QUEENSLAND COURTS

# CORONERS COURT OF QUEENSLAND

# FINDINGS OF INQUEST

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| CITATION: | **Inquest into the death of Albert Eric Bruce Biffin** |
| TITLE OF COURT: | Coroners Court |
| JURISDICTION: | Brisbane |
| DATE: | 3 May 2017 |
| FILE NO(s): | 2013/751 |
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| FINDINGS OF: | Christine Clements, Brisbane Coroner |
| CATCHWORDS: | Health care related death, low care nursing home, complications from incarcerated hernia, adequacy of medical assessment, nursing handover and nursing responsibility |

REPRESENTATION:

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|---|---|
| Counsel Assisting: | Ms Donna Callaghan, Ms Holly Ahern |
| Blue Care, Toowoomba Village and AIN Grabasch, EN Mathew, RN Suarez, CN Padget and Ms Hart: | Mr D Schneidewin i/b HBM Lawyers |
| Dr John Lambie: | Ms J Rosengren i/b Avant |
| EEN Watson, RN Suarez, EEN McGowan, | Ms Sally Robb i/b Roberts & Kane Solicitors |

## Introduction

1. Albert Eric Biffin was born on 27 August 1926 in Camden New South Wales. He died suddenly and unexpectedly at his low nursing care residential facility known as Jacaranda Place. He had lived there independently since December 2012. Jacaranda Place was part of the Blue Care Nursing facility at 256 Stenner Street Toowoomba in Queensland.

2. The facility provides 186 beds for residents ranging from low level acuity in Jacaranda Place to high care patients in Wisteria Lodge and dementia patients in Camellia Court.

3. Mr Biffin had been under the care of his general practitioner, Dr John Lambie, for about twenty-five years.

4. Mr Biffin died on 27 February 2013, at the age of 86.

5. Although Mr Biffin was of advanced age, the cause of his death was unclear and therefore the matter was reported to the coroner. Mr Biffin had experienced a recent umbilical hernia requiring medical treatment by his general practitioner and subsequent nursing care. Investigation followed to;

   - establish the cause of death, and

   - review whether Mr Biffin's death was health care related as defined in the *Coroners Act 2003* (the Act)

6. Section 10 AA of the Act sets out health care related deaths as follows.

   (1) A person's death is a health care related death if, after the commencement, the person dies at any time after receiving health care that-

   (a) either-

   (i) caused or is likely to have caused the death; or

   (ii) contributed to or is likely to have contributed to the death; and

   (iii) immediately before receiving the health care, an independent person would not have recent reasonably expected that the health care would cause or contribute to the person's death.

   (2) A person's death is also a health care related death if, after the commencement, the person dies at any time after health care was sought for the person and the health care, or a particular type of health care, failed to be provided to the person and-

   (a) the failure either-

   (i) caused or is likely to have caused the death; or

   (ii) contributed or is likely to have contributed to the death; and

(b) when health care was sought, an independent person would not have reasonably expected that there would be a failure to provide health care, or the particular type of health care, that would cause or contribute to the person's death.

(3) For this section-

(a) health care contributes to a person's death if the person would not have died at the time of the person's death if the health care had not been provided; and

(b) a failure to provide health care contributes to a person's death if the person would not have died at the time of the person's death if the health care had been provided.

(4) For this section, a reference to an independent person is a reference to an independent person appropriately qualified in the relevant area or areas of health care who has had regard to all relevant matters including, for example, the following-

(a) the deceased person's state of health as it was thought to be when the health care started or was sought;

(b) the clinically accepted range of risk associated with the health care;

(c) the circumstances in which the health care was provided or sought.

(5) In this section-

Commencement means the commencement of this section.

Health care means-

(a) any health procedures; or
(b) any care, treatment, and advice, service or goods provided for or purportedly for the benefit of human health.

**Cause of death**

7. With consent of Mr Biffin's family, a full internal autopsy order was made and examination was undertaken by forensic pathologist Dr Terry. It was noted Mr Biffin was well nourished. The major findings at autopsy were:
   (i) Incarcerated umbilical hernia containing ischaemic small bowel;
   (ii) Bronchopneumonia;
   (iii) Cardiomegaly (meaning with concentric left ventricular hypertrophy and dilated ventricular chambers);
   (iv) Mild-to-moderate to severe coronary artery disease, requiring pacemaker;
   (v) Benign nodular hyperplasia of the thyroid gland and benign cortical adenoma; and
   (vi) Fibrosis of liver (early cirrhosis).

8. Dr Terry's report recorded there was an incarcerated umbilical hernia which contained an ischaemic appearing loop of small bowel 120mm long with adjacent haemorrhagic mesentery. The segment of bowel was purple in colour and had a slightly thickened wall. The small bowel proximal to the hernia was slightly dilated. Fibrin was not identified over the serosal surface of the small bowel.

9. There was no ascites. There was a small Meckel's diverticulum 30mm long which was non-inflamed. The large bowel was normal and contained solid faecal material.

10. Dr Terry concluded Mr Biffin died due to complications of incarcerated umbilical hernia. He considered death most likely followed cardiac arrhythmia induced by electrolyte imbalance in conjunction with sepsis due to the effects of necrotic and poorly functioning small bowel.

11. He also noted there was concurrent bronchopneumonia which most likely made Mr Biffin more susceptible to the effects of electrolyte imbalance and septicaemia. Moderately severe coronary artery disease was identified. The pathologist noted the presence of a pacemaker as well as benign prostatic, adrenal and thyroid disease.

**Events leading to Mr Biffin's death**

12. Mr Biffin's death on 27 February 2013 was unexpected and raised questions about the adequacy of both the medical care and nursing home care provided, particularly in the last few days prior to his death. These findings are however prefaced by the circumstances that Mr Biffin lived independently in a low care facility. He was not residing in a high dependency unit nor was he in a hospital. He did however have extensive medical history and was becoming more vulnerable and dependent. As recently as 21 February 2013 he was assessed as having profound hearing loss requiring new hearing aids as well as difficulties with his vision. His wife was living separately in a higher care facility and he visited her as often as he could.

13. A registered nurse was available to attend residents in Wisteria Lodge and Jacaranda Place if called upon by staff caring for the residents. On Sunday 24 February 2013 at 11:30 a registered nurse reviewed Mr Biffin at the request of an enrolled or assistant in nursing because of vomiting. The registered nurse was told it was not a large vomit but more dry retching. She did not know how long the vomiting or dry retching had been going on.

14. The registered nurse's entry in the progress note was:

    'Called to see Mr Biffin re: complaining of lower abdo pain and episodes of vomiting and dizziness. Physical obs checked by staff. BP under 102/79, P 48, T 36.8, states he feels tired. Staff reported not a large amount of vomit noticed but only dry retching and he is up and down to the toilet. O/E (on

examination) noticed a? Hernia (large lump to his abdomen). Advised staff to give Bruce a Movicol to rule out constipation and give his regular paracetamol for possible pain and discomfort. Staff also advised him to rest, sit down today. Staff to continue to monitor.'

15. When assessed by the registered nurse Mr Biffin was sitting in his chair with his wheelie walker nearby. He complained of feeling unwell and told her he had a 'tummy ache'. He was able to speak with the nurse without any difficulty. He denied pain and did not appear to be in distress. The registered nurse saw a large lump about the size of a $0.50 piece which she described as being pink and inflamed. Mr Biffin told her it was a hernia and it was not painful. He did not seem to be concerned about the hernia. The nurse did not recall touching or examining the hernia. She did not know how long the hernia had been present as this was the first time she had met Mr Biffin. The nurse thought he might be constipated and therefore authorised as required Movicol.

16. Staff in Jacaranda Place were directed to keep an eye on Mr Biffin and to hand over information regarding his condition to the registered nurse coming onto the night shift that evening. She did not think he was in distress or sufficiently unwell to warrant calling a doctor or family members. She said that his physical observations were within normal limits. The nurse was reassured that Mr Biffin was able to respond to her questions and mobilise.

17. On the afternoon of Sunday 24 February another registered nurse who was one of three registered nurses rostered on the afternoon shift, reviewed Mr Biffin. He was based in the Wisteria lodge, the high care area with 32 beds on the floor above Jacaranda Place. The registered nurse had a patient load in Wisteria and would only attend Jacaranda if specifically called. At 16:00, the nurse recorded giving Mr Biffin further Movicol as he had not moved his bowels for two days.

18. At 21:00 that evening the same registered nurse made the following entry:

'Given further Movicol as Bruce states bowels not open for the past 2 days. Reported copious amount of vomit at 20:48 hours; complaining of pain at central and lower left abdominal area. Noted prominent bulging of umbilical hernia. Warm to touch. Given ordine as above. Head of bed elevated, given vomit bag, Bruce advised to notify staff. Obs: BP 158/71, P 48, T 36.7 C. To monitor overnight. Dr Lambie notified and follow-up tomorrow. Also noted offensive wound D/C discharge (L) lower leg." The registered nurse notified Dr Lambie by means of a facsimile sent to his practice premises at 21:45 on 24 February 2013. The message stated:

"Dear Dr

Re-: Bruce was given Movicol for reported constipation, a nurse initiated medication. At 21:00 hours tonight, Bruce had big vomit. Obs: BP–158/71, P–48, T–36.7C.

C/O (complained of) pain of his umbilical hernia which is warm to touch. Also noted offensive exudate of his chronic ulcer at the L lower leg.

Could you please make arrangements for assessment visit. Attached is medication chart. Thanking you."

19. Dr Lambie became aware of Mr Biffin's hernia for the first time on the morning of Monday, 25 February 2013 when nursing home staff rang the surgery at about 10:30. He had not seen or been informed of the facsimile sent to the surgery on the preceding evening at 21:45 hours by RN Suarez. Dr Lambie recalled being told by his reception staff that nursing home staff reported Mr Biffin had a lump in his abdomen and was in pain and had vomited once. Dr Lambie was seeing other patients at the time and considered the circumstances were not urgent and decided he would visit Mr Biffin during his lunch period. This was usually between 12:30 and 14:00 when he performed house calls.

20. In the interim period from 21:00 on the Sunday evening, until Dr Lambie attended on the early afternoon of Monday 25 February, the following interactions between staff and Mr Biffin occurred.

21. There was a nursing direction to monitor overnight which meant that if there was a recurrence of pain or vomiting, formal observations should be repeated.

**Dr Lambie's attendance on Mr Biffin on 25 February 2013.**

22. On arrival at the nursing home Dr Lambie approached the nursing station and asked one of the nurses to accompany him to see Mr Biffin. He did not review the progress notes prior to seeing Mr Biffin nor obtain any history from the nursing staff. He could not recall the name or the professional position of the female staff member. He knew that staff ranged from personal carers to registered nurses but he could not differentiate the roles by the uniforms. He expressed general faith in their capacity to care for residents.

23. Dr Lambie asked Mr Biffin how long the lump had been there. He said Mr Biffin was vague in his response. Dr Lambie asked if he was experiencing significant pain, and he asked him whether he had vomited. Mr Biffin said he had vomited once. Mr Biffin told him the pain started a couple of days ago and was around his umbilicus. Dr Lambie agreed Mr Biffin told a nurse in Dr Lambie's presence that he felt sick and unwell, as was expected by Dr Lambie given the presence of the hernia. Dr Lambie disagreed that Mr Biffin expressed any concern. He said Mr Biffin expressed his experience of pain by slight restlessness.

24. Dr Lambie stated he did not ask any questions about his bowels, whether he was eating or drinking or still felt nauseous. Dr Lambie acknowledged his conversation with Mr Biffin was very brief. Later in his evidence Dr Lambie stated Mr Biffin had told him he had not opened his bowels for 3 days. He recalled Mr Biffin was lying in bed. He then examined Mr Biffin noting the acute hernia was a significant size, recorded as 2–2 5 cm. He said 'it may have been slightly larger than that'.

25. Dr Lambie said the hernia appeared to be the normal colour of stretched abdominal skin, described by him as ivory. Mr Biffin was a large man and Dr Lambie observed him as he lay in bed. His abdomen was not distended. He palpated the abdomen for tenderness and some tenderness was evident as expected around the hernia. Mr Biffin did not exhibit any signs of tenderness or discomfort of the abdomen outside 2 or 3cm from the umbilicus.

26. Dr Lambie described Mr Biffin as very slightly tender over the hernia, which was of normal temperature compared to the rest of the skin. He then checked for the presence of any other hernias. There were none. No mass was detected in the abdomen which might have caused the hernia. Dr Lambie did not have his stethoscope with him and did not therefore listen for bowel sounds in the abdomen. No other examination was performed including a rectal examination. Dr Lambie then informed Mr Biffin he had a hernia and he would attempt to reduce it to relieve his discomfort. Dr Lambie considered this was appropriate as there was no evidence of any sign of overt bowel obstruction or overt strangulation.

27. The orifice through which the hernia had protruded was observed after reduction to be 1.5cm. Dr Lambie stated in his evidence that if an orifice is smaller than 1.5cm an obstruction or strangulation is more likely to occur.

28. To reduce the hernia Dr Lambie applied gentle pressure over the apex of the hernia as it was lying above the skin. By doing this he was able to reduce the volume by pushing some of the bowel contents back into the intestine inside the abdomen. He continued the pressure using both hands; 'It tended to want to come out the sides where I did not have my fingers, so I used both hands,' he said.

29. After there was no visible hernia above the surface of the skin Dr Lambie said he was able to put his index finger in up to the second joint, 'about an inch'. He could not feel any bowel and he 'palpated around the circumference of the hernial orifice, which was smooth with nothing–no other tissue attachment to it'.

30. Dr Lambie then packed the orifice with Jelonet (paraffin impregnated gauze) which was provided by nursing staff at his request. He then placed ordinary surgical gauze on top to a 3cm thickness. A combine cotton dressing was

placed over this and strapped firmly in place with a good length of Elastoplast adhesive bandage strapping. This was to ensure it was firm enough not to loosen. The strapping was placed horizontally, vertically and diagonally, and caused some compression of the bandage.

31. Dr Lambie could not recall any further conversation with Mr Biffin. He recalled there were two nursing staff present when he examined Mr Biffin. He was then accompanied by nursing staff back to the nursing station. He told the female staff member that 'hopefully the hernia will remain in place'. He instructed her to contact him directly or via the surgery if there was any increased pain, increased amount of vomiting or general decline in his condition. He said he communicated to the staff member that he wanted to know if there was any vomiting or increased pain especially.

32. Dr Lambie had no recollection of any conversation at the nursing station involving a staff member expressing the view that Mr Biffin was more unwell than simple constipation. Dr Lambie considered the hernia was the explanation for his reduced eating, dry retching, vomiting and abdominal pain.

33. Dr Lambie did not request nursing staff to perform vital signs observations or to keep an eye on fluid or oral intake. He said that although Mr Biffin was constipated, this was a usual situation for him and it was of little significance on 25 February 2013 when he reviewed Mr Biffin.

34. Dr Lambie's note in the nursing home record was as follows:

'Umbilical hernia, reduced and strapped.

Constipated–Movicol.'

35. Dr Lambie believed Movicol may help him relieve the incomplete small-bowel obstruction. He diagnosed incomplete small-bowel obstruction due to the prolapsed hernia, which he had examined and considered was full of bowel. There was some oedema.

36. Dr Lambie estimated the visit was between 10 and 15 minutes duration. He instructed nursing staff to leave the dressing until he reviewed it in 48 hours. He agreed in hindsight that it would have been better to include in the nursing home record the instructions given to the nurse to contact him if there was an increase in abdominal pain, continuing vomiting or general deterioration.

37. After his return to the surgery Dr Lambie entered in his own records; 'local hernia reduced-some improvement. Strapped.'

**Nursing staff involvement with Mr Biffin after Dr Lambie's visit**

38. There was no review by a registered nurse recording observations until the same registered nurse who reviewed Mr Biffin on the Sunday evening

returned and saw Mr Biffin the following afternoon on Monday 25 February at 16:30. This was after Dr Lambie had visited Mr Biffin around lunchtime.

39. At 13:55 on Monday 25 after Dr Lambie's visit, an Assistant in Nursing documented Mr Biffin's observations as follows: BP 157/70, pulse 45 and temperature 36.9.

40. Subsequently at 14:30 that afternoon an enrolled endorsed nurse recorded that Mr Biffin complained of nausea that morning and had refused some of his medications. She described him as looking generally unwell and complaining of being nauseated and sick before and after Dr Lambie's visit.

41. At 16:30 that afternoon a registered nurse recorded issuing two more sachets of Movicol with no result for constipation.

42. The next entry in the medical record is dated Tuesday 26 February at 09:00 when the clinical nurse made the first of two identical entries in the chart, both recording two doses of Movicol for constipation. The second dose was recorded at 14:00. No other information was recorded by the clinical nurse in the record.

43. An enrolled nurse then recorded an entry relating back to the time of 13:00 earlier that afternoon. The note recorded Mr Biffin was tired and had stayed in bed the whole day. It confirmed he had been given Movicol x2 at 09:00 and 14:00 and was awaiting the result. It was noted he had a small amount of lunch and due medications were administered.

44. At 18:00 that evening the clinical nurse again recorded authorisation of Movicol. The entry is followed by the clinical nurse stating:

    'Nil reported vomiting today.'

45. The clinical nurse confirmed at the time her duties were to oversee the enrolled nurses and the assistants in nursing from Wisteria and Jacaranda units, as well as other duties including, rostering and clinical issues and problems. The clinical nurse did not have direct resident care responsibility, rather the responsibility to oversee all residents including keeping an eye on those with a change in their health status or who had been unwell. She agreed it was expected that she would review and assess such residents.

46. Many of the staff who interacted with Mr Biffin in the last few days of his life did not know Mr Biffin, but the clinical nurse did. She had performed numerous assessments upon his admission. She knew him to be a quiet, gentle person who did not complain. As recently as 20 February 2013, she had performed a cognitive assessment for Mr Biffin. The result was some short term memory loss but minimal cognitive loss.

47. She acknowledged at the inquest her memory of events was scant given the passage of time. Her entry in the records was also very brief. She agreed that by the end of her shift at 18:00 on the evening of 26 February Mr Biffin had taken 10 doses of Movicol to address his constipation over two days without result. She agreed this was a high dose. She could not recall but stated she would have asked staff caring for him whether he had vomited and therefore recorded the entry 'Nil reported vomiting today.'

48. She said she did recall at the end of her shift Mr Biffin was sitting in his chair, just not looking very well. She instructed the enrolled nurse to 'take his observations and act accordingly'. This was not documented. She explained she expected if the observations were abnormal then the enrolled nurse would report to the registered nurse who was working in the other unit or ring Dr Lambie. She could not be certain she had told the enrolled nurse to ring Dr Lambie if observations were abnormal. Her only certain recall of events was at the 18:00 entry at the end of her shift. She did not hand over to the other registered nurse working in the other unit, she spoke with the enrolled nurse who was to continue until later that evening. She said it was not the practice to hand over to someone at the level of registered or clinical nurse.

49. She recalled she would have been alert to any signs of pain or vomiting which could indicate obstruction. She was unaware of any ongoing pain or vomiting since Dr Lambie had visited. She stated she would have arranged Mr Biffin's transfer straight to hospital if she had been concerned.

50. She said variously that she was not very familiar with obstructed bowel but agreed with a proposition put to her that Mr Biffin's situation was not a classical presentation. She did not perceive there to be a relationship between the reduced hernia and the ongoing constipation. She considered the hernia had been resolved.

51. The clinical nurse was quite clear she would have sent Mr Biffin straight to hospital had there been vomiting in the context of ongoing unresolved constipation.

52. Her only recalled observation of Mr Biffin's physical appearance was that he appeared quite pale. She confirmed it would be at the instigation of a doctor, clinical/registered nurse that regular observations were commenced. She also acknowledged it was the first shift for the enrolled nurse in that unit who was working that evening shift alone.

*The clinical nurse held a more senior position and responsibility than any of the other staff involved with Mr Biffin. Even though the clinical nurse did not have direct nursing involvement with Mr Biffin the position necessarily involved most responsibility for overview of a resident who had recently been reviewed by a doctor and had a procedure to reduce a hernia. A verbal*

*instruction to take his observations and act accordingly was lacking in providing guidance and instruction for less experienced staff.*

53. The enrolled nurse who cared for Mr Biffin on the evening of 26 February had not previously met him. A verbal only instruction to 'take his observations and act accordingly' to an enrolled nurse on the first shift in these circumstances was, in my view, less than the recent history required of a senior clinical nurse. In the broader sense, she did not demonstrate a familiarity with the last few days of Mr Biffin's circumstances, even after access to the records. Nor was there demonstrated a review and assessment of whether Mr Biffin's overall wellbeing had deteriorated and a decision made following such an assessment. Ultimately as clinical nurse there was a responsibility to overview Mr Biffin's circumstances during the period stated by Dr Lambie.

54. The enrolled nurse working that evening was on her first shift in that unit. She had a written list of cares to be provided to residents which had been prepared by the assistant in nursing. She recalled it was handed over to her that Mr Biffin wasn't well and his bowels had not opened. There had been a procedure and he had not been well since. She had been told he had not had a shower for a few days and she was to encourage him to do so. She was also told that observations were being taken a couple of times in the day and had been within normal limits. She referred to a handover sheet with information that was given and verbally handed over to the staff commencing the next shift.

55. Early on that evening, she recalled Mr Biffin was feeling unwell and confused to time and place. She assumed this was due to him being unwell and elderly. He did not eat much dinner. She encouraged him to shower but he did not feel well enough.

56. The enrolled nurse stated she took his observations which were documented as follows at the end of her shift at 22.00 that evening:

    'Feeling lethargic and unwell. Ate very little, fatigued. Confused to place and time. Obs taken- BP 95/55, pulse 64, temp 36.4 C. Refused shower. Stated feels too sick. Staff tried a few times with no luck. Settled at 21:45 hours.'

57. In her statement, she said the observations were within normal limits. According to her review of notes over twenty-four hours Mr Biffin's condition was the same and had not deteriorated. She did acknowledge when questioned that his blood pressure was very low at 95/55, and lower than his previous records. She appeared to have been influenced by the handover from the clinical nurse who did not seem to be particularly worried about low blood pressure but was more worried that the bowels had not opened.

58. The enrolled nurse was however quite clear that had she believed Mr Biffin's condition deteriorated over her shift, she would have contacted the registered nurse to assess Mr Biffin and if necessary transfer him to hospital.

59. She then handed over to the next nurse, an assistant in nursing indicating the recent history, including that Mr Biffin was not feeling very well and required the nurse to assist him to the bathroom. She reported that his bowels had still not opened. He was apparently settled at 21:45.

60. It was at about 23:00 when Mr Biffin's daughter, Heather Haas received a phone call from him. He was in a confused state prompting her to immediately drive to the facility, arriving at about 23:15. When she arrived she discovered her father had vomited and the assistant in nursing was cleaning him up as well as the bed clothes. The assistant in nursing had called the registered nurse who attended from another unit at about 23:30. The registered nurse was caring for two other units of high level care residents. She quickly reviewed the notes which indicated Mr Biffin had not vomited previously that day. It was about 23:45 when she entered the room where the assistant in nursing and Mr Biffin's daughter were present. The registered nurse had not met Mr Biffin previously. He was seated in bed and she immediately noticed his strange yellow pallor. She heard crackly respirations and noted confusion but he did not report pain. She observed bile stained vomit on his pyjama top. She took and recorded observations noting blood pressure was a little low.

61. She saw the assistant nurse was struggling to help Mr Biffin change his top as he was a big man and she went to help before ringing the ambulance.

62. It was at this point that Mr Biffin suddenly collapsed and became unresponsive. The registered nurse administered oxygen via nasal prongs as she was unable to place a Hudson mask due to copious fluids from Mr Biffin's mouth and nose. The bed was lowered and Mr Biffin was rolled into the recovery position. The ambulance was called. Attempts to resuscitate were ineffective/impossible in the circumstances due to fluids emanating from Mr Biffin.

63. Paramedics attended and commenced efforts to resuscitate before ceasing at about 00:30 when Mr Biffin was declared deceased.

**Evidence from Dr John Lambie**

64. Dr John Lambie was Mr Biffin's general practitioner since 1988. Over that period he reviewed Mr Biffin on 260 occasions. Dr Lambie was very experienced and practised as a general practitioner in Toowoomba for 43 years before his retirement. He was additionally qualified as a surgeon and gained his fellowship of the Royal College of Surgeons in Edinburgh in 1970. He used those specialist skills for 17 years whilst working in a group general practice. After moving to sole general practice there was insufficient referral base to continue his surgical practice.

65. Dr Lambie's records documented Mr Biffin's medical history which included:

    Coronary artery disease treated with a pacemaker inserted in 2006;

    Cholecystectomy in 2011;

    Hypertension;

    Transient ischaemic attack;

    Pulmonary embolism 1996;

    Chronic renal impairment;

    The Gastro-oesophageal reflux disease;

    Gout; and

    Traumatic leg ulcers.

66. More recently Mr Biffin suffered from memory loss with early dementia, decreased mobility and lymphoedema associated with his leg ulcers.

67. Dr Lambie recalled Mr Biffin was an intelligent and active man who had worked as a real estate agent after moving off the farm. He described him as quiet and gentle, a stoic man who nonetheless would 'certainly let you know…… If he was ill'.

68. After attending upon Mr Biffin on Monday 25 February Dr Lambie returned to his surgery and made the following entry in his own records; 'local hernia reduced – some improvement. Strapped.'

69. Following Mr Biffin's death, Dr Lambie's next record in his notes was made on 27 February 2013 stating: 'Sudden death. Brainstem infarct (pontine).'

70. He explained he was informed by a police officer of the circumstances of Mr Biffin's death. Dr Lambie had not expected Mr Biffin to deteriorate and die so suddenly and therefore concluded a stroke like event was the most likely cause of death.

71. He included the condition of partially incarcerated umbilical hernia – 3 days, as the other significant condition contributing to death. He explained partially incarcerated umbilical hernia as 'the hernia stuck out…. prolapsed and required manual reduction.'

72. Since Mr Biffin's death and the subsequent knowledge of the cause of death after the autopsy, Dr Lambie reviewed medical texts which suggested to him it was not the wisest thing to do to reduce the hernia. However, he was adamant that on the day of his examination and decision to reduce the hernia

there was no sign of infection, no strangulation, and no contraindication to reduce the hernia.

73. Dr Lambie did not consider the possibility that the bowel may still have been compromised within the hernia after he reduced it because he explored all around the orifice with his finger and it was clear.

74. He disagreed with the suggestion put to him that it was appropriate to transfer Mr Biffin to hospital when he reviewed him. He was confident he had reduced the hernia and he expected the bowel would then recover to normal function. Based on his experience he expected it would take 24-36 hours for Mr Biffin to feel better after the hernia had been reduced.

75. Dr Lambie acknowledged Mr Biffin's death was a dreadful experience for his family as well as for him as the treating doctor. He felt shattered at Mr Biffin's death despite feeling that the treatment he had provided was adequate. After considering the cause of death established by autopsy Dr Lambie considered Mr Biffin's presentation was not a classic one, primarily because of the absence of colicky pain or repeated vomiting.

76. Finally, at the inquest there was a degree of confusion about whether or not Mr Biffin had experienced a prior umbilical hernia which was repaired, which was not documented in Dr Lambie's 25 year history. It is clear that Dr Lambie was unaware of this if in fact it was part of Mr Biffin's history when Dr Lambie visited Mr Biffin on 25 February 2013. It is noted he had undergone a prior cholecystectomy. This may have been the cause of confusion.

**Expected standards of care at the Blue Care facility at the time of Mr Biffin's death and since.**

77. Ms Donna Hart was the Integrated Service Manager at Blue Care in Toowoomba from December 2012. She had overarching responsibility for governance and financial management of various Blue Care facilities in the surrounding areas.

78. Her evidence detailed arrangements in place and changes that had been implemented since she commenced in her role. She confirmed at the time of Mr Biffin's death it was an expectation that staff would take observations if there had been a change in a resident's condition.

79. Although the Service Manager stated the facilities have continuity of staff for residents this was not the reality for Mr Biffin in the last few days of his life when many of the staff who cared for him had not previously done so.

80. The history also shows the qualification level of staff involved with Mr Biffin's care during this period of time did not match the expected staffing qualifications said to be operative at the time. This is a significant issue. With

no disrespect to the staff members involved, it was apparent that the handover of information from one shift to another might have included information that Mr Biffin had a procedure, but there was not necessarily any appreciation of what the procedure was, and the significance of any symptoms which occurred subsequently.

81. Since then, changes have been made to add another clinical nurse in the dementia unit and a greater number of qualified staff. This was part of an overall review and enhancement of management underpinning nursing care called the Residential Management System. This was introduced in late 2013. Part of this initiative included a new position described as a Data Governance Role, held by a registered nurse.

82. The data based system electronically records all clinical information about residents in accordance with clinical guidelines. The registered nurse in the role then conducts daily audits of the information checking for any abnormality requiring further investigation or escalation. The system generates handover reports which stipulate what observations are to be taken and with what frequency.

83. Additionally Blue Care has also introduced and made it known that a particular senior staff member can always be contacted if a more junior staff member has concerns about a resident's wellbeing. This was to address a concern expressed during the course of the inquest by an assistant in nursing who felt unable to communicate concern effectively to Dr Lambie.

**Independent expert review**

84. The inquest was assisted by independent expert opinions reviewing Mr Biffin's care.

**Dr Robert Kable**

85. Dr Robert Kable is a general practitioner with 31 years' experience who is an examiner of the Royal Australian College of General practitioners. He was requested by solicitors acting for Dr Lambie to provide an independent opinion in relation to Dr Lambie's involvement.

86. He agreed the known history for Mr Biffin at the time he was seen by Dr Lambie was consistent with constipation or alternatively a bowel obstruction. He agreed that when the symptoms presented in the presence of the recently complained of hernia, that the condition was linked to the hernia.

87. The question was asked how the two possible diagnoses could be distinguished. He identified increased profuse vomiting and spasmodic colicky pain as signs of obstruction. He also referred to peristalsis, (the movement of the gut) being evident on observation of the abdomen.

88. To establish a diagnosis Dr Kable stated he would:
    - Question whether the bowels had been opened;
    - Examine the abdomen for any sign of obvious distension;
    - Check for any visible peristalsis (movement of the bowel);
    - Examine all four quadrants of abdomen by palpation;
    - Check other hernial orifices for signs of hernia; and
    - Listen to the bowel with a stethoscope.

89. If it was an obstruction he would expect pain all around the abdomen, not just the umbilicus. On tympanic percussion of the abdomen a sound like an empty drum or tinkling or much reduced sounds would be a sign of obstruction. In summary the examination should include:

    Observation;

    Palpation;

    Percussion; and

    Auscultation.

90. If observation and palpation occurred and there were no signs of distension or severe pain and there was an explanation of the umbilical pain given by the presence of the hernia, then that was sufficient to exclude obstruction.

91. Dr Kable remarked the hernia could have caused the constipation or the constipation could have caused the hernia.

92. He said it was important to exclude the possibility of obstruction before attempting to reduce the hernia because the constellation of symptoms raised the possibility of a bowel obstruction.

93. Dr Kable was strongly of the view that for elderly people it is a sensible thing to do to reduce the hernia if it can be done easily and strapped. He expressed the view that it was dangerous for old people to go to hospital and should be avoided if possible.

94. He did not consider there was a need for closer observations after the hernia had been reduced because it had been easily reduced. He said however umbilical hernias had a higher risk of recurring. Dr Kable indicated verbal instructions to nursing staff to observe whether he was eating, vomiting, whether his pain had increased or changed in the quality of pain were important. He did not consider four hourly observations were necessary. The focus should be on any deterioration of symptoms.

95. Dr Kable also noted Dr Lambie used the terminology of a partially incarcerated hernia whereas Dr Kable would use the term reducible hernia.

96. Overall Dr Kable considered it was reasonable for Dr Lambie to reduce the hernia because he had ruled out gut obstruction. He did not think there was any indication requiring Mr Biffin to be sent to hospital. He agreed a non-urgent elective follow up referral to a surgeon for permanent repair of the hernia was appropriate.

**Professor David Gotley**

100. Professor Gotley is a consultant surgeon at the Princess Alexandra Hospital and Mater Private Hospital. He was also requested by solicitors acting for Dr Lambie to provide an independent opinion in relation to Dr Lambie's involvement.

101. He provided an example of recently performing a reduction of a hernia in his professional rooms. He also noted this occurred mostly in the elderly where there was risk with surgery due to co-morbidities. Professor Gotley differentiated hernias as;

(i) reducible,
(ii) not reducible/incarcerated, or
(iii) strangulated.

101. Professor Gotley referred to the Sabiston's Text of Surgery which stipulated -

'Incarcerated hernias are difficult to differentiate from those in which the strangulation process has begun and therefore are considered surgical emergency.'

102. He explained that if there is any sign of intestinal obstruction one must visualise and palpate all potential hernial sites. He agreed that the umbilical hernia is more likely to cause strangulation of the bowel because the sacs are smaller.

103. The classical presentation of a strangulation of bowel in a hernia, or strangulated hernia with bowel in it, is one that is tense, tender and irreducible.

104. He distinguished an incarcerated hernia which is not necessarily tense or tender and can be reduced. To summarise, if the hernia is easily reducible and not tender it is not incarcerated and therefore it is not strangulated. He agreed that there was a high incidence of recurrence of umbilical hernias and a risk of incarceration and strangulation to some degree. He described the particular orifice in Mr Biffin's case as a moderate sized neck of hernia. He agreed it was desirable that Mr Biffin be observed closely over the next day or two or three to be certain the reduction had been successful and no damage had occurred in the process. In particular, he would be more interested in symptoms improving rather than the issue of recurrence of the hernia per se.

105. His review of the record and from Dr Lambie's evidence at inquest was an impression of a general sense of Mr Biffin being unwell. Professor Gotley did not consider the information suggested an acute situation but rather more one of Mr Biffin gradually becoming unwell over a few days.

106. He would be very interested to know how Mr Biffin improved generally, but regular pulse and blood pressure and oxygen saturations were not necessarily the focus.

107. Where a reduction of the hernia had been successfully and easily achieved without obvious signs of strangulation he would elect a time period to review the patient. He would anticipate the need for surgical correction once appropriate assessment of risk factors was undertaken. He preferred an elective approach.

108. He pointed out the difficulty of expert review in placing oneself in the position of the clinician at the time exercising clinical judgement.

109. Review of the autopsy report indicated the hernia had recurred. Dr Lambie's technique of filling the hernial defect in the abdominal wall with folded gauze and strapping down the dressing was a long-standing technique, particularly outside hospital settings.

110. Professor Gotley's review of the record did not lead him to the conclusion of bowel obstruction on 25 February 2013. Ultimately, the fact the hernia was easily reduced was confirmation that the bowel was not obstructed. The hernia was not tense, tender and irreducible which would be consistent with strangulation.

111. Professor Gotley described colicky pain as quite intense that eases off and then comes back again in waves. He acknowledged that he often gave verbal instructions to nursing staff and the senior nurse on duty and this was a reasonable thing to do. The requirement to notify him of any further vomiting, increased abdominal pain or general deterioration was appropriate.

112. Overall Professor Gotley considered this an extremely unfortunate circumstance. The findings at autopsy indicated 120mm loop of bowel was found in the hernia, which had recurred. It was purplish in colour with some bruising or blood staining of the mesentery, indicating vascular compromise along the lines of strangulation. The hernia had been clinically reduced 30 hours beforehand. In the subsequent period there had been re-herniation and strangulation at some point. There had been some obstruction but was not particularly advanced.

113. Professor Gotley confirmed Mr Biffin's history was not a classical bowel obstruction. It was not a classical presentation of strangulation. The initial examination on 25 February did not record the hernia as tense and tender and difficult or impossible to reduce. Thirty hours later at autopsy there were some signs of intestinal obstruction. He concluded there has been a re-

herniation closer to the time of death but he could not delineate the timeframe in which this had occurred.

**Dr William Braun**

114. Dr William Braun is a consultant general surgeon at Metro North Hospital health service and Holy Spirit Northside and Northwest Private Hospital. As with the previous expert witnesses his practice was predominantly in an acute setting, particularly of elderly patients. He was experienced with emergency acute presentations of elderly patients with hernias including from nursing homes.

115. In Dr Braun's opinion after reviewing all of the information Mr Biffin had a small bowel obstruction secondary to an incarcerated hernia with bowel ischaemia. This led to severe sepsis, bronchopneumonia and cardiac arrest.

116. He considered Mr Biffin should have been transferred to hospital on Sunday 24-25 February. On the Sunday Dr Braun considered the symptoms experienced by Mr Biffin were consistent with classic bowel obstruction given the hernia itself, abdominal pain, vomiting and constipation.

117. It is noted Counsel Assisting considered and submitted the actions taken by the registered nurse at the time of assessment and communication via facsimile on the evening of 24 February were appropriate. This is in the context that Mr Biffin would be reviewed the following morning and had settled. This submission is accepted.

118. Dr Braun's assessment differed to the other two experts. Given his conclusion of bowel obstruction he considered the administration of Movicol was contraindicated and likely to contribute to electrolyte imbalance and dehydration.

119. Dr Braun agreed with Professor Gotley that the notes were quite vague and it was difficult to say exactly what was occurring at the nursing home. Dr Braun understood Mr Biffin had an acute hernia which had not been previously present. He referred to a previous cholecystectomy in the notes as a confusing factor which may have suggested a previous hernia repair.

120. Dr Braun noted Mr Biffin was consistently described as not being a person who would complain and not one to freely confide to other people his symptoms. It was documented he had abdominal pain and vomiting although how much vomiting was hard to ascertain. He had not opened his bowels for three days. Dr Braun therefore concluded it was more likely than not that he had a bowel obstruction, an incarcerated hernia containing small bowel and his symptoms were attributable to those circumstances.

121. Dr Braun considered the reduction of the hernia was incomplete and obstruction continued. He pointed to the gradual deterioration consistent with a bowel not propulsing.

122. Dr Braun was critical with respect to Dr Lambie's taking of Mr Biffin's history. The conversation was very brief and insufficient.

123. With respect to the examination he remarked there was no documentation of the examination at the time. He recalled Dr Lambie examined the abdomen, the hernia orifices, he felt the hernia and attempted to reduce it.

124. Dr Braun noted Dr Lambie's evidence that he had inserted his index finger into the orifice and felt the around the circumference for any defect. Dr Braun accepted that the hernia appeared to be reduced, but the presentation the following day appeared to him to be inconsistent. There was a gradual decline in all aspects which he considered were more consistent with ineffective reduction of the hernia which recurred.

125. He explained in obese patients it is possible to put a finger in the deficit and feel around the rim whilst the hernia has not been completely reduced.

126. Dr Braun's explanation of why he thought the hernia had not been fully reduced was somewhat difficult to understand. He considered the totality of the clinical records and Mr Biffin's condition indicated he was deteriorating over some time with no opening of the bowel, and central lower abdominal pain and vomiting. He considered that there was an obstruction prior to Dr Lambie performing the reduction of the hernia. In Dr Brauns' opinion the reduction was probably not complete and his condition then gradually deteriorated until the final collapse.

127. Dr Braun stated if he had any suspicion the bowel was obstructed or the hernia strangulated he would at the least require blood tests to check electrolytes. He would not have attempted a reduction in a low care facility. Dr Lambie had no such suspicion.

128. Finally, Dr Braun considered the absence of reported pain on Tuesday 26 February was likely due to the section of bowel being ischaemic (dead).

**Conclusions**

129. Mr Biffin was quite elderly with a significant range of co-morbid conditions known to his long standing treating general practitioner, Dr Lambie. When nursing home staff requested Dr Lambie's attendance to review Mr Biffin it is quite apparent that Dr Lambie's assessment of Mr Biffin's condition was limited. He did not seek information from the nursing staff who had requested the medical review for Mr Biffin. He had not seen the facsimile sent to his practice the previous evening. Therefore, he was unaware of the information that the registered nurse assessed Mr Biffin's pain as sufficient to require oral morphine. That medication had been previously authorised by Dr Lambie on an as required basis for another condition.

130. Dr Lambie did not read the nursing home progress notes, either before or after attending on Mr Biffin when he wrote up a two-line note. Therefore, his history taking and examination of Mr Biffin was the only avenue to inform him of the background events and symptoms leading to the nursing staff's requests for Dr Lambie to review Mr Biffin.

131. Dr Lambie knew Mr Biffin over many years and described him as a gentle and stoic man who none the less would state his mind. Knowing the character of Mr Biffin as he did, it was incumbent on Dr Lambie to ensure he carefully questioned Mr Biffin about the nature of his pain and the extent of his vomiting. However, Dr Lambie's conversation was extremely brief given the total interaction, including physical examination and reduction and strapping of the hernia, took between 10 and 15 minutes.

132. In that time he physically examined Mr Biffin's abdomen and the hernia, which he did not consider to be 'tense'. He saw no sign of distension and he checked the other hernia orifices. In the absence of his stethoscope he did not listen to the bowel nor did he percuss the abdomen. These were examinations which would add to the overall assessment to exclude an obstruction before consideration could be taken to safely reduce the hernia.

133. He concluded the hernia and constipation were responsible for Mr Biffin's symptoms. He was able to reduce the hernia. He checked around the rim of the orifice and found it to be clear of any other tissue and therefore concluded the reduction was successful. The appearance of the colour of the hernia did not alarm him.

134. He told nursing staff to monitor Mr Biffin's condition particularly regarding any vomiting, pain or overall deterioration.

135. Expert opinion varied regarding Dr Lambie's overall care. There was agreement that the history taking was inadequate. Dr Kable was satisfied that Dr Lambie had sufficiently ruled out possible bowel obstruction by physical examination of the abdomen and palpating the abdomen but without listening to the bowel or percussing the abdomen. It seems a somewhat circular explanation to state that if the hernia could be reduced (which Dr Lambie believed he had achieved) it therefore follows that the hernia was not incarcerated.

136. The paucity of Dr Lambie's communication with Mr Biffin to elicit a history as well as the briefest of summary notes meant it was difficult for reviewing experts to determine whether or not it was appropriate for Dr Lambie to attempt the reduction of the hernia. There was limited information and variation of views between the experts which results in an inability to reach a conclusion whether it was appropriate or not to attempt to reduce the hernia.

137. The effectiveness of Dr Lambie's direction to nursing staff about what matters should be communicated to him is questionable. He made no note in the record detailing what matters should be reported to him. The enrolled nurse

who was in attendance during the examination and back at the nursing station afterwards could not recall any details being handed over by Dr Lambie, but this was some significant time later when a statement was provided. Dr Lambie conceded it would have been preferable had he done so. Although Dr Kable stated it was his practice to give verbal instructions to nursing staff this could hardly be considered as good practice. Dr Lambie conceded he did not know what level of nursing the staff member held when he said he passed on instructions to monitor any vomiting, pain or overall deterioration.

138. It was confirmed at autopsy that the umbilical hernia had recurred. Given the variation in expert evidence it cannot be determined whether the initial reduction performed by Dr Lambie was complete or that the hernia recurred which was a known risk in particular of an umbilical hernia.

139. In all these circumstances it is considered that Mr Biffin's death was a health care related death. He died due to complications of an incarcerated umbilical hernia which had been treated by physical reduction and strapping approximately thirty hours earlier. The hernia was either ineffectively reduced or recurred. This occurred within the period Dr Lambie expected nursing staff would monitor Mr Biffin's wellbeing and contact him prior to an anticipated review in a couple of days. Although there was no evidence of vomiting, or complaint of pain the overall impression was Mr Biffin was indeed deteriorating. His blood pressure was falling, he was not taking responsibility for his own showering which was most out of character, and he was disinterested in his food and remaining in bed. Unfortunately nursing staff involved in this period were generally not known to Mr Biffin and did not appreciate these behaviours were not signs of general age or decline. The 'handover' from one shift to another was ineffective in alerting staff to assess Mr Biffin's overall condition rather than a narrow focus on whether or not his bowel function had returned. This failure was a combination of inadequate directions and lack of documentation on the record by Dr Lambie and the lack of overall nursing responsibility particularly in the clinical nurse role as time progressed and Mr Biffin's condition deteriorated rather than improved.

140. An acknowledgement was made by Counsel for Blue Care that it was regrettable that no contact had been made with Mr Biffin's family simply to inform them that he had been sufficiently unwell to call the doctor to attend. Mr Biffin of course retained capacity for decision making but he was obviously unwell and his character such that he was somewhat reticent to make complaint. It cannot be said whether such notification would have altered the outcome.

**FINDINGS SECTION 45(2)**

141. The deceased person was Mr Albert Eric Bruce Biffin

142. Mr Biffin notified nursing staff he was unwell on the morning of 24 February 2013. He was reviewed by a registered nurse who documented symptoms

of lower abdominal pain, vomiting and dizziness and the presence of an umbilical hernia. He was constipated. That same Sunday evening he vomited copiously and a facsimile request was sent seeking review by his doctor on the following day. On 25 February Mr Biffin's general practitioner Dr Lambie attended and examined and assessed Mr Biffin. Dr Lambie concluded Mr Biffin's symptoms were due to an umbilical hernia and constipation. He said he considered and excluded the possibility that Mr Biffin was suffering from an obstructed bowel and he reduced the hernia. He packed and taped the hernia orifice. He noted on the record a direction to administer Movicol for constipation. He gave brief verbal instructions to contact him if Mr Biffin's condition deteriorated or he had abdominal pain or vomiting occurred. Subsequently there was no record of complaint of pain or vomiting but Mr Biffin's overall condition deteriorated until his final collapse immediately following vomiting at about 23:15 on 26 February 2013.

143. Mr Biffin died from a cardiac arrest. The causes of his death were complications of an incarcerated umbilical hernia. An electrolyte imbalance and sepsis developed as result of a necrotic and poorly functioning small bowel.

144. Mr Biffin died in the early hours of 27 February 2013.

145. Mr Biffin died at Jacaranda unit at the blue care facility at 256 Stenner Street Toowoomba in Queensland

146. The medical cause of death was complications of an incarcerated umbilical hernia. Cardiac arrest was triggered by an electrolyte imbalance and sepsis which developed as a result of a necrotic and poorly functioning small bowel.

**RECOMMENDATIONS**

(1) It is recommended Blue Care introduce a requirement for personal carers and assistants in nursing to enter any variation in a resident's condition in the progress notes. The note should document to whom it was escalated and the enrolled nurse or registered nurse record in the progress notes the assessment and response.

(2) Blue Care encourage visiting medical officers to document the diagnosis and management plan, including any planned review and indications for earlier escalation. Such a policy might introduce procedure and training for registered nurses, enrolled nurses and endorsed enrolled nurses to assist them in requesting visiting medical officers to state and preferably record their diagnosis and treatment plan. It is not intended in this recommendation that the primary responsibility for communication and documentation would transfer from the doctor. However, the interests of the resident/patient should be the primary focus in ensuring that there is a written record of a doctor's instructions to nursing staff following an attendance at a nursing home facility. The record must be sufficient to inform nursing staff from one shift to another what action the doctor

requires and in what circumstances the doctor or emergency services should be contacted.

(3) Blue Care consider further training of personal carers and assistants in nursing authorising them to make entries in the medical records where appropriate. This recommendation recognises it is people in these roles who often have greatest continuity of contact with the resident and therefore the greatest appreciation of any change in the wellbeing of a resident in a nursing care facility.

Chris Clements

Coroner

Brisbane

3 May 2017