at 8.20am it was thought that he was in multi-organ failure due to intra-abdominal sepsis. After a discussion with Dr Treacy he was booked for an urgent laparotomy to identify the source of the sepsis.

22. The operation commenced at 10.00am. The small bowel was hidden within dense adhesions. Dr Treacy found three separate patches of ischaemic necrosis of the small bowel. The right colon was also ischaemic. The bowel had perforated and there were four litres of faecal peritonitis. The ischaemic bowel and faeces were removed. There was a plan to have another look in 24 to 48 hours. He was returned to ICU at 1.00pm.

23. Mr Fensom remained critically ill. He was receiving high levels of blood pressure support, renal replacement therapy and was on a ventilator. However he continued to deteriorate. He had further operations on 11, 13, 15, 17 and 19 October 2010. Those were variously to relieve abdominal pressure, change the dressing, remove gangrenous stomas, remove further sections of necrotic bowel and remove faecal peritonitis.

24. On his final trip to the theatre the extent of the necrosis in his bowel was thought incompatible with survival. He died at 10.50pm that day. His death was not reported to the Coroner. The reason for that omission was said to be because from the time he was transferred to ICU his prognosis was poor and death was an expected outcome.

Expert Report

25. On 9 May 2018 my Office obtained a review from a General and Gastrointestinal Surgeon in Brisbane, Dr Rob Finch. In speaking of the laparoscopy undertaken on 8 October 2010 Dr Finch commented:

> Unfortunately this is where this case starts to unravel slightly. I think it is quite clear that the findings at this laparoscopy done on 8/10/2010 are where the misdiagnosis and subsequent confusion begins. In hindsight there was clearly no significant complication with the sac and this would fit with the patient's presentation predominantly with right upper quadrant pain. It would be very unusual for complications of a fundoplication to present predominantly with right sided abdominal pain. This is much more likely to be left sided abdominal pain or epigastric pain. The operating notes mention that the tissues at the hiatus were oedematous and this necessitated opening the hiatus to release pressure at that point. Despite this the endoscopy was largely normal. It is clear that the underlying diagnosis of ischemic bowel was missed at this point and this has led to a 48 hour delay.
>
> On 9/10/2010 Mr Fensom was reviewed several times. It is noted that his pain was poorly controlled and his CRP was 320. It was variously noted in the hospital notes that he had a tender and guarded abdomen. Later that evening he had to be admitted to ICU and these notes indicate that he had peritonitis at that point. He needed to be ventilated and placed on inotropes for support. He went back to theatre on 10/10/2010 for a laparotomy and this note indicates extensive intra-abdominal adhesions that need to be divided and ultimately there was a large amount of faecalent peritonitis that was concealed beneath the omentum in the infracolic compartment. There was also ischaemic small and large bowel necessitating right hemicolectomy, small bowel resection, formation of an end ileostomy and a mucous fistula. At this point too, the patient had pseudomonal sepsis as there was a positive blood culture which subsequently grew pseudomonas.
>
> At this point the patient was in multi organ failure with faecalent peritonitis, ischemic bowel and pseudomonal sepsis. The expected mortality from this would be greater than 50%. From this point I really cannot criticise any of the management that occurred. Mr Fensom was looked after in the intensive care setting and was returned to theatre multiple times during the following week. All of the surgical care seemed appropriate. The main issue here is that he had a missed diagnosis and unfortunately had an operation that was

> done laparoscopically. I think the findings of that operation were misinterpreted. Unfortunately, his doctors considered it was likely that he had a complication of his fundoplication at this time and obviously this was reasonable however there was certainly not enough seen at the time of that repeat laparoscopy on 8/10/2010 to explain his severe pain and particularly right sided pain. This unfortunately led to a 48 hour delay before his next surgical intervention which appropriately was a laparotomy and this made the diagnosis of ischemic bowel secondary to an adhesive gut obstruction and faecalent peritonitis. I think at this point it was almost certain to be an irreversible problem. The patient was managed appropriately for the next nine days but ultimately succumbed from multi organ failure and sepsis after a week in ICU.

26. A copy of that report was provided to the Top End Health Service on 11 May 2018. On 8 June 2018 the Top End Health Service responded, agreeing that the death should have been reported to the Coroner and stating that the diagnostic process was in accordance with published best practice and in their opinion "the vast majority of surgeons in such a situation would agree with the treatment plan …" In the opinion of the Top End Health Service, "the care was appropriate, and as events unfolded, it became obvious that this was a condition with a very poor survival probability".

27. In support of that view the Top End Health Service obtained a report from a surgeon in Cairns. That was provided to the Coroner's Office on 29 July 2018. The surgeon wrote, "I would most probably have done exactly the same thing as the treating surgeon, very likely committing the same mistake". However he did think Mr Fensom should have been taken back to theatre on 9 October 2010 when it became obvious that he was deteriorating rather than waiting until 10 October 2010.

28. On 19 July 2018 Dr Treacy provided a statement. He apologised to Mrs Fensom for the years of uncertainty she had endured. He said he should have reported the matter to the Coroner and would learn from the constructive criticism of Dr Finch so as in the future to give his patients the best treatment possible.

29. On 17 August 2018, the Director of Surgical Services at the Top End Health Service, Dr Mahiban Thomas provided a statement. He acknowledged that the level of suspicion of bowel ischaemia was inadequate.

30. He went on to say that in more recent years the Hospital had initiated a "Complex Case" protocol that required a multi-disciplinary team to become involved. He said that had improved the outcomes for patients significantly. He believed that the surgical service had become more transparent, accountable and better prepared to avoid similar failings. Dr Mahiban was an impressive witness who appeared to be striving to provide the best surgical service possible. I commend him for that.

31. On the evening of 16 August 2018 Top End Health Service provided their institutional response. It seems that the Top End Health Service had some difficulty accepting that the diagnosis of ischaemic bowel should have been made at an earlier point in time. Included was an article from the *World Journal of Emergency Surgery*, titled "Acute mesenteric ischemia: guidelines of the World Society of Emergency Surgery". The article noted that the incidence of acute admissions of ischaemic bowel is low, representing an uncommon cause of abdominal pain. The article went on to say:

> … although the entity is an uncommon cause of abdominal pain, diligence is always required because if untreated, mortality has consistently been reported in the range of 50%. Early diagnosis and timely surgical intervention are the cornerstones of modern treatment and are essential to reduce the high mortality associated with this entity …
>
> Severe abdominal pain out of proportion to physical examination findings should be assumed to be acute mesenteric ischemia until disproven. The key to early diagnosis is a high level of clinical suspicion."

32. In evidence Dr Charles Pain sought to suggest that it was only with the benefit of hindsight that it could be seen as a "missed diagnosis". That

seemed a rather untenable position, given the emphasis in the article on a high level of clinical suspicion. Moreover, Dr Rob Finch thought it should have been picked up, the Director of Surgery at Royal Darwin Hospital acknowledged the level of suspicion was inadequate and Dr Treacy accepted the views of Dr Rob Finch.

33. These questions and answers were provided during the inquest:

> Counsel: Why do you insist on the benefit of hindsight when the head of surgery has just acknowledged that it should have been picked up?
>
> Dr Pain: Well I defer to surgical opinion on that, but I think – I would hope …
>
> Coroner: If you defer to his opinion on that, why don't you agree with it?
>
> Dr Pain: Well, I don't want to sound difficult, your Honour, I'm just trying to be truthful really, that this is undoubtedly a difficult diagnosis to make that was missed … it's a question of how difficult it was to make that diagnosis in these circumstances.

34. There is no question that it is a difficult diagnosis. But Mr Fensom had a history of ischaemic bowel and bowel obstruction going back to 1997. That history was known to the doctors. When he returned to the hospital suffering extreme levels of pain, either ischaemic bowel or bowel obstruction was considered by the first two doctors: The emergency physician thought it was "diverticulitis or a subacute bowel obstruction", the General Surgical Registrar provided a differential diagnosis of "ischaemic bowel (unlikely)". The following day at 1.30pm the surgical cover thought it, "bowel obstruction, bowel perforation, or a myocardial infarction".

35. The issue appears to be that Mr Fensom was returned to the surgeon who had performed the original operation. The surgeon's mind was more directed at the possibilities of complications from the operations he had performed than having the necessary high level of suspicion of ischaemic bowel.

36. The Top End Health Service also favoured the report of the surgeon from Cairns. However, given the report of Dr Finch and the views of Dr Thomas and Dr Treacy, it is difficult to see the utility of the report. As I asked during the evidence:

> "Do I take it that he would have made the same inadequate judgement?"

37. That is not a matter that should provide comfort to the Top End Health Service nor provide an excuse not to learn and improve.

38. In evidence Dr Pain conceded that on any version, Mr Fensom should have been taken to theatre at the point he began to deteriorate. That was well before he was taken to the ICU. He was taken to ICU 17 hours before he was taken to theatre and the ischaemic bowel confirmed.

Communication with family

39. Mrs Fensom stated:

> "About 5.00pm [8 October 2010] the doctor came and said, "David is going for a Cat Scan he will either go to Theatre or ICU. I started to follow. The doctor sent me back and the last words I ever heard David say is "Where is my wife". He was told, "I sent her back".
>
> I waited ages before I was told David was in ICU. When I saw him he was in a coma with things hanging off everywhere.
>
> Over the next 11 days David went to Theatre 5 times, on the 11th day a lady doctor rang to say they didn't think David would make it out of theatre. He lived 10 – 11 hours more. During all these 11 days I never saw a doctor.
>
> After the last operation David's daughter and I sat with him and the doctor put his head around the curtain and said, "you have been in this position before" and I said , "never this bad" and he walked off."

40. Mrs Fenson said the only explanation of his death that she obtained was from the death certificate. Six weeks after her husband's death someone from ICU rang to ask if she was okay. Mrs Fensom said:

> "if someone passes away in ICU, they don't worry about who's left behind whereas if you go in hospice or palliative care, they worry about you and they make sure you're okay and nobody cared about me. I was just left. So I've had a lot to deal with over the last eight years and I still can't handle it. As far as I'm concerned, when I lost David, I lost my life as I knew it."

Unexpected Death

41. Mr Fensom's death was not reported to the Coroner. Dr Treacy did not report the death. He conceded he should have done so. The doctors in ICU did not report the death. The director of ICU said that was because when they received him into ICU he was not expected to survive.

42. However, his death was clearly unexpected to his wife, it was unexpected to the surgeon who operated on him. His death was certainly not expected when he was admitted to hospital for the repair of his hernia. It was not expected when he returned to the ED in pain two weeks later. It was not expected when the surgeon undertook the laparoscopic procedure to check how the hernia repair had gone. It was not expected during the 48 hours he deteriorated until he underwent a laparotomy.

43. The *Coroner's Act* provides that **reportable deaths** must be reported to the Coroner at section 12:

> (3) A medical practitioner who is present at or after the death of a person must report the death as soon as possible to a coroner if:
>
> (a) the death is a reportable death; or
>
> …
>
> Maximum penalty: 40 penalty units.

44. Reportable deaths are in part defined as:

> ***reportable death means:***
>
> being a death:
>
> (iv) that appears to have been **unexpected**[1], unnatural or violent or to have resulted, directly or indirectly, from an accident or injury;

Improvements and prospective improvements

45. Dr Mahiban Thomas told me that as of January 2019 where a death occurs he will institute an hour's "pause" the day after a death. All clinical activity will be shut down for the team involved. That will allow for debriefing and "completion of all paperwork and to ensure communication with the family at the appropriate level".[2] As a system that sounds encouraging.

46. I was told that on 25 September 2018 a Grand Round will be presented addressing communication issues.

47. Dr Pain provided evidence that the Death Occurrence Form was to be revised to, in effect, require that the Consultant explain why a death was not being reported to the Coroner. It was said that the Top End Health Service was "confident" that the improvement would "ensure all reportable deaths are reported".

Formal Findings

48. Pursuant to section 34 of the *Coroner's Act*, I find as follows:

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[1] My emphasis
[2] Statement dated 17 August 2018 paragraph 9

(i) The identity of the deceased is David Colin Fensom, born on 20 November 1942 in Sydney, New South Wales.

(ii) The time of death was 10.50pm on 19 October 2010. The place of death was Royal Darwin Hospital in the Northern Territory.

(iii) The cause of death was multi-organ failure due to septic shock consequent on faecal peritonitis due to perforated ischaemic bowel.

(iv) The particulars required to register the death:

1. The deceased was David Colin Fensom.
2. The deceased was Caucasian.
3. The deceased was an Engineering Sales Representative at the time of his death.
4. The death was not reported to the Coroner.
5. The cause of death was confirmed by Dr Dianne Stephens.
6. The deceased's mother was Annie May Fensom (nee Solway) and his father was Thomas Charles Barton Fensom.

Comment

49. This inquest was held together with another inquest, that of Mr Henry Wilson (also known as Albert Wilson). Both were discretionary inquests. The deaths of Mr Fensom and Mr Wilson were six years apart. However, many of the same issues are present in each. In both it seems that significant levels of pain were overlooked and in part due to that, appropriate diagnosis was delayed.

50. In each case communication with the family was poor. In each case the death was not reported to the Coroner. In each case the Top End Health Service took a defensive posture and in each case had made little or no improvement by the time of the inquest.

51. It is not right that Mrs Fensom had to wait eight years to find out why her husband died. It is of utmost importance that the Top End Health Service implement proper and robust procedures to ensure proper communication with families during treatment and after death (if that be the outcome) is a part of the culture of the workplace. That needs to be audited.

52. It does not seem too much to expect that the institution would check on and speak to families after the unexpected death of a loved one and ensure that they have been afforded proper communication, open disclosure and their reasonable needs met.

53. During the course of the inquest the Top End Health Service conceded that such breakdowns in communication occurred far too often. I said:

> "From the hospital's point of view, the family's point of view and the Coroner's point of view, I'm glad that that's recognised, because I don't know how many Coronial inquests I've done with suspicious families where it turns out the medical treatment was okay, but the communication after the death was defensive, not good enough, and we end up going through all this trauma. When, if there had been good communication before and after the death, with families fully appreciating the dangers, the illness, the risks, we wouldn't have to go through Coronial inquiry after Coronial inquiry where the main issue turns out to be bad communication with grieving families."[3]

54. It is also not too much to expect that the Top End Health Service will ensure that all deaths of its patients that are reportable pursuant to the *Coroners Act* are reported in accordance with the law.

Recommendations

55. I **recommend** that Top End Health Service ensure that medical staff have all necessary induction and training in relation to appropriate communication

[3] Transcript 22 August 2018 pages 75 and 76

with patients and families about symptoms, pain, prognosis, risk of procedures and limits of care.

56. I **recommend** that Top End Health Service speak to families after the death of a loved one and ensure that the family have been afforded proper communication, open disclosure and their reasonable needs are being met.

57. I **recommend** that Top End Health Service ensure that all deaths of patients that are reportable pursuant to the *Coroners Act* are reported in accordance with the law.

Dated this 21st day of September 2018.

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GREG CAVANAGH
TERRITORY CORONER