MAGISTRATES COURT *of* TASMANIA

CORONIAL DIVISION

Record of Investigation into Death (Without Inquest)

Coroners Act 1995
Coroners Rules 2006
Rule 11

I, Simon Cooper, Coroner, having investigated the death of William Ernest Pears

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

a) The identity of the deceased is William Ernest Pears;
b) Mr Pears died as the result of complications following laparoscopic cholecystectomy;
c) The cause of Mr Pears' death was intra hepatic sepsis and intrahepatic haematoma; and
d) Mr Pears died during the night of 7-8 September 2015 at the George Town Hospital, George Town in Tasmania.

Introduction

1. In making the above findings I have had regard to the evidence gained in the comprehensive investigation into Mr Pears' death. The evidence comprises:

- Police Report of Death for the Coroner;
- An opinion of the forensic pathologist who conducted the autopsy;
- Results of toxicological analysis of samples taken at autopsy;
- A detailed affidavit of Mrs Lorraine Pears, Mr Pears' widow;
- Medical Imaging Reports;
- Medical Records – Tasmanian Health Service;
- Medical Records – George Town Hospital;
- Medical Records – St Vincent's Hospital, Melbourne;
- Medical Reports (x2) – Associate Professor V Usatoff;
- Medical Report – Prof J Froelich;
- Medical Report – Mr R Millar
- Medical Report – Dr A J Bell;
- Relevant police and witness affidavits; and
- Forensic and photographic evidence.

What a Coroner Does

2. Before looking at the circumstances surrounding Mr Pears' death, it is necessary to explain the role of a coroner. A coroner in Tasmania has jurisdiction to investigate any death which appears to have happened after a medical procedure where the death may be causally related to that procedure. Mr Pears' death meets that description.

3. When investigating any death, a coroner performs a role very different to other judicial officers. The coroner's role is inquisitorial. She or he is required to thoroughly investigate a death and answer the questions (if possible) that section 28 of the Co*roners Act* 1995 (the "Act") asks. Those questions include who the deceased was, how he or she died, what was the cause of the person's death and where and when it occurred. This process requires the making of various findings, but without apportioning legal or moral blame for the death. A coroner is required to make findings of fact from which others may draw conclusions. A coroner may also, if he or she thinks fit, make comments about the death being investigated or, in appropriate circumstances, recommendations with a view to preventing similar deaths in the future. In short, the purpose of the investigation is to attempt to find out why someone died and, if possible, learn lessons from the death to prevent similar deaths occurring in the future.

4. A coroner does not impose punishment nor award monetary compensation – that is for other proceedings in other courts, if appropriate. Nor does a coroner have the power to charge anyone with crimes or offences arising out of the death the subject of investigation. In fact, a coroner in Tasmania may not even say that she or he thinks someone is guilty of an offence. I should make it very clear that I do not consider anyone has committed any offence in relation to Mr Pears' death.

5. As noted above, one matter that the Act requires is that a finding be made about how death occurred. It is well settled that this phrase involves the application of the ordinary concepts of legal causation. Any coronial inquiry necessarily involves a consideration of the particular circumstances surrounding the particular death so as to discharge the obligation imposed by section 28(1)(b) upon the coroner.

Background

6. Mr Pears was born in Launceston on 2 November 1948 and was aged 66 years at the time of his death. He was married to Lorraine for 47 years and together the couple had two sons. Mr Pears was a hard working and active man who particularly enjoyed fishing, shooting and other outdoor activities. Until mid-2011, his health was apparently excellent.

7. On 20 July 2012, Mr Pears underwent surgery at the Launceston General Hospital ("LGH") to remove his gall bladder. Removal of his gall bladder was necessary as he had a stone in it. The surgery was supposed to take an hour but took approximately eight hours due to complications.

8. During the procedure, the hepatic duct to the right lobe was torn away from Mr Pears' bile duct. As a result, Mr Pears spent approximately five days in the LGH intensive care unit ("ICU"). He was then in the ward for about a week before returning home. Approximately three days after his discharge home Mr Pears returned to the LGH.

9. He had another operation as an infection had occurred after the initial surgery. This time infected tissue was removed. Mr Pears was in hospital for about a week following the surgery. After discharge and his returning home, it is evident that his health began to deteriorate.

10. On 7 December 2012, Mr Pears was taken to Melbourne and admitted to St. Vincent's Public Hospital. He underwent further surgery and was discharged on 16 December 2012.

11. Unfortunately, Mr Pears continued to have problems with high temperatures and infections upon returning to Tasmania. He returned to hospital a number of times for treatment in relation to this including the LGH and the George Town Hospital.

12. Mr Pears was re-admitted to St. Vincent's Public Hospital on 6 January 2014 and 19 October 2014. On both occasions, he underwent surgery to clear damaged bile ducts and biliary dilatations. Both between those dates and afterwards, Mr Pears was admitted to the LGH and George Town Hospital with high temperatures and further infection which was treated with antibiotics.

13. Mr Pears returned to the St. Vincent's Public Hospital on 19 January 2015, 4 May 2015, 3 June 2015 and 20 July 2015 where he had blood tests, CT Cholangiograms, MRIs and H.I.D.A. scans. The various investigations showed slow bile drainage and whilst there was still flow, no further dilatations were done.

14. On 10 August 2015, Mr Pears was admitted to the St Vincent's Public Hospital for the eighth occasion, to enable dilatations to be performed. Whilst there, he slowly deteriorated and it would appear that his liver began to fail. Eventually, nothing further could be done for him. On 4 September 2015, by now critically ill, Mr Pears was transferred to George Town Hospital to be closer to family. He received palliative care.

Circumstances Surrounding the Death

15. On 7 September 2015, Mr Pears was last seen alive by Lorraine who was staying in the room at the hospital with him. Lorraine drifted off to sleep at approximately 10.30pm. At approximately 1.20am the following morning, 8 September 2015, Lorraine awoke and checking on her husband found he had passed away. She informed hospital staff who contacted police. Police attended, examined Mr Pears' body and photographed it.

Investigation

16. The fact of Mr Pears' death was reported in accordance with the requirements of the *Coroners Act* 1995. His body was formally identified and transferred by mortuary ambulance to the Royal Hobart Hospital ("RHH").

17. At the RHH the then Tasmanian State Forensic Pathologist Dr Christopher Lawrence carried out an autopsy. Dr Lawrence expressed the opinion, which I accept, that the cause of Mr Pears' death was hepatic failure and intrahepatic sepsis and intrahepatic haematoma. In short, I am satisfied that Mr Pears' death was due to complications of the laparoscopic cholecystectomy performed at the LGH on 20 July 2012, and his subsequent treatment.

18. I note that toxicological analysis of samples taken at autopsy indicated only the presence of therapeutic medications.

19. The treatment Mr Pears underwent became the focus of the Coronial Investigation. I turn now to consider that issue in detail.

20. The evidence is that on 9 May 2011 Mr Pears suffered a bout of non-specific right upper quadrant pain. He suffered further pain two days later and consulted his GP. An ultrasound was performed and liver function test carried out. The ultrasound report says:

> "*The liver is increased in size and shows fatty infiltration. The gall bladder shows sludge. The CBD [common bile duct] measures 5 mm. Both kidneys and spleen appear normal. The pancreas is not well visualised.*
>
> *Comment: Hepatomegaly with fatty infiltration. Some gallbladder sludge".*

[Hepatomegaly is the medical term for enlargement of the liver].

21. Mr Pears was referred to a consultant surgeon in Launceston. The surgeon saw Mr Pears on 30 May 2011. She diagnosed him as suffering from acute cholecystitis (inflammation of the gall bladder). Mr Pears was placed on the waiting list for a laparoscopic cholecystectomy. Medical records indicate that at this time Mr Pears was told about the potential complications of such surgery. Mr Pears was then left under the care of his GP until surgery.

22. He was eventually admitted to the LGH for the laparoscopy to be performed on 20 July 2012. The procedure was performed by Dr R Yap, a third year advanced surgical trainee. Dr Yap was supervised by Dr G Pande, an experienced surgeon. Dr Yap had, at the time of Mr Pears' procedure, assisted at 70 laparoscopic cholecystectomies and was the primary surgeon in 40 cases. Associate Professor Val Usatoff, a surgeon specialising in liver, pancreas and biliary system, reviewed Mr Pears' treatment. He said, and I accept, that it was not inappropriate for Dr Yap to perform "an anatomically normal laparoscopic cholecystectomy under the supervision of Dr Pande but that [he] would expect him to need support with more difficult cases".

23. The relevant surgical notes indicate that Mr Pears' anatomy was pathological because of scarring and fibrosis. The same notes indicate that Dr Yap, appropriately, called for assistance from Dr Pande. Dr Pande advised Dr Yap to proceed with the operation, but to avoid the common bile duct.

24. Dr Yap proceeded but encountered further difficulty because the presence of fibrosis meant he could not find a clear plane of dissection. He re-called Dr Pande for assistance (Dr Pande was in the next theatre). This led to an open laparotomy being performed. In the process, a hole was found in the right hepatic duct, which was appropriately repaired.

25. The decision to change the focus of the procedure to an open cholecystectomy was described by Professor Usatoff as being "dependant very much on the intra operative findings" as well as the experience of the operator. He also suggested another option was to abandon the procedure altogether. It is unclear whether the latter alternative was considered in relation to Mr Pears. It certainly should have been, and had it been, the outcome for Mr Pears may well have been very different.

26. That having been said, I also accept Professor Usatoff's opinion that the operation performed by Dr Pande to repair the damage to the right hepatic duct was "entirely appropriate and certainly got [Mr Pears] out of a difficult situation".

27. However, it seems clear enough that Mr Pears' left hepatic duct was also damaged – but unfortunately, the damage was not detected. This seems to me, looking at the evidence as a whole, to have been the cause of all the problems which subsequently befell Mr Pears, and led to his untimely death.

Discussion

28. Because the damage to Mr Pears' left hepatic duct was not detected on 20 July 2012, it was not repaired then. The fact that it was not identified, or repaired, meant that subsequent surgery (such as that performed in November 2012) proceeded in a way which likely exacerbated Mr Pears' condition, rather than ameliorating it. Whether it should or could have been identified is difficult to answer. I note Professor Usatoff, who had access to some relevant imaging said such imaging can be difficult to interpret, but at the same time there appeared to be some confusion in radiological reports.

Comments and Recommendations

29. I **comment** that the circumstances of Mr Pears' death illustrate the need for operators to consider, when difficulties are encountered whilst performing a laparoscopic cholecystectomy, alternatives such as an open procedure or abandoning the cholecystectomy altogether.

30. I convey my sincere condolences to Mr William Ernest Pears' family and loved ones.

Dated 3 April 2020 at Hobart in the State of Tasmania.

Simon Cooper
Coroner