QUEENSLAND COURTS

CORONERS COURT OF QUEENSLAND

FINDINGS OF INVESTIGATION

CITATION:	**Non-inquest findings into the death of Mr H.**
TITLE OF COURT:	Coroners Court
JURISDICTION:	CAIRNS
DATE:	17th of April 2025
FILE NO(s):	2022/1430
FINDINGS OF:	Melinda Zerner, Coroner
CATCHWORDS:	CORONERS: Poor bowel care in an RACF; Faecal impaction; Faecal overflow; Inadequate resident assessment and monitoring in an RACF

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Background

1. Mr H was born on 8 April 1932 and died on 29 March 2022 at the Townsville University Hospital (TUH). He was 89 years old.

2. A doctor from the TUH reported Mr H's death to the Coroner because his death had been identified as a potential health care related death within the definition of a reportable death in the *Coroners Act 2003*. His family were concerned about the management of Mr H's bowels and his severe constipation.

3. The role of a Coroner is to investigate reportable deaths to establish, if possible, the cause of death and how the person died. The purpose of a coronial investigation is to establish the facts, not to cast blame or determine criminal or civil liability. An investigation is about attempting to find the root cause of the incident that precipitated the death and in appropriate circumstances to analyse systemic failures that contributed to the death and to design remedial responses.

4. In making my findings, they are based on proof of relevant facts on the balance of probabilities. I am not able to make adverse findings against, or comments about individuals, unless the evidence provides a comfortable level of satisfaction that they caused or contributed to the death.

5. Mr H resided at a Residential Aged Care Facility (RACF). According to his admission note at the TUH, he had several medical co-morbidities which included, colon cancer; gastro-oesophageal reflux disease (GORD); aortic sclerosis, osteoarthritis; abdominal aortic aneurysm; hypertension; dyslipidaemia; dry eye syndrome; spinal stenosis; Bowen's disease; cardiac arrythmia; and insomnia.

6. I have reviewed Mr H's clinical records.

7. On 27 March 2022 at 11.48pm, Mr H was seen in the Charters Towers Emergency Department. He had refused his dinner and had had two episodes of vomiting. It was suspected he had decreased bowel activity over a 24 day period. He had been given a fleet enema that day with no effect. The triage nurse records Mr H had altered breathing, shortness of breath, lethargy, and abdominal distention.

8. On assessment, Mr H had a distended, tender abdomen. Bowel sounds were absent. It was thought Mr H had an acute abdomen possibly due to an intestinal obstruction. Treatment was commenced and Mr H was for transfer to the TUH under the surgical team.

9. On 28 March 2022 at or around 5am, Mr H arrived in the Emergency Department at the TUH. He was assessed by a Registrar. It was thought Mr H may have had a bowel obstruction, but it was noted he had been passing small amounts of faeces daily. The registrar thought Mr H was suffering from constipation rather than a bowel obstruction but that a CT scan was required.

10. Mr H had a CT scan which revealed features suggestive of stercoral colitis (occurs when there is chronic constipation), most significantly affecting the descending and sigmoid colon. There was distended large bowel secondary to a large volume of faeces impacted within the distal sigmoid and rectum. The distal rectum was grossly distended. The rectum was noted to be at risk of stercoral perforation.

11. It was decided to try dis-impaction to avoid perforation. Mr H's family were advised his condition was likely an end of life event. His family made travel arrangements to

be with him.

12. Later in the day it was thought Mr H likely had a bowel perforation on clinical grounds. His condition was rapidly deteriorating. Comfort measurers were commenced.

13. On 29 March 2022 at 8.20am, Mr H was declared deceased.

Nursing Home Records

14. Mr H had been reviewed by a General Practitioner regularly at the RACF. It was noted on 7 January 2022, that Mr H's bowels had not been open for seven days. He was assessed. Mr H had no abdominal pain but had a distended abdomen. The GP records under the heading 'Impression' – '*Acute constipation – reasonable to trial other agents as failure of Movicol'*. The plan was for Mr H to be administered lactulose and glycerol suppositories as required. In the five subsequent GP consultations there was no reference to Mr H's bowels.

15. In the RACF progress note of 27 March 2022 at 10.53pm, a Registered Nurse (RN) records,

> *Obs within normal range but patient is very pale and obviously quite sick. Call placed to GCMS on call Dr [redacted]. Given patient had distended abdomen that was painful to palpate, we conferred that a bowel obstruction may be underpinning his current presentation. Further to this, care staff report it has been 24 days since this resident had a large bowel opening. In the intervening period, his bowel profile has been small openings ever* (sic) *few days but nothing substantial. PRN Endone has also been given during this period which would make compaction issues more prevalent. This was the back drop from where we as clinicians approached the first line of his treatment. A stat order for a microlax enema was obtained via phone order. The microlax was administered into a loaded bowel but only a small efflux of stool was produced. This occurred at 2100hrs.*

16. I am assuming the microlax is the 'fleet' enema which was referred to by the hospital staff, but this is not entirely clear. There is no evidence Mr H was administered a Fleet enema.

17. The nursing home recorded Mr H's bowel activity on a bowel chart. The last time they had opened was on 24 March 2022, the nurse notes it was small and a 'type 4'. The same was documented on 23 March 2022. There are other references to either bowels not opening or opening a small amount.

General Practice Records

18. I obtained Mr H's GP records. The consultation of 7 January 2022 is noted. There is a further record on 21 January 2022, wherein Mr H was reviewed for constipation. There was no assessment or intervention recorded except for 'Drug sheet printed'. On 25 January 2022, Mr H was reviewed by the GP, a Nurse Practitioner, and a resident medical officer. It was for a new pressure injury to Mr H's right heel and his sacrum. There was no reference to constipation.

19. Mr H was reviewed relatively frequently in February 2022. There was no mention of constipation or an abdominal assessment. There were issues with Mr H's behaviour and reference to him possibly being in pain. This was addressed by adjusting his medications.

20. I also obtained Mr H's Medicare records the last consultation was by a GP from the GP clinic on 17 February 2022. According to the Pharmaceutical Benefits Scheme claims history, the last prescription for medication was for analgesia on 4 March 2023 by the Nurse Practitioner attached to the GP clinic.

21. An old prescription of 8 September 2021 for 'Macrogol – 3350 + Sodium Chloride + Bicarbonate + Potassium Chloride' (laxative) was filled on 24 March 2022. From the nursing home records I cannot see that this was administered.

22. Following Mr H's passing, a case conference was held on 26 May 2022. It was with GPs, the Nurse Practitioner, and a hospital representative. There was a discussion about:

    a. The lack of escalation of Mr H's care, and that a medical officer was not notified prior to Mr H's acute deterioration.

    b. It was noted Mr H was in respiratory isolation when his bowel symptoms began. The focus of care was on respiratory symptoms. After Mr H was cleared from respiratory isolation he was walking around in no apparent distress and his vital signs were stable.

    c. It was discussed that bowel charts may not have been appropriately reviewed regularly by the relevant medical officers, and that medical officers are guided by the nurses flagging/requesting review on behalf of a patient.

    d. It was confirmed bowel charts were now being regularly checked for all unwell patients, and it was recommended nursing staff undergo training on how to recognise stools/bowel movements and to chart appropriately.

Forensic Pathologist Examination

23. An external autopsy and an internal autopsy to the extent necessary to identify the cause of Mr H's death was ordered.

24. The forensic pathologist found Mr H had a markedly expanded bowel, with bowel surface bleeding but without a site of physical obstruction or recent perforation. There was some bowel wall necrosis, with displacement of faecal matter into the outer layers of the bowel wall.

25. Mr H also had severe hardening and narrowing of the arteries of his heart and the rest of his body; lung congestion; clots in bother of his legs; kidney cysts; and stiffening of his heart valves with heart enlargement. He had benign masses in his prostrate and left kidney.

26. The toxicology results showed the presence of pain killers (paracetamol, morphine, and metabolites), and an anti-nausea agent (ondansetron). All were at blood levels below the reported potentially individually lethal ranges.

27. The forensic pathologist concluded the cause of Mr H's death was, '*most probably a combination of biochemical consequences of colonic pseudo-obstruction and faecal*

loading, on a background of atherosclerotic and cardiovascular disease'.

Review by Senior Forensic Physician

28. Dr Ian Home was asked to review the care which was provided to Mr H. He states,

> *Whilst the bowel movements were diligently charted, with frequent recordings of bowels not open, when Mr H did pass a motion, they were almost universally described as small in volume but classified as type 4 (like a sausage, smoother and soft, i.e, 'normal') in appearance according to the Bristol stool chart.*
>
> *The last time Movicol was administered was on 27 March 2022, which was three days (recorded as four) since the previous motion. Prior to this, the last time I could identify that any medication to assist his bowels was given was on 09/03/22, at which time his abdomen was assessed by a registered nurse who noted tenderness on palpation with firmness on the left lower quadrant, suggestive of significant faecal loading. Instructions were to administer an enema if the bowels did not open by the following day. This was not administered although on 11/03/22 a moderate size motion was recorded.*
>
> *I could see no evidence of any further examination of Mr H's abdomen after 09/03/22 despite ongoing issues with passing only small amounts of faeces. Whilst it is not possible to determine if they were related to abdominal discomfort, there are a number of entries indicating agitation and pain for which medication were seemingly administered without identifying the source of distress.*

Review by Townsville Hospital and Health Service

29. A clinical review was undertaken by the Townsville Hospital and Health Service (THHS) following Mr H's death. The author of the clinical review report sets out a helpful succinct summary of what occurred at the RACF,

> *This gentleman had a range of factors which predisposed him to constipation, including a history of bowel cancer, reduced mobility due to dementia, and opioid analgesia. For the period between 4 March 202 and 27 March 2022, the gentleman experienced worsening constipation. On the evening of 27 March 2022, the gentleman became unwell, with two large vomitus containing partly digested food. He had a distended and tender abdomen and was pale. Nursing staff contacted his general practitioner (GP) when concerns were identified about a bowel obstruction. A microlax enema was ineffective. The resident continued to deteriorate throughout the evening. Nursing staff could not re-establish contact with the GP and could not access a doctor at Charter Towers Hospital (CTH) by phone, so a decision was made to transfer the resident by ambulance to CTH.*

30. Three contributing factors were identified. They include,

    a. *Bowel care and intervention: the resident experienced increasing constipation in the 23 days prior to his transfer to hospital. There were missed opportunities to recognise and escalate management of constipation between 4 and 27 March 2022, most clearly on 8, 10, and 17 March 2022. The systemic practice of recording constipation-related faecal smearing and overflow as a 'small motion', and an over-attribution to 'type four' or 'five'*

motions during the shift-by-shift bowel assessment likely shifted clinical focus away from constipation, and a lack of central clinical oversight for bowel care limited the amount of intervention provided.

b. *The gentleman's medical care was shared between his visiting GP, visiting geriatrician, and rural hospital physicians. The arrangements for nursing to medical officer escalation of care vary between days and times. These escalation arrangements are not documented. Ambiguity about escalation arrangements and expectations reduced the likelihood of sufficient bowel care and resulted in discontinuity of care when clinical issues were escalated.*

c. *The gentleman had an Acute Resuscitation Plan (ARP), Advanced Health Directive (AHD), Statement of Choices, and geriatrician clinical notes which consistently documented that he was not for surgery and was for palliation in Charters Towers if possible. When he was transferred from* [the RACF] *there was a loss of information about these wishes, resulting in a transfer to Townsville for surgical review, and subsequently palliation in Townsville. A reliance on local storage of key health directive documents, in a way that is not visible to all health professionals, contributed to the loss of this information during handover.*

31. As a result of the review, three recommendations were made which are linked to the contributing factors. It was noted the RACF implemented five actions to ensure appropriate bowel management which included a new bowel chart and more education.

Response from THHS to opinion by Forensic Physician

32. The Townville Hospital and Health Service (THHS) operate the RACF Mr H was residing in. I sought clarification from THHS. I have been advised,

a. The Nurse practitioner employed by the GP practice prescribed all the constipation related medications administered to Mr H.

b. There was no prescription for lactulose or glycerol. The PRN (as required) prescriptions were for a Bisacodyl suppository on 6 January 2022 and Movicol sachets on 31 August 2021. His regular medication was Coloxyl with senna two tablets each night, his last dose being on 28 March 2021.

c. Mr H received Movicol on 7 March 2022 (one sachet), 9 March 2022 (two sachets), 27 March 2022 (one sachet).

d. A 'Toolbox talk' had been provided to staff during the time Mr H resided there. It covered faecal impaction and faecal incontinence, with a discussion regarding overflow. It also included medications and medical conditions which may contribute to issues with the bowel.

e. Since Mr H's passing, there had been other educations sessions on 'Constipation/Bowel Management in March 2023.

f. In January 2025, I was advised all staff at the RACF were in the process of completing the 'Altura – Bowel Management' module. The module covers:

i. abdominal assessment

ii. the Bristol stool chart;

iii. constipation;

iv. diarrhoea;

v. digital rectum examination;

vi. digital removal of faeces; and

vii. faecal impaction.

g. The description for this course is 'Discover the key principles promoting healthy bowel function and their impact on bowel disease. Explore effective strategies to promote healthier bowel habits'. The learning outcomes include:

i. Recognise key elements of bowel functions.

ii. Describe bowel assessment.

iii. Apply appropriate bowel management strategies to promote healthier bowel habits.

33. Additionally, I have been advised since Mr H's death:

a. There has been significant cultural improvements and increased awareness. This includes the medical escalation pathway, education, and awareness regarding the impact of medications on bowel function.

b. The Model of Care has changed and includes the medical escalation process.

c. The RACF is employing is own part time Nurse Practitioner which will strengthen the staff mix and the escalation pathway.

Conclusion

34. After considering the material obtained during the coronial investigation, I consider I have sufficient information to make the necessary findings required by s45(2) of the *Coroners Act 2003* in relation to Mr H's death.

35. Mr H was on several medications which caused constipation. While the RACF had a bowel monitoring chart in place, the staff did not recognise that it was likely Mr H was constipated and that the small bowel motions he was having was faecal overflow. The NP or the GP were not asked to review Mr H after 4 March 2022.

36. As identified in the clinical review there was a missed opportunity for the staff of the RACF to recognise and escalate management of Mr H's constipation between 4 and 27 March 2022. This resulted in Mr H having an impacted bowel which ultimately led to his demise. I acknowledge the challenges in caring for a resident with cognitive impairment but note Mr H was unsettled which may have been a sign of pain. I find there was a lack of assessment and escalation in his care.

37. Mr H had several medical comorbidities. His life expectancy was guarded but I find the deficits in care resulted in an earlier death than otherwise may have occurred. I accept the forensic pathologist's opinion as to the cause of Mr H's death.

38. I am not satisfied that it is in the public interest to hold an Inquest (formal court hearing) because in my view drawing attention to the circumstances of this death does not warrant holding an inquest to attempt to prevent deaths in similar circumstances happening in the future. There is also no uncertainty or conflict of evidence as to justify the resources required for the use of the judicial forensic process and no suspicious circumstances that have not been resolved or resulted in criminal charges. On that basis I have determined that an Inquest is not required. However, I sought permission from Mr H's family to publish a de-identified version of these findings so nurses in other RACF's can potentially learn from the circumstances concerning Mr H's death.

39. I extend my condolences to Mr H's family and friends for their loss. To lose someone is such circumstances is very difficult. I acknowledge that no words can adequately express their sorrow, or the impact Mr H's loss has had on them all.

I close the investigations.

Melinda Zerner
Coroner

17 April 2025