MAGISTRATES COURT *of* TASMANIA

CORONIAL DIVISION

Record of Investigation into Death (Without Inquest)

Coroners Act 1995
Coroners Rules 2006
Rule 11

(These findings have been de-identified in relation to the name of the deceased, family, friends and others by direction of the Coroner pursuant to s57(1)(c) of the Coroners Act 1995)

I, Simon Cooper, Coroner, having investigated the death of Mrs M

Find, pursuant to Section 28(1) of the *Coroners Act* 1995, that

a) The identity of the deceased is Mrs M;
b) Mrs M died as a consequence of recurrent intra-abdominal sepsis and surgical complications following endoscopic duodenal perforation in June 2019;
c) The cause of Mrs M's death was multi organ failure; and
d) Mrs M died on 17 April 2020 at the Royal Hobart Hospital, Hobart, Tasmania.

In making the above findings I have had regard to the evidence gained in the investigation into Mrs M's death. The evidence includes:

- Police Report of Death for the Coroner;
- Tasmanian Health Service – Death Report to Coroner;
- Medical records – Gastrohealth, Hobart;
- Medical records – Mr R Bohmer, general surgeon;
- Medical records – Geeveston Medical Centre;
- Medical records – Tasmanian Health Service – Royal Hobart Hospital;
- Medical records – Hobart Private Hospital;
- Medical records – Calvary Hospital;
- Précis – medical records – Ms L Newman, forensic nurse; and
- Report for the Coroner – Dr Anthony J Bell, medical advisor to the Coroners Office.

On 30 April 2019, Mrs M underwent a gastroscopy. A carpet like lesion was found in her duodenum. A biopsy of the lesion showed it to be a tubulovillous adenoma.

A CT scan of her abdomen was performed on 1 May 2019. The CT scan did not detect mass lesions of the duodenum. Mrs M was referred for a second opinion to a gastroenterologist, Dr W Osler.

On 11 June 2019, Dr Osler resected a large adenoma from the second part of Mrs M's duodenum. Whilst the procedure was being carried out Mrs M's duodenum was perforated.

Later that evening Mrs M was returned to theatre for an emergency laparotomy. Mr R Bohmer, general surgeon (who had referred Mrs M to Dr Osler), performed the surgery. He was unable to close completely the perforation of the duodenum. Post operatively, Mrs M was transferred to the hospital's intensive care unit.

Thereafter, Mrs M suffered months of debilitating pain with various transfers between the Calvary Hospital, the Hobart Private Hospital and the Royal Hobart Hospital. She developed acute pancreatitis and sepsis. The amount of treatment Mrs M received is reflected by the fact that her medical records at the Hobart Private Hospital over this period amount to four volumes of some 1,273 pages.

On 24 June 2019, Mrs M was transferred from the Calvary Hospital to the Hobart Private Hospital where she remained until 18 July 2019. On that day she was transferred to the Royal Hobart Hospital for surgery and remained there until 4 August 2019 before being transferred back to the Hobart Private Hospital.

On 1 November 2019, Mrs M was transferred to the Royal Hobart Hospital and underwent a Whipple procedure the same day. A Whipple procedure is a complex operation which involves removal of the head of the pancreas, the first part of the duodenum, the gallbladder and the bile duct. Thereafter, she was transferred, post-operatively, to the Royal Hobart Hospital's intensive care unit, and following improvement, transferred back to the Hobart Private Hospital on 7 November 2019.

It was not until about mid-December 2019 that Mrs M was well enough to be discharged home from hospital.

On 6 April 2020, after five or so days of functional decline and recurring falls, Mrs M was readmitted to the Royal Hobart Hospital. Upon admission, she was critically unwell and in septic shock. She underwent yet another laparotomy on 9 April 2020 (her fourth since June

2019). Mrs M's condition did not improve and eventually a decision was made to transition to end-of-life care. She died on 17 April 2020.

The Royal Hobart Hospital reported the fact of Mrs M's death in accordance with the requirements of the *Coroners Act* 1995. Her body was formally identified and then transferred to the hospital's mortuary. At the mortuary, experienced forensic pathologist, Dr Andrew Reid, examined her body and after reviewing her medical records provided a report. Dr Reid expressed the opinion in that report that the cause of Mrs M's death was multi organ failure. Dr Reid considered the antecedent causes of her death were recurring intra-abdominal sepsis and surgical complications, resulting from the endoscopic duodenal perforation on 11 June 2019. I accept Dr Reid's opinion as to the cause of Mrs M's death.

The circumstances of Mrs M's death required further investigation by the Coronial Division Medico-Legal Committee. Her treatment was comprehensively reviewed by Ms L Newman, forensic nurse, who provided a detailed précis of her treatment. That précis has informed these findings.

In addition, the medical advisor to the Coronial Division, Dr Anthony Bell MB BS MD FRACP FCICM, reviewed Mrs M's treatment and provided a report.

Dr Bell said in his report:

> "*Following the duodenal perforation the management was a good quality with excellent interaction between many specialists. The outcome of [*Mrs M*] improving at home and looking forward to resuming academic work was an achievement. The final event may well have been treatable but the patient delayed therapy probably due to past experience of months in hospital and multiple surgeries.*"

Mrs M's decision to delay seeking medical intervention in April 2020 is hardly surprising in light of the consequences for her of her original surgery 10 months earlier.

Discussion

I accept that following the perforation of Mrs M's duodenum on 11 June 2019, the treatment she received was of an appropriate standard. I also accept that perforation of duodenal are an acknowledged risk of any resection.

The issue is whether the decision to perform the resection on 11 June 2019 was appropriate or whether a Whipple procedure should have been carried out at that time.

I think it is clear that had a Whipple procedure been carried out on 11 June 2019, then Mrs M's duodenum would not have been perforated and the tragic course that ensured would have been avoided.

Nonetheless, the decision whether to proceed by way of a Whipple procedure or a simple resection was not an easy one.

The decision to attempt to remove the adenoma was appropriate. Although no sign of malignant cells were detected as the result of biopsy, villous adenomas carry significant risk of carcinoma.

This finding, in draft, was sent to the Calvary Hospital and the medical practitioners involved in Mrs M's treatment. Calvary and the medical practitioners were invited to provide comments about the draft finding. None did so. I therefore proceed on the basis that no issue is taken by the hospital or the medical practitioners involved with anything in this finding.

Comments and Recommendations

The circumstances of Mrs M's death are not such as to require me to make any comments or recommendations pursuant to Section 28 of the *Coroners Act* 1995.

I convey my sincere condolences to the family and loved ones of Mrs M.

Dated 13 August 2021 at Hobart in the State of Tasmania.

Simon Cooper
Coroner