CORONERS ACT, 1975 AS AMENDED

SOUTH *AUSTRALIA*

FINDING OF INQUEST

An Inquest taken on behalf of our Sovereign Lady the Queen at Adelaide in the State of South Australia, on the 14th and 15th days of February 2005, the 19th and 26th days of April 2005, the 9th, 17th and 31st days of May 2005 and the 3rd day of June 2005, before Wayne Cromwell Chivell, a Coroner for the said State, concerning the death of Ruth Bengta Maria Sorensen.

I, the said Coroner, find that Ruth Bengta Maria Sorensen aged 69 years, late of 36 Minns Street, Seaton, South Australia died at Seaton, South Australia on the 24th day of July 2002 as a result of faecal peritonitis due to small bowel obstruction and perforation due to peritoneal adhesions. I find that the circumstances of her death were as follows:

1. Introduction

1.1. Mrs Ruth Sorensen was born on 1 November 1932. At the time of her death on 24 July 2002, she was 69 years old.

1.2. Mrs Sorensen presented to The Queen Elizabeth Hospital ('TQEH') at about 11:30pm on 22 July 2002. She had developed abdominal pain and vomiting during the day and had called a locum doctor who administered Stemetil for the vomiting and referred her to the hospital

1.3. Mrs Sorensen was seen by Dr Stuart Mauro in the Emergency Department at 11:50pm. Dr Mauro examined her and prescribed intravenous fluids and Panadol.

1.4. At 2:30am on 23 July 2002, Dr Mauro discharged Mrs Sorensen, who was in the company of her son, with a recommendation to see her General Practitioner.

1.5. Mrs Sorensen continued to suffer severe abdominal pain throughout the day until, at about 6:10am on 24 July 2002 she collapsed in the laundry of her home. An ambulance was called, but despite energetic efforts to resuscitate her, she was in full cardiac arrest and resuscitation efforts were ceased at about 6:35am.

1.6. Mrs Sorensen's life was formally declared extinct at 7:55am by her General Practitioner, Dr Chek (see Exhibit C2a).

2. Cause of death

2.1. A post-mortem examination of the body of the deceased was performed by Dr J D Gilbert, Forensic Pathologist, on 25 July 2002. Dr Gilbert's conclusion was that the cause of Mrs Sorensen's death was peritonitis due to 'small bowel obstruction and perforation due to peritoneal adhesions' (Exhibit C3a, p1).

2.2. His examination of the small intestine revealed:

> 'There was gross dilatation of the proximal 90% of the small bowel with serosal congestion. The serosal surfaces were focally coated by purulent exudate. The distal ileum was obstructed in the right iliac fossa by dense fibrous adhesions binding down the terminal ileum and right fallopian tube and ovary, possibly associated with previous appendicectomy. A 0.7 cm perforation of the distal ileum was identified immediately proximal to the point of maximal obstruction. Just distal to this point the lumen was narrowed down to only a few millimetres in diameter by adhesions...'
>
> (Exhibit C3a, p2)

2.3. Dr Gilbert commented:

> '1. Death was due to faecal peritonitis due to small bowel obstruction and perforation resulting from dense peritoneal adhesions around the distal ileum probably resulting from previous appendicectomy.
>
> …
>
> Review of the TQEH notes indicated that the deceased had been previously described in 1999 by her GP as 'stoic' when she waited for 2 painful days before presenting with a strangulated umbilical hernia that was ultimately treated surgically at the hospital.
>
> It is disappointing that basic blood tests and an abdominal X-ray were not performed at the TQEH. Given the post mortem findings, it was quite likely that the seriousness of her condition could have been recognised had these basic tests been

> done and that the death may have been prevented. Overview of the case by a general surgeon or accident and emergency specialist is recommended.
>
> 2. There were no findings to indicate other than natural causes for the death.'
>
> (Exhibit C3a, p5)

2.4. Conclusion

I accept Dr Gilbert's opinion, and find that the cause of Mrs Sorensen's death was faecal peritonitis due to small bowel obstruction and perforation due to peritoneal adhesions.

3. Background

3.1. In September 1999 Mrs Sorensen underwent a laparotomy operation for the repair of a strangulated umbilical hernia. Part of the small bowel had become inset in the incarcerated hernia and had become ischaemic, but this did not require resection and the defect was repaired. The surgery note in TQEH clinical record indicates that Mrs Sorensen had a good recovery from this operation.

3.2. It is of some significance that the referral letter from her General Practitioner, Dr John Moore, to TQEH said:

> 'How stoic!
>
> Mrs Sorensen has waited the weekend to call us because of what must be a strangulated UH (umbilical hernia)!'
>
> (Exhibit C6a)

3.3. It is entirely possible that Mrs Sorensen's stoicism worked against her during the evening of 22/23 July 2002.

3.4. Events leading to admission

The statement of Mr Jan Sorensen, who lived with his mother at the Seaton address, records that during the evening of Monday 22 July 2002 his mother began complaining of stomach and back pains. Mr Sorensen's statement does not record the attendance of the locum. However, a note in TQEH clinical record, apparently filled out by a doctor employed by the Adelaide Metropolitan Locum Service, records that Mrs Sorensen had complained for several days of nausea/right upper quadrant pain and vomiting. He found moderate tenderness on examination of the abdomen. The blood pressure was normal at 140/60, but the heart rate was raised at 120 beats per

minute. He administered an intramuscular injection of Stemetil for the vomiting and recommended attendance at TQEH for further investigation.

3.5. Mr Sorensen drove his mother to TQEH, arriving at just after 11:30pm.

3.6. At 11:50pm, Mrs Sorensen was examined by Dr Stuart Mauro in the Emergency Department.

3.7. Dr Mauro told me that he had no independent recollection of his consultation with Mrs Sorensen (T36). His note of his consultation reads as follows:

> 'Allergies - No
> Medications - No
> Vomiting for 4/7 (4 days)
> Only diarrhoea slightly
> but abdo (abdominal) cramps
> Called locum tonight
> Nil vomiting since given IM (intramuscular) Stemetil
> OE (on examination) alert and orientated
> Nil distress
> Periphery warm and well perfused
> Chest - clear
> Abdo (abdomen) - tender epigastrium and periumbilical area
> C/- (complaining of) back pain also started after vomiting
> Tender here and reproduces pain
> = Musculoskeletal pain
> P (plan) fluids/Panadol - will review.'
> (Exhibit C6a)

3.8. Dr Mauro acknowledged that he did not reach a diagnosis of Mrs Sorensen's condition. He said that he thought that she probably had 'gastro' but he had not formed a definite conclusion about that, particularly because her diarrhoea was described as 'slight' (T41).

3.9. As to his plan, Dr Mauro explained that he prescribed intravenous fluids as a response to Mrs Sorensen possibly being dehydrated as a result of vomiting, which was consistent with the elevated pulse rate of 126 beats per minute noted by the nurse at midnight. Alternatively, this high pulse rate could have been due to pain (T44).

3.10. Dr Mauro has no further recollection of any dealings with Mrs Sorensen that evening. On the clinical record, he has noted:

> 'D/C (discharge) comfortable at 02:30 with son to see GP'
>
> (Exhibit C6a)

3.11. Dr Mauro was unable to recall whether he saw Mrs Sorensen at that time, or whether he received a request for discharge via the nurse and agreed without examining her again. He acknowledged that this was inappropriate (T62).

3.12. In particular, it should have been apparent that Mrs Sorensen was still unwell. Her pulse rate, taken at 2:10am, was still abnormal at 122 beats per minute and she was still complaining of 'pain on movement' (see observation and medical record, part of Exhibit C6a).

3.13. Dr Mauro composed a discharge letter for Mrs Sorensen to take to her General Practitioner. He Wrote:

> 'Dear Ng Chek
>
> Ruth Sorensen presented to the Emergency Department at The Queen Elizabeth Hospital on the 22 Jul 2002 at 23:32. The presenting problem was gastrointestinal - abdominal pain.
>
> The diagnosis was vomiting, not blood.
>
> Has come in complaining of nausea and vomiting for 4 days, successfully treated with maxalon and fluids. At 0300 she is well and keen to go. I am happy with this but have suggested GP review as she mentions similar problems in past.
>
> Stuart Mauro
> Casual Medical Staff'
>
> (Exhibit C6a)

3.14. As I have already mentioned, Dr Mauro was unable to recall whether the information in the letter about Mrs Sorensen's condition, in particular that she was 'well and keen to go', came directly from her or via the nursing staff (T64).

3.15. Mr Sorensen's statement records her stay at TQEH and what happened afterwards as follows:

> 'Ruth and I got to the hospital and they placed her onto a hospital bed. Nurses did checks on her and administered a drip into her arm. Ruth laid on this bed, with the nurses and doctors doing random checks on her for the next few hours. She drank about 3 glasses of water while at the hospital. I bought her a 600ml bottle of Fanta while at the hospital

because she was complaining that the injection the doctor gave her made her mouth dry and thirsty.

At about 3.30 a.m. on 23rd of July 2002, nurses told Ruth that she could go home. The doctor at the Queen Elizabeth Hospital gave her tablets called Codalgin for pain. He said they would be stronger than Panamax and to take them home with her. The doctor told her that she would be in pain for a few more days, and he would forward a letter about the situation to her General Practitioner, Dr. Chek of Woodville South Medical Centre. He did not specifically say what was causing the pain.

While driving her home from the hospital, she complained continuously about the pain she was still in.

Ruth got into bed when we got home from hospital, she did not go to sleep, and she told me that she was still in a lot of pain. Throughout the day, she drank all of the Fanta I had bought her, and started drinking a 2 litre bottle of Creaming Soda. Ruth drank about 400mls of this before the morning of the 24th of July.

Ruth was in bed all day on Tuesday the 23rd of July, and she was in constant pain. Over the course of the day Ruth had at recommended intervals eight of the painkillers given to her by the doctor at the Queen Elizabeth Hospital.

At about 12.30 p.m. I took a plate of lunch into Ruth who was still lying in bed. Lunch consisted of some home made stew made from lamb chops, peas, carrots and a stockpot mix. I saw her have about 2 mouthfuls of stew before she refused to eat any more, as well as drinking some of the creaming soda at this time. Ruth is not on any other medication, and I did not see her take any other medication throughout the day.

At about 8.30 p.m. on 23rd of July 2002, I went into Ruth's bedroom and said good night, I then went to bed. Ruth's state had not changed at all since coming home from the hospital, I could see that she was still in a lot of pain.

At about 4.30 a.m. 24th of July 2002, I was up getting ready for work. I went in to Ruth's bedroom to see if she wanted me to get her anything. She was still in the same state, she said she did not want me to get her anything.

I went on getting ready for work. I had to put my things into my vehicle, which was out the back of the house, I could see through the back windows of the house while doing this. I saw through the windows that Ruth was up, walking through the kitchen and laundry towards the toilet.

When she was out of my sight I heard a funny noise, a thudding noise. I ran inside to find her hanging onto the side of the washing machine, in the laundry near the entrance of the toilet. I tried to help her stand but her legs were not working could not hold her up.

I rang my brother Erik SORENSEN who lives next door at 34 Minns Street SEATON, with his wife Suzanne SORENSEN and told him to come quickly as Ruth had fallen down. Erik took about 15 seconds to come from next door. Erik and I lifted Ruth onto a wooden kitchen chair and then we both lifted this with her on it into the lounge room. Suzanne, my sister in law rang the ambulance, the time was about 6.10am, 24th July 2002.

Over the phone an ambulance operator told us to lay Ruth onto the floor, in the foetal position, during this whole time she was mumbling. Erik and I could not understand her,

> her breathing was becoming very shallow. Erik and Suzanne both tried to find Ruth's pulse in her neck, they said it was hard to find and very faint. Erik rang the ambulance again and told them the situation was worsening.
>
> Ruth was semi-unconscious by the time the ambulance arrived about 5 minutes later. I saw the paramedics kneel beside Ruth checking for a pulse. I left the room with my brother Erik and Suzanne stayed with Ruth in the lounge room, while the paramedics worked on trying to resuscitate her.
>
> After about 20 minutes the Paramedics came into the kitchen with Suzanne and she told us that Ruth was gone and they could do no more to help her.'
>
> (Exhibit C1a, pp2-4)

3.16. What is now apparent is that Mrs Sorensen was suffering from an obstruction of her small bowel which, if correctly diagnosed, would have required surgical treatment. This may have prevented the later perforation and spilling of gastric contents into the peritoneal cavity leading to peritonitis and eventual death.

4. Issues arising at inquest

4.1. Associate Professor Anthony Brown, Senior Staff Specialist in the Department of Emergency Medicine at the Royal Brisbane Hospital, and Associate Professor in the Department of Anaesthesiology and Critical Care, in the School of Medicine, University of Queensland, has provided a report containing his opinions in relation to the standard of care provided to Mrs Sorensen in this case.

4.2. Associate Professor Brown has extensive experience in clinical emergency medicine as well as in the teaching of that discipline. He is a member of the Court of Examiners of the Australian College for Emergency Medicine and the Undergraduate Education Committee of that organisation.

4.3. Associate Professor Brown was extremely critical of the standard of care provided by Dr Mauro to Mrs Sorensen. In particular, he said:

> '1a: I am highly critical of the care provided by Dr SL Mauro of TQEH ED, and consider that the care Dr Mauro gave Mrs Sorensen in the evening of 22nd July and the early hours of 23rd July 2002 to be a gross departure from a reasonable standard of care for the following reasons:
>
> 1b(i): Dr Mauro failed to take an adequate history of the true nature of Mrs Sorensen's abdominal pain, thereby demonstrating major deficiencies in his data gathering and recording.

In response, Dr Mauro said ‘I agree’ (T51).

1b(ii): Dr Mauro thus failed to record any details at all about the nature, severity, localization, precipitating or relieving factors, and periodicity of Mrs Sorensen's abdominal pain. These details are essential to begin to formulate the initial diagnostic hypothesis.

In response, Dr Mauro said 'it seems largely true' (T55).

1b(iii): Dr Mauro also failed to document the history of a previous abdominal operation, even though it was clearly recorded on the front of the printed Triage ED Record. This was a critical piece of information, as it is an important risk factor for the development of a bowel obstruction.

When asked if he agreed with that criticism, Dr Mauro said 'yes' (T56).

1b(iv): Finally Dr Mauro failed to document when Mrs Sorensen had last had her bowels open, or the nature of her vomiting, both of which again would have added essential diagnostic information to the presenting history.

In response, Dr Mauro said 'I haven't mentioned anything of much significance. There is a brief reference to diarrhoea slightly, which is not very helpful' (T56).

1c(i): Dr Mauro failed to perform an adequate physical examination, as he apparently paid no attention to her abnormal vital signs. These included a raised temperature and a raised pulse rate, which were not recorded or referred to by Dr Mauro at all. These should have been noted and should immediately have alerted Dr Mauro to the likelihood of significant illness in Mrs Sorensen.

In response, Dr Mauro said 'the criticism, as with all of them I think, is fair enough … the notes are far from adequate and it really leaves you sort of wondering what I was thinking instead of knowing absolutely. That's just really not good enough.' (T57).

1c(ii): Dr Mauro also failed to record the presence of the two surgical scars on Mrs Sorensen's abdomen; one in the right iliac fossa and one to the left of the umbilicus. These in similarity to point 1b(iii): above should have alerted him to the possibility of the presence of an underlying bowel obstruction.

In response, Dr Mauro said that he agreed that he had not noted the presence of the surgical scars. When asked to comment he said 'not conclusively. The whole thing just looks like it was done a little bit quickly' (T57-T58).

1c(iii): Dr Mauro failed to record the presence, absence or nature of Mrs Sorensen's bowel sounds, that would have provided important information to suggest the likelihood of serious illness such as a bowel obstruction (causing, increased bowel sounds) or peritonitis (causing reduced or absent bowel sounds).

In response, Dr Mauro said that he accepted that he did not note Mrs Sorensen's bowel sounds (T58).

1d(i): Dr Mauro failed to request any diagnostic laboratory tests at all, such as a full blood count (FBC), urea and electrolytes and liver function tests (ELFTs), an amylase or lipase and a urine test.

In response, Dr Mauro agreed that he did not order any diagnostic laboratory tests. He said:

> 'In my experience … they're not always helpful. They can actually be a downright nuisance but that's no excuse for not doing them' (T58).

1d(ii): As elderly patients (over the age of 65 years) with abdominal pain present a difficult diagnostic dilemma, they require extreme vigilance in assessing. In the context of undiagnosed vomiting and abdominal pain, *all* the above tests would be considered essential as the normal standard of care, to look for the possibility of serious illness.

1d(iii): On the balance of probabilities, it is more likely than not that there would have been some abnormalities in those tests such as a raised white cell count, a low bicarbonate, or a raised urea that would have alerted Dr Mauro to serious underlying illness.

1d(iv): Whilst it is also true that in the elderly patient with abdominal pain, blood tests may be misleadingly normal or only minimally abnormal, this in no way excuses the necessity to do them in the first place.

1e(i): Dr Mauro failed to request a plain abdominal x-ray to assess for a bowel obstruction. This was absolutely indicated in Mrs Sorensen's case in view of her undiagnosed abdominal pain and vomiting, on a background of a known previous abdominal surgical operation in 1999.

In response, Dr Mauro said that he agreed that a plain abdominal X-ray was absolutely indicated (T60).

1e(ii): On the balance of probabilities, it is more likely than not that had Mrs Sorensen had an abdominal x-ray (AXR) it would have demonstrated evidence of a small bowel obstruction, such as centrally dilated gas-filled loops of bowel.

1e(iii): The actual cause of the small bowel obstruction would not have been able to be diagnosed from this AXR, which in Mrs Sorensen's case was adhesions from previous abdominal surgery. However, regardless of the underlying aetiology of the small bowel obstruction, the abnormal AXR alone would have triggered the immediate admission of Mrs Sorensen by the duty surgical team.

1f(ii): This diagnosis of gastroenteritis was *not* supported clinically, as it *must* include a clear and relevant history of both vomiting *and* diarrhoea. Mrs Sorensen did not have any recent significant diarrhoea.

Dr Mauro said he did not diagnose gastroenteritis although he acknowledged that he entertained the possibility (T50-T51).

1f(iii): In any case, it is an unsafe practice to make a diagnosis of gastroenteritis in an elderly patient with undiagnosed abdominal pain, until all the other more serious possible diagnoses have been actively considered and ruled out. Dr Mauro made no attempt to do this.

In response, Dr Mauro agreed with this comment (T61).

1g(i): Dr Mauro failed to observe Mrs Sorensen for an adequate period of time. The decision to discharge her was apparently made at 02:30 which was only two hours and 40 minutes after Dr Mauro initiated his consultation.

In response, Dr Mauro said 'his comment is correct' (T61). When his counsel put to him that he was not sufficiently assertive, he said:

> 'I think that's reasonable to say. Whatever happened at 2:30, and I can't remember, what happened wasn't correct, I should have reviewed the patient and if I wasn't comfortable with a patient's going home I should have said to her quite clearly. And that probably would have been enough' (T63)

1g(ii): Dr Mauro claimed he had adequately observed Mrs Sorensen for four hours. This did not actually occur.

1g(iii): However, as suggested in 1f(iii): concerning the elderly patient with undiagnosed abdominal pain, there should be a low threshold to admit to hospital for a proper period of 24 hours observation to rule out serious illness.

1g(iv): The role of the doctor is then to recommend admission and advise the patient of the importance and relevance of this admission, even if the patient would naturally prefer to go home. Discharging an elderly patient with abdominal pain should be the exception rather than the rule.

1h(i): Dr Mauro actually subsequently admitted in his Police Statement that he had failed to make a diagnosis, yet he had also made no attempt to investigate Mrs Sorensen properly at the time, or even admit her to hospital, despite the fact that being elderly she was at high risk of a missed diagnosis.

1h(ii): The diagnosis of "gastroenteritis" in an elderly patient with abdominal pain is a notorious misdiagnosis, that may lead a physician to a premature closure in his or her diagnostic paradigm. This then prevents that clinician from using the necessary intellectual rigour to pursue a more relevant diagnosis in this often difficult clinical quandary.'

(Exhibit C8, pp8-10)

4.4. Dr Mauro agreed with the general comments made by Associate Professor Brown about the treatment of elderly patients with abdominal pain. He said:

> 'I mean when you just look at the notes and the articles then yes. I mean clearly things have gone wrong and most of them related to my managing the history and examination and subsequent management of this patient. But there's a reason for all of that and I

> guess most directly I think the main reason here is that I wasn't alert enough and that at 2.30 I wasn't again alert enough to the possibilities and assertive enough.' (T65)

Dr Mauro further commented that he was ‘experienced enough to have known better’ (T66), and he denied that his actions were influenced by bed pressure (T67). He concluded:

> '… there's nothing that I can come up with to say that I was called to bag and mask somebody for three hours that might have explained things a bit better. There's nothing that I can think of to explain why the notes and history are so brief. And in fact being busy and stressed at the Queen Elizabeth Hospital is pretty much, sort of … par for the course' (T79)

4.5. The materials appended to Associate Professor Brown’s report make it abundantly clear that when treating the elderly, undiagnosed abdominal pain is a dangerous sign. For example, in the text ‘The Clinical Practice of Emergency Medicine (3rd Edition 2001)’ the following passage appears:

> 'The elderly patient who presents with abdominal complaints can become a diagnostic dilemma. Such patients may have intra-abdominal free air or free pus within the abdomen, with few objective findings until late in their course … Some patients initially diagnosed as having gastroenteritis return with the classic findings of acute appendicitis or small bowel obstruction. A patient with gastroenteritis must have gastritis, manifested by vomiting, and enteritis, manifested by diarrhoea. If the diagnosis of gastroenteritis is made without evidence of both upper and lower gastrointestinal involvement, the diagnostic accuracy is questionable, and major surgical conditions can be overlooked.'
>
> (Exhibit C8)

4.6. Further, in an article by E David Bryan MD, appearing in eMedicine entitled ‘Abdominal Pain in Elderly Persons’ (last updated 11 September 2003), the author states:

> 'The evaluation of elderly patients presenting with abdominal pain poses a difficult challenge for the emergency physician. It is also destined to become an increasingly common problem because the elderly population in the United States is growing rapidly. The definition of elderly varies among authors, but for the purpose of this subject, age 60 years is a reasonable starting point. Studies have demonstrated that among elderly patients presenting to the ED with abdominal pain, at least 50% require hospitalisation, and 30-40% eventually require surgery for the underlying condition. Approximately 40% of elderly patients presenting with abdominal pain initially are misdiagnosed, contributing to the overall mortality rate of approximately 10%.
>
> …
>
> Understanding that elderly patients may present very differently than their younger counterparts also is important. Elderly patients are more likely than younger patients to

> present with vague symptoms and have non-specific findings on examination. Many elderly patients have a diminished sensorium, allowing pathology to advance to a dangerous point prior to symptom development. Elderly patients with acute peritonitis are much less likely to have the classic findings of an acute abdomen. They are less likely to have fever or leukocytosis. In addition, their pain is likely to be much less severe than expected for a particular disease. Because of these factors, many elderly patients with serious pathology initially are misdiagnosed with benign conditions such as gastroenteritis or constipation ...
>
> A careful history and physical examination as well as a high index of suspicion are crucial to prevent missed diagnoses.'
>
> (Exhibit C8, pp1-2)

4.7. Conclusion - quality of treatment

The evidence is clear that Mrs Sorensen received a standard of treatment from Dr Mauro at TQEH on the evening of 22 July and the early morning of 23 July 2002 which was seriously inadequate. Dr Mauro has acknowledged the force of Associate Professor Brown's many and detailed criticisms of his treatment that evening. What remains a mystery is how such a departure from an appropriate standard of care could have arisen. Evidence which I have heard since that time suggests that Dr Mauro was regarded as a competent and careful Medical Practitioner and had been re-employed at TQEH on a number of occasions. His own inability to explain his behaviour that night is deeply troubling.

5. Further evidence

5.1. After the oral evidence had concluded, and while I was writing these findings, I received further information which caused me to initiate further inquiries in this matter. A warrant was issued pursuant to Section 13(1)(c) of the Coroners Act, 1975 as a result of which various documents concerning Dr Mauro were received from the Medical Board of South Australia ('MBSA'). On the basis of this further material, the inquest was reconvened and further oral evidence was taken from various witnesses. Dr Mauro was also recalled to address a number of the issues which arose during this further hearing.

5.2. Background

The evidence disclosed that Dr Mauro first consulted Psychiatrist Dr Penelope Roughan in July 1999. Dr Roughan diagnosed a severe anxiety disorder. In addition, Dr Roughan became concerned during subsequent consultations that Dr Mauro was

abusing cannabis. She counselled him against this, and on 10 August 1999 she recorded that he agreed to reduce his use.

5.3. Dr Mauro continued to see Dr Roughan throughout 1999 and 2000. His illness became acute on several occasions following crises in his personal life.

5.4. By November 2000, Dr Roughan was also concerned by Dr Mauro's excessive use of temazepam and cannabis to sleep. She changed his medication from temazepam to diazepam and organised a 'reducing schedule' by which Dr Mauro should have reduced his usage of both substances.

5.5. On 23 November 2000, the MBSA received a letter dated 21 November 2000 from the Adelaide Metropolitan Locum Service. The letter stated in part:

> 'Patients have reported Dr Mauro to be behaving in an inappropriate and at times irrational manner, to be appearing to be under the influence of 'drugs', to have dilated pupils, to be speaking in a slurred voice and appearing to be 'not with it'. We have also experienced problems with Dr Mauro in terms of reliability, and irrational and at times hysterical behaviour towards our telephonist.'
>
> (Exhibit C14)

The letter went on to say that Dr Mauro had denied these allegations.

5.6. As a result of the letter, Mr David Wilde, then Registrar of the MBSA wrote to Dr Mauro on 15 December 2000 inviting him to a meeting on 13 February 2001. On 31 January 2001, Dr Mauro saw Dr Roughan and presented as extremely anxious before his appearance at the MBSA. She said that she was 'quite concerned about him' (T191). She did not consider that it was necessary to report her concerns to the MBSA.

5.7. Dr Mauro went to Broken Hill during this period to act as a locum and reported that it 'went well' (T189).

5.8. On 13 February 2001 Dr Mauro attended a meeting at the MBSA with Professor Ross Kalucy and Mr David Wilde, who constituted 'Committee A'. Professor Kalucy is a prominent consultant Psychiatrist, and had previously been president of the MBSA from 1990 to 1997. Mr Wilde was the Registrar of the MBSA. 'Committee A' is an apparently ad hoc committee constituted by the MBSA to deal with doctors who were considered at risk due to health issues, including those who had developed a

dependence on drugs. The Committee has no legal standing (it is not mentioned in the Medical Practitioners Act 1983), and practitioners were apparently referred to it by the Registrar pursuant to discretions granted to him by the Act. It is unnecessary for me to comment on the legal validity of this practice for the purpose of these findings.

5.9. Dr Mauro met with Committee A on 13 February 2001. Professor Kalucy said that he was 'obviously extremely anxious' (T269). When asked if there was anything in that meeting that raised concerns about Dr Mauro's ability to perform his duties as a Medical Practitioner, Professor Kalucy replied 'no'. No inquiry was apparently undertaken as to the veracity of the allegations made in the letter from Adelaide Metropolitan Locum Service (T318)

5.10. During the meeting, Dr Mauro acknowledged that he suffered from an anxiety disorder. He authorised Professor Kalucy to discuss his health with Dr Roughan. It is not clear whether the Committee proposed to take any further action on the matter at that point.

5.11. Professor Kalucy said that he telephoned Dr Roughan very soon after the 13 February 2001 meeting (T269). Dr Roughan said she had no memory of having been contacted (T192). There is no record in either the MBSA file or Dr Roughan's records that any such telephone conversation took place. I am not persuaded that it did.

5.12. Dr Mauro consulted Dr Roughan on 28 February 2001 and 9 May 2001. In the May consultation, he reported that he had worked in Lightning Ridge in New South Wales. He had enjoyed the work, but a crisis developed in his personal life when he returned as a result of which his condition had deteriorated severely.

5.13. Dr Mauro saw Dr Roughan on three occasions in May 2001. On the last occasion on 25 May 2001 she had become so concerned with his excessive cannabis use that she referred him to Dr Daryl Watson, another consultant Psychiatrist, for a second opinion.

5.14. Dr Mauro saw Dr Watson on 6 June 2001. Dr Watson wrote a detailed and very helpful report of his findings (Exhibit C9), from which the following points emerge:

- Dr Mauro told him that he was using 10 cones of cannabis per day. This is to be contrasted with his statements to Dr Roughan when he told her that he used 10 cones per week (T195);

- Dr Mauro said he did not see the need to reduce his cannabis consumption;
- Dr Watson diagnosed that Dr Mauro had suffered a recurrent major depressive episode, and regarded Dr Roughan's diagnosis of anxiety disorder as 'less likely';
- Dr Watson also thought that Dr Mauro had a substance use (cannabis) disorder and he suspected that Dr Mauro was minimising the impact of his drug usage when they spoke;
- Dr Watson recommended a more aggressive trial of antidepressant medication, by gradually increasing his dosage of Cipramil to a maximum of 60mg per day. He approved the concurrent use of diazepam, which he suggested should be reduced very gradually;
- Dr Watson told Dr Mauro that his ongoing use of cannabis was 'very likely contributing to his current symptoms and problems with treatment';
- As to Dr Mauro's work ability, Dr Watson said:

> 'I would consider it reasonable for him to continue in practice at the moment under close supervision and with a clear plan of management. This plan should include a rapid move to abstinence from illegal drugs. In his case I would see this as being an essential component if the Medical Board is not going to take a more formal role. If he is unable to agree to this plan you have little option but to notify the Medical Board. Hopefully this would allow him to continue working providing he accepts this type of treatment guideline.'
>
> (Exhibit C9)

5.15. When he gave evidence, Dr Watson explained that by 'close supervision', he meant clinical supervision and not direct supervision in the workplace. He had in mind frequent visits to Dr Roughan, and monitoring of Dr Mauro's mental state, particularly when he was working (T380).

5.16. As to his comments about Dr Mauro's ongoing use of cannabis, Dr Watson said:

> 'Q. Your comment 'I would see this, that is a rapid move to abstinence from illegal drugs as being an essential component if the Medical Board is not going to take a more formal role'. If you were managing a patient in that sort of situation, would you ask the patient to undergo regular urine analysis.
>
> A. Yes, urine testing, yes.
>
> Q. And if they were unwilling to comply with that, then that would be the situation when you - as you say - would have little option but to notify the board.
>
> A. Yes.

> Q. Because you're concerned about your responsibility under the Act if you're unable to satisfy yourself about that particular component.
>
> A. Yes.' (T383)

5.17. It is common ground that Dr Roughan did not institute a program of regular urinalysis to monitor whether Dr Mauro was abstinent from using cannabis. Indeed it is evident from later consultations that Dr Mauro was continuing to use cannabis, although he asserted that he was doing so to a lesser extent.

5.18. Dr Roughan saw Dr Mauro again on 8 June 2001, when he told her that he was returning to Lightning Ridge. She did not see him again until 5 October 2001, by which time his employment was terminated. I will not examine the details of what happened in New South Wales, except to say that Dr Mauro disputed the allegations made against him which resulted in a charge of assault. This charge was later dismissed. By the time Dr Roughan saw Dr Mauro again, his psychiatric condition had again deteriorated markedly. She saw him again on 10 October, 24 October and 8 November 2001, by which time his condition had improved again and he was working half-time (T207).

5.19. On 9 November 2001 Professor Kalucy telephoned Dr Roughan and requested a report concerning Dr Mauro. This contact appeared to have been prompted by a telephone call from Dr Mauro’s solicitor inquiring about progress from the February meeting. Apart from the telephone call about which Dr Roughan and Professor Kalucy disagree, there appears to have been no other action taken by the MBSA in the meantime.

5.20. Dr Roughan wrote a report to Professor Kalucy that day. The report is Exhibit C11. Dr Roughan outlined Dr Mauro’s history, her diagnosis, the treatment she had administered, the fact that she had referred him to Dr Watson for a second opinion and a summary of that opinion. She reported that she believed that Dr Mauro was again using significant amounts of cannabis to sedate himself but little diazepam. She said she was seeing him at fortnightly intervals, and planned to continue to encourage him to cease using cannabis. She reported:

> 'It would seem that he is probably able to work effectively at least in a reasonably controlled environment.'
>
> (Exhibit C11, p3)

She indicated that his ongoing use of cannabis was 'of concern'.

5.21. This report was apparently not seen by Professor Kalucy until 17 January 2002. In his statement, Professor Kalucy said that:

> 'It did not raise any concerns regarding Dr Mauro's ability to practice.'
>
> (Exhibit C13, paragraph 15)

Professor Kalucy took no further action in relation to Dr Mauro at that time. He said that he left the file open (ibid).

5.22. Dr Mauro commenced employment at TQEH in the Emergency Department on 1 March 2002 as a casual Medical Officer.

5.23. Dr Roughan saw Dr Mauro again on 7 December 2001 and 15 January 2002 and then on 28 February 2002 when he told her that the complaint arising from the incident at Lightning Ridge had been referred to the Medical Board of New South Wales. She said that he was much less anxious at this consultation, and not depressed at all. She noted a 'significant improvement' in his reaction to crises (T211). When she saw him again on 27 March 2002, she commented:

> 'This period was the most functional I had ever seen him in every way.' (T211)

5.24. On 4 June 2002 there was a further meeting of Committee A at which Professor Kalucy, Mr Gordon Miksa, Acting Registrar, Dr Mauro and his solicitor were present. After some discussion, the notes taken by Mr Miksa record:

> 'Prof stated that he acknowledged Dr Mauro has an illness but in his opinion this does not affect his competency as a doctor.
>
> Doctor is considering stopping his cannabis taking.
>
> Conclusion: Board Members are unaware of his situation. Await 6 to 7 months and then invite Dr Mauro to attend – February 2003
>
> …
>
> Doctor has indicated that he will not be renewing his New South Wales medical registration.' (T338-T339)

5.25. Mr Illingworth, counsel for the MBSA, argued that the MBSA had no jurisdiction to entertain a complaint arising from events in New South Wales. While this is strictly true, the Committee still had not resolved the allegations previously placed before it which cast doubts upon Dr Mauro's fitness to practise. One might have thought that

the events in New South Wales might have prompted Committee A to consider whether Dr Mauro's health had again become problematic and required investigation. In any event, Mr Illingworth's submission overlooks the fact that Professor Kalucy's conclusion was that Dr Mauro's illness did not affect his competency as a doctor. He was quite happy at that time to form that conclusion regardless of the fact that these events occurred in New South Wales.

5.26. On 29 June 2002, Dr Mauro saw Dr Roughan again. He was facing another personal crisis concerning certain events which occurred in New South Wales while he was attending the court case there. She described his reaction as 'minor' when compared with previous reactions to similar crises. She said that she had no concerns about his ability to continue in his employment in the Emergency Department at TQEH (T213). This was the last occasion at which Dr Mauro's health was assessed prior to the events involving Mrs Sorensen on 22 to 23 July 2002.

5.27. Those events have already been discussed in the earlier part of these findings. I am left in some doubt about when Dr Mauro first became aware of Mrs Sorensen's death on 24 July 2002. He told me 15 February 2005:

> ' I have a picture in my head but as I've said, I'm a bit confused now about what's memory and what is myself having gone over things so many times. The picture in my head is of me being at the emergency department being told by one of my consultants that Mrs Sorensen had passed away and of me being given some information about it.
>
> Q: Do you think that was relatively soon after the event.
>
> A: I believe so, yes.
>
> Q. Because the first record of interview was not until October the following year, so more than a year later.
>
> A. Correct.
>
> Q. But you'd been aware of the event long before that.
>
> A. I believe so, yes.' (T79)

5.28. In contrast, when he gave evidence on 31 May 2005 he adopted his statement which reads:

> 'I now believe that to be wrong. I have gone through Dr Roughan's records of her consultations with me. I have told her of the significant anxiety causing events in my life. Dr Roughan's notes show that I first told her about the death of Mrs Sorensen at about the time I was interviewed by coroner's investigators. For that reason I am now certain that I was not told of Mrs Sorensen's death while I was employed at TQEH.'
>
> (Exhibit C7d, pp8-9)

5.29. Events of 25-26 July 2002

On 26 July 2002, two days after Mrs Sorensen's death, nursing staff in the Emergency Department at TQEH reported to Dr Tom Soulsby, Consultant, that Dr Mauro had on two separate occasions during that shift removed diazepam from the pharmacy imprest cupboard. Written statements were received from four nurses concerning these events. In a letter to Dr Mauro dated 26 July 2002, Dr Soulsby summarised the allegations against him as follows:

> '1. That on the first occasion at 0300 you removed a number of boxes of medication from the pharmacy cupboard in the general area, entered the ENT/EYE room and left, leaving behind two empty packets of Diazepam concealed in the rubbish bin.
> 2. That on the second occasion at 0655 you removed a box of Diazepam from the pharmacy imprest cupboard.
> 3. That a further two empty boxes of Diazepam were found in the Radiology rubbish bin.
> 4. That you were observed to have removed sachets of medications from the drug cupboard and placed them in your pocket.'
>
> (Exhibit C15a)

5.30. A meeting was convened at TQEH on 29 July 2002 at which Dr Mauro was interviewed. Dr Alphonse Roex, the Executive Director of Medical Services, reported:

> 'At the meeting, Dr Mauro admitted the theft of the Diazepam on two occasions during the nightshift of the 25th/26th of July 2002. He said that he meant to remove the drug, Cipramil, as his prescription had expired and it was two days before he was going to consult his psychiatrist but he accidentally took Diazepam. He also made mention of suffering a dental abscess. I asked Dr Mauro to provide a urine specimen for analysis, which he did, and I told him that further investigations needed to take place.'
>
> (Exhibit C15, pp2-3)

5.31. In his statement, Exhibit C7d, Dr Mauro had an elaborate explanation for his behaviour. He said:

- He had developed dental pain during that nightshift;
- One of the Resident Medical Officers, he thought Dr Steele, gave him several injections of local anaesthetic into the painful area;
- He thought he had developed a dental abscess and that he may not be able to see Dr Roughan for his upcoming appointment;

- His prescribed supply of Cipramil had either run out or was going to run out in the next few days;
- During the course of the shift, while obtaining medications for patients, he took two boxes of what he believed to be Cipramil tablets;
- He took the sheets of tablets from the two boxes and placed them in his rear pocket and put the boxes in the rubbish bin;
- Later in the same shift, again while obtaining medication for a patient, he took two further boxes of Cipramil and treated them in the same way;
- Towards the end of the shift, Margaret Crockford told him that he looked awful, he told her about the dental abscess, she offered to get him some Panadeine Forte, he accepted, and she gave him some;
- He thought that Ms Crockford also obtained some antibiotics for him as well;
- After the shift he went home, took two of the Panadeine Forte tablets, one of the diazepam tablets that he already had from Dr Roughan's prescription, and a smoke of marijuana. He took his usual dosage of Cipramil. In evidence he said that his mother brought this for him - she works as a Practice Manager in a medical practice;
- He did not realise that he had taken diazepam until several days later when he checked the pockets in his trousers and realised that he had taken four packets of diazepam instead of four packets of Cipramil (Exhibit C7d).

5.32. Quite frankly, I find this explanation quite incredible. A number of aspects of the explanation do not seem to make sense. For example:

- He mistook diazepam for Cipramil on two separate occasions, nearly four hours apart;
- He had been taking both medications for a substantial period of time and was familiar with both;
- He took the tablets out of the boxes and discarded them and still did not notice his error;

- On both occasions he was obtaining medication for patients, and yet seemed able to correctly identify the medication he needed for them, but not for himself;
- His appointment with Dr Roughan did not seem urgent, and there was no reason to think he would not be able to see both a dentist and her in the next few days;
- He could have telephoned Dr Roughan for a prescription for Cipramil if he needed it;
- He sought no dental treatment afterwards;
- Margaret Crockford gave evidence that at this time she was in Malaysia on holidays. In any event, she was employed as Administrative Director, and only worked between 8am and 4pm.

The more one analyses Dr Mauro's explanation, the less credible it seems. His behaviour seems entirely inconsistent with his protestations that his capacity to practise medicine that evening was not in anyway impaired. His behaviour seems more consistent with someone who was agitated or confused or flustered, rather than someone calmly going about his professional duties while treating patients.

5.33. Dr Mauro categorically denied that he was suffering a panic attack or any other manifestation of his anxiety disorder, either that night or on the night of 22/23 July 2002 when he treated Mrs Sorensen.

5.34. On 6 August 2002, a letter was written to Dr Mauro terminating his employment at TQEH. A letter was also written to the MBSA advising them of the termination (Exhibit C15, p3).

5.35. Having been notified by TQEH, the MBSA invited Dr Mauro to a further meeting with Committee A on 13 August 2002. This was attended by Professor Kalucy, Dr Chris Baggoley, Mr Wilde, Dr Mauro and his solicitor.

5.36. In his statement, Exhibit C13, Professor Kalucy said that the Committee regarded the theft of medication as very serious, that it was concerned about the positive results from the drug screen ordered by TQEH which detected the presence of benzodiazepines, opiates and THC (cannabis), that they were worried that Dr Mauro was not in good shape, and they were concerned about the possibility that his health had deteriorated to the point that it may have impacted on patient care. They decided

to instigate an assessment of his ability to practise as quickly as possible, and requested that he undertake to submit to regular urine testing. They arranged an appointment with Dr Rene Pols, a Consultant Psychiatrist, to perform an assessment of his ability to practise.

5.37. It is not necessary for me to further discuss what happened after this time, except to observe that Dr Pols' report was duly received by the Committee, and that he rejected the notion that Dr Mauro's anxiety disorder had put patients at risk. Dr Mauro's certificate of full registration was returned to him on 16 December 2003 (the legal status of 'full' and 'limited' registrations is not clear to me at this point).

5.38. Conclusions

Taking all of the above evidence into account, I believe that the following conclusions can be drawn about Dr Mauro, and about his ability to practise medicine and whether or not that was a causative factor in his less than adequate treatment of Mrs Sorensen:

- Dr Roughan is obviously a conscientious and concerned psychiatrist who did her best to treat Dr Mauro, who because of his medical qualifications, his high intelligence, and his unusual personality, would not have been an easy patient;
- Dr Roughan clearly exercised close clinical supervision of Dr Mauro to the extent that she was able. When Dr Mauro was either interstate or overseas, she accepted his assurances that he was well, and abstaining from cannabis;
- Dr Watson gave very clear opinions about the way in which he suggested that Dr Mauro should be treated. He considered that it was appropriate for Dr Mauro to continue working as a Medical Practitioner, but under close clinical supervision, including ongoing monitoring of his abstention from cannabis. This did not occur;
- When Dr Mauro came to the attention of Committee A of the MBSA, allegations by patients of Adelaide Metropolitan Locum Service were not investigated, and Dr Mauro's denials were accepted without further inquiry. Apart from eventually obtaining a detailed report from Dr Roughan about nine months after their initial meeting with Dr Mauro, and convening a meeting on 4 June 2002 five months later, Committee A did little else to monitor Dr Mauro's capacity to practise medicine in the relevant period up until July 2002 when Mrs Sorensen died;

- It would appear that the incidents referred to in these findings, and other incidents since July 2002 which have not been discussed have never been referred to the MBSA, and have at all times been dealt with by Committee A. Since Committee A had no legal status, this is a matter of concern;

- TQEH did not make detailed inquiries about Dr Mauro's history before employing him in March 2002, but even if they had, they would not have received any relevant information from the MBSA. They had no information before them to indicate that Dr Mauro was in any way impaired in his ability to practise medicine in the Emergency Department at the hospital;

- There is no evidence before me which establishes that Dr Mauro's ability to practise medicine on the night of 22/23 July 2002 was impaired either by drugs, mental illness or otherwise;

- I do not accept Dr Mauro's explanations for his behaviour three nights later when he removed four packets of diazepam tablets from the imprest cupboard at TQEH without authority, but there is no evidence to connect this behaviour with any act or omission of Dr Mauro on the night he treated Mrs Sorensen;

- There is no satisfactory explanation before me as to why his treatment of Mrs Sorensen was so seriously deficient that night;

- TQEH acted promptly and appropriately by dismissing Dr Mauro as soon as it became aware of his removal of the medication;

- After it became aware of Dr Mauro's actions on 25/26 July 2002, the MBSA took more positive action in relation to Dr Mauro before eventually removing restrictions upon his right to practise in December 2003.

6. <u>Recommendations</u>

6.1. I am empowered by Section 25(2) of the Coroner's Act 1975 to make recommendations if I am satisfied that to do so would 'prevent, or reduce the likelihood of, a recurrence of an event similar to the event that was the subject of the inquest.'

6.2. I am always reluctant to make prescriptive recommendations in areas such as the clinical practice of medicine. There is insufficient evidence before me upon which I

could base a recommendation which could form the basis of a detailed policy and/or procedure to guide a medical practitioner in an Emergency Department dealing with an elderly patient complaining of abdominal pain.

6.3. In the circumstances, I consider that the most appropriate recommendation is as follows:

- That the Directors of Emergency Departments in all hospital in South Australia re-evaluate their policies and procedures insofar as they apply to patients presenting with abdominal pain, and in particular elderly patients with a history of abdominal surgery, in light of the criticisms made by Associate Professor Brown herein, and in light of the academic articles he has produced.

6.4. Having regard to my findings about the events of 25-26 July 2002, I am not authorised by Section 25(2) of the Coroners Act 1975 to make recommendations concerning the activities of Committee A of the MBSA in relation to Dr Mauro. However, I draw this issue to the attention of the Minister for Health.

Key Words: Hospital Treatment; Abdominal Pain; Bowel Obstruction

In witness whereof the said Coroner has hereunto set and subscribed his hand and

Seal the 3rd day of June, 2005.

____

Coroner

Inquest Number 4/2005 (1980/2002)