STATE CORONER'S COURT
OF NEW SOUTH WALES

Inquest:	**Inquest into the death of John Reginald Beech**
Hearing dates:	15-19 August 2011, Parramatta
Date of findings:	11 November 2011
Place of findings:	State Coroner's Court, Glebe
Findings of:	Magistrate Sharon Freund, Deputy State Coroner
Findings:	I find that John Reginald Beech died at Sydney Adventist Hospital on 24 April 2007 directly from postoperative intra-abdominal bleeding and its consequences its antecedent cause being a malignant colonic polyp.
File number:	0704/07
Representation:	Mr. David Hirsch, Counsel Assisting instructed by Stephen Hogan solicitor, Crown Solicitors Mr. Woods instructed by Avant Mutual Group Ltd for Drs Loder and Reeder; Mr. Gregg instructed by MDA National for Drs Morris and Unwin; Ms. Lonergan for Dr Choong; Mr. Maybury instructed by HWL Ebsworth Lawyers for Sydney Adventist Hospital ("SAH").

Inquest into the death of John Reginald Beech

FINDINGS

John Reginald Beech was 64 years old when he died on 24 April 2007 at the Sydney Adventist Hospital in the suburb of Wahroonga. He is survived by his wife Dora, children Rebecca, Matthew and Daniel, and siblings Jan and Graeme. Mr. Beech died after his family made the difficult decision, after lengthy discussions with hospital staff, to take him off life support one week after he had a cardiac arrest following surgery. It was explained that Mr Beech had suffered hypoxic brain damage and his prospects for any meaningful recovery and reasonable quality of life were very poor. The surgery in question was a high anterior resection in relation to a previously removed malignant polyp in his bowel and hernia repair. It was performed by Dr. Loder, colorectal surgeon, on 17 April 2007 at the Sydney Adventist Hospital.

In relation to the delay between Mr. Beech's death in 2007 and today, I note that initially on 8 May 2008 a Coroner looking at the matter was of the view that the need for an inquest should be dispensed with, however upon representations being made by Mrs Beech to the State Coroner that decision was reversed and the matter was assigned to a Deputy State Coroner and the matter ultimately listed for inquest before me.

A coroner's function is to attempt to answer five questions: Who died? When did he or she die? Where did he or she die? What was the cause of death? And finally, what was the manner of death? The cause of death is the immediate physical cause. The

manner of death refers to a way a person dies, including the surrounding circumstances. A coroner may also make recommendations concerning public health or safety issues arising out of the inquest into the death in question.

In relation to Mr. Beech's death there is no issue in relation to the identity, date, place or direct cause of his death. The sole issue to be determined by this inquest was in relation to the manner of Mr. Beech's death arising out of the surrounding circumstances namely the care and treatment he received immediately following his initial surgery by Dr. Loder at the Sydney Adventist Hospital on 17 April 2007.

A number of issues arose during the course of the inquest in relation to the surrounding circumstances leading up to Mr. Beech's death, these include:

1. What was the cause of Mr. Beech's haemorrhage following his surgery?

2. What were the clinical signs or symptoms suffered by Mr. Beech, of the post-operative haemorrhage?

3. When did the various medical personnel become aware of the signs and symptoms and conclude that Mr. Beech was haemorrhaging?

4. Should Mr. Beech have been returned to the Operating Theatre earlier and if so when?

5. What was the cause of Mr. Beech's cardiac arrest?

6. What was the cause of Mr. Beech's hypoxic brain injury?

I will deal with each of these issues in turn.

WHAT WAS THE CAUSE OF MR. BEECH'S HAEMORRHAGE FOLLOWING HIS SURGERY?

The Post Mortem report dated 9 April 2008[1] revealed the following:

"*Three sutures were identified around the pancreatic head and body (one may represent a ligated vessel during the second abdominal surgery)…*"[2]

Dr. Loder's initial evidence contained in his first statement dated 16 September 2009[3] in relation to the second operation performed on Mr. Beech stated as follows:

"..I proceeded directly to perform an exploratory operation and found there was a large quantity of blood within the abdomen which I estimated to be approximately 6000mL. The cause of the bleeding was from a small artery in the lesser sac. This was secured by suture…"[4]

Thereafter in his second statement dated 16 August 2011[5], which I note was prepared and served on the second day of the inquest, he stated as follows:

"At the second operation, I discovered a large amount of blood within the peritoneal cavity. There was a small artery, less than 1 mm in diameter, bleeding in the region known as the lesser sac. This region lies behind the stomach and is closely related to the body and tail of the pancreas. This is the site of attachment of the transverse mesocolon which is routinely mobilised during the operation. The most likely intraoperative cause of Mr. Beech's haemorrhage was a traction injury to a small pancreatic artery over the body of the pancreas. It is most likely that this vessel spasmed during the first operation, explaining the lack of bleeding at that time."[6]

There were a number of major inconsistencies and changes in relation to evidence provided to the inquest by Dr. Loder in relation to the death of Mr. Beech and I will deal

1 Volume 1, Tab 5 exhibit 1;
2 Ibid at page 9;
3 Volume 1, Tab 10;
4 Ibid at paragraph 11;
5 exhibit 12;
6 Ibid at paragraph 29;

with those inconsistencies and changes in more detail during the course of these findings. However, his evidence as to what he discovered during the course of his second operation has been corroborated by the post mortem findings.

Accordingly I am satisfied that the cause of Mr. Beech's bleed was the injury to the small pancreatic artery which was repaired by Dr. Loder during the course of the second operation.

WHAT WERE THE CLINICAL SIGNS OR SYMPTOMS SUFFERED BY MR. BEECH OF THE POST-OPERATIVE HAEMORRHAGE?

The hospital records in relation to Mr. Beech's initial operation performed by Dr. Loder on 17 April 2007 record that Mr. Beech's surgery commenced in Operating Theatre 8 just after 3pm[7]. It was completed at approximately 5.55pm with Dr. Morris, anaesthetist accompanying him to the recovery ward. Dr. Morris remained with Mr. Beech for approximately 15 minutes. At that time the hospital records indicate that Mr. Beech had:

- Normal blood pressure – 132/86;
- Normal Heart rate of 95 beats per minute;
- Restlessness on removal of airway and gaining of consciousness at approximately 6.05pm;

Dr. Morris pursuant to his usual practice ordered a PCA ("**patient controlled analgesia**") and a chest x-ray to check the position of the central venous catheter

[7] operation records found Volume 2 Tab 44 indicate "time out" 3.08pm;

("**CVC**")[8]. Thereafter Dr. Morris returned to Operating Theatre 8 to commence the anaesthetic for the next patient on Dr. Loder's operating list, Mr. Wyndham. That operation started almost immediately on his return (I note that the "Time Out" in relation to Mr. Wyndham's operation is 6.05pm).

After Dr. Morris returned to the operating theatre all the evidence indicates that Mr. Beech's blood pressure continued to fall despite the fact:

a) that Mr. Beech reported that he was in significant pain (reported as 8-9/10) and was given 2mg of morphine on 4 separate occasions. The expert evidence indicates that significant pain would usually increase a patient's blood pressure[9]; and;

b) He was also given fluids. which would increase blood pressure, but this had no significant effect as the blood pressure continued to fall despite this.

After being notified by recovery Dr. Morris attended on Mr. Beech at about 7.00pm.

Dr. Morris provided his first statement for the purposes of this inquest in September 2009. It was extremely light on detail in relation to his care and treatment of Mr. Beech whilst he remained in recovery. It stated:

"*Approximately one hour later, I was informed by the Recovery Ward that Mr. Beech's condition had suddenly and unexpectedly deteriorated. I therefore arranged for Mr. Beech to be reviewed by the intensivist. I understand that the intensivist organised for Mr. Beech to be transferred to the Intensive Care Unit for treatment. Mr. Beech was also to receive a blood transfusion as his blood count was low. Dr. Loder was*

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[8] I note that the x-ray records indicate that the x-ray was performed on Mr. Beech at approximately 6.18pm and reviewed by Dr. Morris but it was his evidence that he was not present at the time of the x-ray and the review was done at a later time;

[9] Dr. Choong: Transcript 17/08/11 pages 26.10 and 27.40;

subsequently contacted by the intensivist, and informed that Mr, beech needed to return to theatre for surgery, as he was suffering from continued bleeding."[10]

The second statement prepared by Dr. Morris in about August 2011[11] (shortly before the commencement of the inquest) provided more detail namely that:

"I believe that I was informed about the drop in Mr. Beech's BP at around the time I was wheeling Mr. Wyndham into recovery. It is my recollection I was told that Mr. Beech's BP had suddenly deteriorated, and that his pulse rate was low.

I then reviewed Mr. Beech. I requested that a transducer be attached to his arterial line, to enable a more accurate monitoring of his BP to be performed. However, there was no obvious cause for his hypotension. As Mr. Beech's low BP and low pulse rate were suggestive of a cardiac cause, I ordered an ECG. This was reported as being normal.

It is not uncommon for patients with low BP to be suffering from an anaphylactic reaction to a particular medication. I therefore administered adrenaline to Mr. Beech, as this is a drug which is specific for anaphylaxis, in addition to raising the BP. I considered it to be possible that Mr. Beech had suffered as allergic reaction to IV morphine or some other medication that he had received"[12].

Nurse Balmaceda was the nurse assigned to care for Mr. Beech in recovery after his surgery. She gave evidence on the first and second days of the hearing. Nurse Balmaceda provided two statements in relation to this inquest. The first dated 13 July 2009[13] and the second undated provided shortly before the commencement of the inquest[14]. Despite not having a clear independent recollection of the events of 17 April 2007, the statements provided by Nurse Balmaceda together with her contemporaneous notes recorded at the time she was attending to Mr. Beech make it clear that she observed him to be "warm and pale"[15] on his arrival in the recovery ward and that she attended to taking Mr. Beech's observations (namely his Blood Pressure

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10 Volume 1, Tab 11 paragraphs 11-13 inclusive;
11 Exhibit 7;
12 Ibid at paragraphs 21 – 24 inclusive;
13 Volume 1 tab 22;
14 Exhibit 9;
15 Volume 2 tab 46 pages 112 and113;

and Heart Rate) every 15 minutes. It is clear from these contemporaneous medical notes that Mr. Beech's Blood pressure continued to fall[16] from when Dr. Morris initially left recovery to attend on the Wydham operation until he was contacted at about 7pm.

Accordingly, I am satisfied that as at 7pm that Mr. Beech had been suffering from hypotension for a period of not less than 50 minutes with his blood pressure falling despite fluids being given, together with a heart rate that remained normal until the drop at 6:55pm.

WHEN DID THE VARIOUS MEDICAL PERSONNEL BECOME AWARE OF THE SIGNS AND SYMPTOMS AND CONCLUDE THAT MR. BEECH WAS HAEMORRHAGING?

As previously indicated, Dr. Morris clearly became aware of the symptoms exhibited by Mr. Beech at about 7pm when he was notified by Recovery that Mr. Beech's blood pressure was dropping and that he had a low heart rate. He however, failed to diagnose why Mr. Beech was so unstable.

His actions between 7pm and until Dr. Reeder attended the Recovery Ward around 7:45pm included the following:

a) He remained with Mr. Beech for an extended period of time (causing Dr. Loder to come looking for him at or a little after 7:30pm and for Nurse Robinson, who was in charge of the theatres, to make inquiries as to his whereabouts);

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[16] per Volume 2, tab 46 page 112;

Time	Blood Pressure	Heart Rate per minute
5.55pm	132/86	95bpm
6.10pm	95/70	95bpm
6.25pm	83/56	92bpm
6.40pm	84/59	95bpm
6.55pm	69/43	35bpm

b) He requested review by an intensivist; and

c) He was observed to be "stressed" according to Nurse Balmaceda[17].

All of this reflected a concerned medical practitioner whose patient was unstable and who was unsure about the reason for the instability and symptoms being exhibited.

Furthermore, Dr. Morris's second statement and oral evidence reflected this uncertainty about what was ailing Mr. Beech. Dr. Morris conceded that in effect he did not know why Mr. Beech remained hypotensive. He considered a differential diagnosis of a cardiac issue or an allergic reaction to a drug but had not really considered the possibility of a postoperative bleed as he had observed minimal blood loss during surgery[18].

Dr. Mason Reeder was the Career Medical Officer who was working in intensive care on 17 April 2007 who attended on Mr. Beech in recovery after being called upon by Dr. Morris to assist in diagnosing the cause of Mr. Beech's hypotension and, by this time, an increasing heart rate (tachycardia). It was the evidence of Dr Reeder that he:

a. Attended on Mr. Beech between about 7.40 and 7.50pm after a request from Dr. Morris;

b. Found Mr. Beech to be "persistently hypotensive and tachycardic";

c. Had been advised by Dr. Morris that he was concerned that Mr. Beech had suffered an anaphylactic reaction as he required adrenalin to maintain his blood pressure;

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17 Exhibit 9 paragraph 27;

18 Transcript 17/08/11 pages 89.49 and 92.5

d. Was concerned about the possibility of bleeding and as a result ordered urgent pathology to rule out that possibility, namely blood gases and haemoglobin despite Dr. Morris' hypothesis of anaphylaxis; and

e. Arranged for Mr. Beech to be transferred to the ICU;

The results of the blood gas analysis were received shortly after 8.04pm. Those results showed haemoglobin of 61 ("**the Blood Gas Result**").

By this time it is uncontroversial that Dr. Morris had left recovery and returned to Operating Theatre 8 to commence the next operation on Dr. Loder's list, on Mr.O'Loan, and that Dr. Loder was aware at this point (prior to the commencement of the O'Loan Operation) that blood tests had been preformed on Mr. Beech and one of those tests to be performed was a Blood Gas Result. What is unclear is as follows:

1. Whether the O'Loan operation had in fact started (namely Dr. Loder had put knife to skin") when the Blood Gas Result was available;

2. Whether the Blood Gas Result established that Mr. Beech was bleeding and so required a return to the Operating Theatre to fix the bleed; and

3. Whether Dr. Loder should have delayed the O'Loan procedure for the Blood Gas Result to actually become known.

I shall deal with each of these issues in turn:

I initially need to consider whether the O'Loan operation had in fact started (namely Dr. Loder had put knife to skin") when the Blood Gas Result was available and whether Dr. Loder had been informed of the result. As at that point Dr. Loder clearly became unable to defer Mr. O'Loan's surgery and interpose Mr. Beech.

Mr. Gregg, counsel for Dr. Morris quite rightly submits that neither Dr. Morris nor Dr. Loder was advised of the actual Blood Gas Result, but that they were told by Dr. Reeder that Mr. Beech had "low Haemoglobin".

It was the evidence of Dr. Reeder that after he received the Blood Gas Result, which according to the result printout found in the medical records was sometime shortly after 8.04pm he:

1. He rang the Operating Theatre and advised them that Mr. Beech's haemoglobin was low and "*that he had had a bleed or that a bleed was likely,… that we would start transfusing him and that given the fact that they were in theatre I didn't think that he should remain in recovery and he should come to the ICU*"[19];

2. That he could not recall the time of that conversation or whether he had telephoned Dr. Choong in the ICU first or after his call to the Operating Theatre;

In relation to the O'Loan operation we know the following from the medical records namely that:

- At 8:18pm Dr. Morris inserted a CVC line;
- At 8:26pm Dr. Morris inserted a right subclavical and arterial line;
- At 8:40pm "time out" was called.

Accordingly, on the evidence available to me I am satisfied that Dr. Loder commenced the O'Loan surgery shortly after 8:40pm, namely he put "knife to skin". Therefore from this point in time Dr. Loder would be unavailable to reoperate on Mr. Beech until the completion of the O'Loan surgery.

[19] Transcript 16/08/11 page 47.1 -5

Dr. Reeder's recollection of what time he first contacted the Operating Theatre to advise Mr. Beech's treating doctors that his haemoglobin was low and that he had had a bleed was vague. In answers to questions by Mr. Gregg, Counsel for Dr. Morris, Dr. Reeder gave the following evidence:

a. that it was sometime after 8pm but before 9pm;

b. that he had two conversations fairly quickly with Dr. Morris and Dr. Choong so I guess round 8.30pm;

c. that he could not recall if he spoke to Dr. Choong or Dr. Morris first;

d. He rang as they started the transfusion which he think started at twenty past eight so 8.30 sometime:

No criticism can be directed towards Dr. Reeder in this regard as it has been over 4 and a half years since he attended and treated Mr. Beech. Furthermore, it was his prompt attention and ordering of the proper bloodwork that led to both the initial and sole diagnosis that Mr. Beech was bleeding.

It was the evidence of both Drs. Morris and Loder that the information that Mr. Beech had suffered a bleed, was only relayed after the O'Loan surgery had commenced.

I have grave concerns about the veracity of the evidence provided to this inquest by Dr. Loder, as his evidence evolved dramatically from his first statement dated 16 September 2009. As previously indicated I will deal with this in more specific detail later in these findings, however his evidence in this regard is corroborated somewhat by the evidence of Dr. Morris. Accordingly, I am satisfied on balance that there is no evidence that either Drs. Loder or Morris had any knowledge of Mr. Beech's actual low haemoglobin Blood Gas Result prior to the commencement of the O'Loan Surgery namely prior to Dr. Loder putting knife to skin.

The second matter I need to consider is whether the Blood Gas Result would provide and did provide a definitive diagnosis that Mr. Beech was bleeding and required a return to the Operating Theatre to fix the bleed.

It was submitted by Mr. Woods, counsel for Dr. Loder, that the Blood Gas Result was evidence merely that Mr. Beech had had a bleed but not definitive of a continued post operative bleed. In support of that submission Mr. Woods refers me to the evidence of Dr Choong who stated, commenting on the evidence of Dr. Macpherson during his oral evidence:

"Q. Then he says:
"There is now no other diagnosis that can be made to account for Mr. Beech's hypotension other than hypovolemia due to blood loss."
Now, I think you said that a sole diagnosis was made after the formal haemoglobin, that certainly one was obtained, but here is the anaesthetist saying that there was no other diagnosis really available after the 61 was obtained. Do you have any criticism of that approach?
A. With all due respect to Professor McPherson I mean - still with the points that I brought up before, I think it is very dangerous to exclude 5 other possible diagnoses even though - I mean I think we all agree, there's no doubt at all that bleeding is the most common problem for low blood pressure following an operation and that is one that you would start treatment for and you would certainly want to rule out very early, you know, to say - I mean once again I don't know all the information that was available to Dr Morris at that time, but - and I would still say that you need to at least go through the process in your mind of excluding other diagnoses and whether or not those were done or not, I don't know.
Q. Well, focusing not on the excluding of diagnosis, but the fact that you now have a piece of information?
A. Mm.
Q. Whatever else was going on, you now have the 61 from the blood gas, which I understand is not the gold standard?
A. No.
Q. But it is important information?

A. Yes.

Q. In the context of what was going on, do you think that it would be reasonable to conclude with the benefit of that evidence that it was probably a bleed and probably not anaphylaxis?

A. Yes."[20]

It was the expert evidence of Professor Morris that:

"The ICU junior doctor when he saw the patient in Recovery did question the cause of hypotension to be due to bleeding and did measure the haemoglobin which was markedly low. Blood transfusion was started in the Recovery Room but the patient was then transferred to the ICU. If instead of this ICU transfer the patient had been taken back to theatre it is extremely likely that Mr. Beech would have survived.."[21]

I am satisfied that the Blood Gas Result provided evidence that Mr. Beech had bled and not that he had continued bleeding. However, that evidence coupled with Mr. Beech's ongoing instability (namely his hypotension, tachycardia and unresponsiveness to fluids), I am satisfied on balance that at the time that result was received namely shortly after 8.04pm that although it may hot have been conclusive it was a fairly good indicator that Mr. Beech had an ongoing bleed which would require a return to the operating theatre to fix.

The final issue to be considered is whether Dr. Loder should have delayed the O'Loan procedure for the Blood Gas Result which he knew would be to hand imminently.

Mr. Woods' ultimately submitted in relation to the Blood Gas Result that even if Dr. Loder had delayed the O'Loan procedure for the Blood Gas Results, those results would have only provided evidence that Mr. Beech had suffered a bleed. It would not and did not provide a definitive diagnosis of continued bleeding. Accordingly, Dr Loder had to weigh up the risks of returning a clearly unstable patient to surgery, in the event

[20] Transcript 17/08/11 page 13-14;

[21] Volume 3 tab 8 page 9.6;

that that surgery ultimately was not required. In support of this submission he referred me to the unchallenged evidence of Dr. Loder who stated, in his second statement:

"*Returning a patient to surgery does have some risks. Inducing anaesthetic in an unstable patient can be a risky procedure. Having accepted the diagnosis of anaphylaxis, I was content to allow Mr. Beech to remain in recovery whist he was stabilised.*

If Mr. Beech had been suffering from anaphylaxis, then the operating theatre is not the best place to treat anaphylactic shock."[22]

Mr. Woods' submission is not without merit however in considering it I must take into account all of Dr. Loder's evidence including:

1. his first statement where he stated:

   "I discussed the case with Dr. Morris and we felt the clinical signs in response to fluid resuscitation and adrenalin were more in keeping with an anaphylactic (allergic) reaction to the administered medication than to blood loss. Dr. Morris and I had a detailed discussion and ***I suggested to him that if there was any doubt we should return him to the operating theatre and explore the abdomen in case of haemorrhage****…"*[23] *[emphasis added]*;

2. his second statement where he stated:

   "When I arrived to review Mr Beech , Dr. Morris had already been there for some time. I discussed with Dr. Morris his disgnosis of Mr. Beech's condition I asked Dr. Morris " do you think he is bleeding?". Dr. Morris replied "no"……I said "if there is ***any chance that he is bleeding we should take him back now****"……"*[24] *[emphasis added];*

Dr, Loder can not have it both ways namely that he was concerned enough on the one hand about the risk of a further surgery on an already unstable patient that he had to wait for a definitive diagnosis of continued bleeding before returning him to surgery but

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22 Exhibit 12 paragraphs 16 and 17;
23 Volume 1 tab 10 paragraph 7;
24 exhibit 12 paragraph 13;

on the other hand was prepared to take Mr. Beech back to the operating theatre and explore his abdomen if there was any chance of bleeding despite the fact that no bloods had been taken to rule out this possibility.

In my view, I am satisfied that the proper conduct for Dr. Loder would have been to delay the O'Loan surgery until he was in receipt of the Blood Gas Results he then could have returned Mr. Beech earlier to the operating theatre, discovered the source of the bleed and repaired it.

It is uncontroversial that between about 9 - 9.15pm Dr. Choong received Mr. Beech's formal haemoglobin results (full blood count) of 71 (which was very low) and immediately concluded that Mr. Beech was suffering from haemorrhagic shock, that is, he was bleeding. It is the evidence of Dr. Choong that upon establishing the sole diagnosis he instructed Dr. Reeder to notify Drs. Morris and Loder that Mr. Beech was bleeding.

Moreover, it was the evidence of Dr. Loder that he became aware during the O'Loan surgery that Mr. Beech was bleeding and continuing to bleed[25]. However, I accept that as Dr. Loder was mid-surgery at the time the sole diagnosis was made and confirmed he could not attend to repairing Mr. Beech's bleed until he had completed the O'Loan operation.

[25] Transcript 19/11/11 at page 39.20

SHOULD MR. BEECH HAVE BEEN RETURNED TO THE OPERATING THEATRE EARLIER AND IF SO WHEN?

Mr. Beech was not returned to the operating theatre from the ICU until about 10.55pm, almost one hour after Dr. Loder completed the O'Loan operation and attended the ICU and examined Mr. Beech and established for himself without a doubt that Mr. Beech's condition was critical and he needed to be returned to surgery to repair the bleed.

He conceded during questions from me, that upon attending the ICU he:

1. was advised by Dr. Choong that Mr. Beech was *"still bleeding and needs to go to theatres . His BP responds transiently to additional fluids and increases in inotropes. We've given more blood, cryo and FFP to correct the coagulophathy. He's becoming more acidotic and his abdomen is becoming increasingly distended…."*[26];

2. Examined Mr. Beech and found his abdomen to be distended;

3. Decided that Mr. Beech needed a further operation to stem the bleeding as he was critical as he had been unstable and bleeding for over 3 hours[27];

4. Conceded that as the surgeon he was in charge of his operating list and the order in which he conducts or carries out those operations; and

5. Decided, despite Mr. Beech's critical and deteriorating condition to proceed with the Tysoe haemorroidectomy rather than interpose Mr. Beech's return to surgery.

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[26] exhibit 10 paragraph 19;

[27] Ibid at page 38-41 inclusive;

I have alluded throughout these findings to the inconsistencies and difficulties with respect to Dr. Loder's tendered statements and how his evidence has evolved since inquiries were commenced into Mr. Beech's death at the SAN. It is appropriate that I deal with these matters now. The three major inconsistencies and difficulties with his evidence can be summarised as follows:

1. Firstly, in his first statement Dr. Loder states that after Mr. Beech's surgery "the next operation I performed was one of several hours duration"[28]. That was clearly not true as he performed 3 separate surgeries after Mr. Beech's initial surgery (namely the surgeries of Wyndham, O'Loan and Tysoe). Dr. Loder conceded during questioning by me that he had gone over in his mind what had happened and why it happened since Mr. Beech's passing but despite this he could provide no explanation for such a fundamental flaw in his first statement.

2. The second major matter for concern is that in his first statement, Dr. Loder states:

   "I discussed the case with Dr. Morris and ***we felt*** *the clinical signs in response to fluid resuscitation and adrenalin were more in keeping with an anaphylactic (allergic) reaction to the administered medication than to blood loss.* ***Dr. Morris and I had a detailed discussion*** *and I suggested to him that if there was any doubt we should return him to the operating theatre and explore the abdomen in case of haemorrhage. In view of his improved vital signs at that time and the belief that the causation was not one of blood loss* ***it was agreed*** *that we should proceed to our next routine operation and the patient would be assessed and managed in the Intensive Care Ward."*[29] *[emphasis added]*;

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[28] volume 1 tab 10 paragraph 8;

[29] Volume 1 tab 10 paragraph 7;

In contrast Dr. Loder's second statement says:

a. *"I discussed with Dr Morris **his diagnosis** of Mr. Beech's condition. I asked Dr Morris "do you think he is bleeding?". Dr Morris replied "no". Dr. Morris explained **his reasoning** to me. Dr Morris said "I gave him lots of fluid and he didn't respond". Dr Morris said " I gave him adrenalin and he responded"…I said " if there is any chance that he is bleeding we should take him back now". Dr Morris responded to the effect that **he was certain that the hypotension was not from bleeding and that we should proceed with the O'Loan operation**."*[30]

b. "*having discussed the matter with Dr. Morris and **accepted his reasoning** in relation to the diagnosis*…"[31]

c. after examining Mr. Beech in the ICU, "***Dr Morris had told me that Mr. Beech "should be fine"** and we should proceed to perform the operation upon Mr. Tysoe*"[32] (Emphasis added)

Dr. Loder's evidence in my view evolves from a position of collaboration and joint decision making in his first statement to one where he relied solely on the experience of his colleague in relation to the diagnosis of Mr. Beech and in the running of his theatre list.

Moreover, when he gave his evidence Dr. Loder commenced by taking responsibility and offered apologies for his errors and those of his team but despite this he maintained that he essentially regretted taking the advice of Dr. Morris with respect to both the provisional diagnosis of anaphylaxis and not delaying Mr. Tysoe's haemerroidectomy in favour of taking Mr. Beech back to surgery.

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30 exhibit 12 paragraph 13;
31 ibid at paragraph 14;
32 ibid at paragraph 27;

3. The third major matter for concern is his excuse (for want of a better description) for not returning Mr. Beech to the operating theatre prior to commencing and completing Mr. Tysoe's surgery was:

"…the performance of the operation on Mr Tysoe would only minimally alter the time that surgery would start on Mr. Beech.

This is because it would have taken time to move Mr. Tysoe away from the theatre so as to set up the theatre to be ready for Mr. Beech…..[as] significant steps in process of Mr. Tysoe's operation having already been taken."[33]

Despite Dr. Loder's evidence the evidence before this inquest clearly indicates the following:

a. Dr. Loder had indicated to Nurse Robinson when they spoke between 9-9:30pm that Mr. Beech was going to be returned to surgery and that he was to go after Mr. Tysoe[34];

b. The records from the O'Loan operation indicated that Operating Theatre 8 was ready for the next surgery at 10.10pm[35];

c. The hospital records from Mr. Tysoe's surgery indicate that he was not taken to theatre until 10.18pm[36], and

d. Dr. Choong was unaware until the commencement of this inquest that Dr. Loder had performed surgery on another patient after his attendance on Mr. Beech in the ICU prior to taking Mr. Beech back to surgery.

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33 exhibit 12 paragraphs 23 to 26 inclusive;
34 Transcript 15/08/11 page 59.15-30;
35 volume 3 tab 18 page 110;
36

Mr Woods submitted that no adverse finding in relation to his client, Dr. Loder can be made by me in relation to the changes and evolution of his evidence, for the following reasons, and I summarise:

1. his client is an experienced and respected medical professional who made and admitted to making mistakes in relation to the care and treatment of Mr. Beech;

2. his client at the time of the first statement prepared it without reference to the hospital records or notes;

3. his client has shown remorse and contrition; and

4. no one during the course of the inquest put to Dr. Loder that he had lied or told an untruth;

Some of Mr. Woods' submissions in this regard have merit, however having regard to the number of inconsistencies in the evidence of Dr. Loder and how it evolved over time, coupled with the lack of an innocent explanation provided by him despite my giving him a clear opportunity to provide one, I am satisfied on balance that but for this inquest and the further inquiries it caused to be conducted (in particular obtaining the hospital records for the other operations conducted by Dr. Loder on 17 April 2007) Dr. Loder is not a witness of truth. Accordingly, I have doubted the veracity of Dr. Loder's evidence in relation to this inquest and have not accepted it unless specifically corroborated by other evidence before me.

Accordingly I find:

1. Dr. Loder erred in not deferring Mr. Tysoe's surgery in favour of returning Mr. Beech to theatre earlier; and

2. I am also satisfied on balance that having regard to all the evidence Dr. Loder should have waited for the Blood Gas Results prior to putting knife to skin in relation to the O'Loan procedure in order to ensure that Mr. Beech was returned to surgery at the earliest possible time.

I now turn to the evidence of Dr. Morris in these proceedings, which was at times vague and unhelpful. His first statement was extremely light on detail. His second statement prepared shortly before the commencement of these proceedings shed some light on the circumstances of Mr. Beech's care and treatment in recovery however in the witness box Dr. Morris had trouble recalling much of the detail of the conversations and their respective timing. Given however the time that has passed (almost 5 years) this is not surprising. Furthermore, whilst giving his evidence his demeanour presented as nervous and emotional. At no time did I find that Dr. Morris sought to exaggerate or adapt his evidence. He readily conceded that he was baffled by Mr. Beech's presenting symptoms and sought help from intensive care for a diagnosis. Accordingly, I accept Dr. Morris as a witness of truth and preferred his evidence to that of his colleague Dr. Loder.

However, I find that Dr Morris erred in that he failed to recognise that Mr. Beech's symptoms namely the hypotension and tachycardia may possibly or even probably have been as a result of a bleed and/or continued bleeding. In not recognising this he failed to order the blood tests that were to ultimately diagnose his condition. In making this finding I note that Dr. Morris did seek assistance from the ICU and those tests were eventually carried out in a timely manner by Dr. Reeder and the time delay that was ultimately caused to Mr. Beech (although there was some) was minimal.

WHAT WAS THE CAUSE OF MR. BEECH'S CARDIAC ARREST?

I am satisfied that the cause of Mr. Beech's cardiac arrest was precipitated by the removal of his central venous line ("CVC") sometime during transport from the ICU to the operating theatre or transport from his bed to the operating table.

There is no doubt that at the time of his transfer to the operating theatre that Mr. Beech was inotrope dependant and the inotropes were being administered to him via the CVC. Dr Choong put the situation succinctly (and I note that both Professor Morris and Dr. Macpherson agree with his conclusion and analysis):

"…the cause of his cardiac arrest, the immediate cause of his cardiac arrest was the dislodgement of the central venous line, because the central venous line was continuously infusing inotrope support which his heart needed. The sudden interruption of that can certainly, as I put in my statement, lead to a very marked instability, even to the point of a cardiac arrest. The reason why I say that partly is that - or mainly is that the fact that we could resuscitate Mr. Beech from the cardiac arrest suggests that once those drugs were given back to him, his heart was able to be supported once again…"[37]

WHAT WAS THE CAUSE OF MR. BEECH'S HYPOXIC BRAIN INJURY?

As Mr Beech was conscious and reassuring his wife Dora in the ICU prior to being transferred to the operating theatre I accept that he was not affected by hypoxia whilst in the ICU as concluded by both Dr. Macpherson and Professor Morris, furthermore I accept that the proximate cause of his hypoxic brain injury was the cardiac arrest.

[37] transcript

CONCLUSION

Accordingly I now turn to the findings I am required to make pursuant to section 81 of the Coroners Act 2009.

I find that John Reginald Beech died at Sydney Adventist Hospital on 24 April 2007 directly from postoperative intra-abdominal bleeding and its consequences its antecedent cause being a malignant colonic polyp.

Pursuant to section 82 of the Coroners Act 2009 I make the following recommendations arising out of the death and subsequent inquest into the death of John Reginald Beech:
That a copy of my findings in this matter be forwarded to the chairperson of the Health Care Complaints Commission in relation to the care and treatment afforded to Mr. Beech by Dr. Loder on 17 April 2007.

11 November 2011

Magistrate Sharon Freund

Deputy State Coroner