IN THE CORONER'S COURT	**)**	**CD 57 OF 2006**
AT CANBERRA IN THE	**)**	
AUSTRALIAN CAPITAL TERRITORY	**)**	

INQUEST INTO THE DEATH OF VALERIE KOLTS

REPORT OF FINDINGS

Coram: Chief Coroner J D Burns

Date: 31 May 2010

FINDINGS: I find that the deceased, Valerie Kolts, died at John James Hospital, Canberra, at 23.12 hours on 3 March 2006. The cause of death was retroperitoneal blood loss in a setting of anticoagulation therapy following hip replacement of the left hip.

1. These proceedings were commenced by the former Chief Coroner in March 2006, but were not completed by the time he retired in November 2009. The evidence clearly established that the deceased died on 3 March 2006. As such four years have now passed during which the family of the deceased have been denied closure by the failure to finalise these proceedings. On behalf of the court I apologise to the family of the deceased, and in particular to the husband of the deceased.

2. On 21 May this year I convened a Directions Hearing in this matter. Counsel for Dr Aubin and for John James Hospital both indicated that there was no further evidence they sought to put before me and they were content to rely upon their earlier written submissions. Mr Kolts, the husband of the deceased, had earlier informed court staff that he did not intend attending.

3. The matters on which the Coroner holding an inquest must make findings, if possible, are set out in section 52(1) of the Act as follows:
    a. *"identity of the deceased; and*
    b. *when and where the death happened; and*
    c. *the manner and cause of death; and*
    d. *in the case of the suspected death of a person-that the person has died."*

4. Section 57(3) of the Act empowers me to make recommendations to the Attorney-General on *"any matter connected with an inquest...including matters relating to public health or safety."*

5. As the Full Court of the Supreme Court of the Australian Capital Territory made clear in *The Queen v Doogan; Ex Parte Lucas-Smith & Ors* [2005] ACTSC 74 the *Coroners Act* is generally concerned with the resolution of relatively straightforward questions such as "What was the cause of this death?" It is not the role of the coroner to seek to attribute blame or fault with respect to a death, although the Act anticipated that comments with respect to a person. The role of the coroner is to determine what happened, and then to make the findings required by section 52(1) of the Act. If in the course of that exercise the coroner identifies a matter relevant to public health or safety or the administration of justice, or some other matter connected to the death that the coroner believes should be brought to the attention of the Attorney-General, the coroner may comment on that matter.

6. In the present case there is no difficulty in making the findings required by section 52(1). The evidence clearly establishes the identity of the deceased, where and when the death happened and the manner and cause of death.

FORMAL FINDINGS

7. I find that the deceased was Valerie Kolts. She died at John James Hospital Canberra at 23.12 hours on 3 March 2006. The cause of death was retroperitoneal blood loss in a setting of anticoagulation therapy following hip replacement of the left hip.

ISSUES RAISED

8. I have read the transcript of the proceedings before the former Chief Coroner on 5 September 2008, together with the exhibits tendered on the hearing and the submissions filed by those granted leave to appear on the hearing, and the letter from Mr Kolts dated 29 January 2008. I note that issues concerning the anticoagulant therapy administered to Mrs Kolts both prior to and subsequent to her hip replacement surgery were ventilated. Having considered the evidence I am not satisfied that there was any lack of care by those treating or attending to Mrs Kolts that in any way contributed to her death. In hindsight, there were certain signs or symptoms that may now be identified as connected with the cause of Mrs Kolts death, but they were not such as to be readily or obviously so connected. It is not at all clear whether the outcome would have been any different had those treating Mrs Kolts recognised those signs or symptoms as potentially connected with the condition that eventually caused her death.

I certify that the preceding 8
paragraphs are a true copy of the
Reasons for Decision herein
by Chief Coroner J D Burns

I Fernandez
Associate