MAGISTRATES COURT *of* TASMANIA

CORONIAL DIVISION

Record of Investigation into Death (Without Inquest)

Coroners Act 1995
Coroners Rules 2006
Rule 11

I, Robert Webster, Coroner, having investigated the death of Anthony George Bennett

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

a) The identity of the deceased is Anthony George Bennett ("Mr Bennett");
b) Mr Bennett died as a result of shock due to bowel ischaemia following massive blood loss due to bleeding of the left internal iliac artery after undergoing an elective repair of an aortic aneurysm;
c) Mr Bennett's cause of death was shock due to bowel ischaemia; and
d) Mr Bennett died on 14 November 2020 at Hobart, Tasmania.

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

- Police Report of Death for the Coroner;
- Affidavits establishing identity and life extinct;
- Royal Hobart Hospital record of death;
- Affidavit of Dr Christopher Lawrence, Forensic Pathologist;
- Affidavit of Jane Bennett, senior next of kin;
- Medical records from Calvary Hospital and Hobart Private Hospital; and
- Report of the coronial medical consultant Dr Anthony Bell.

Background

Mr Bennett was born on 7 May 1943 and was 77 years of age at the date of his death. He was one of 7 children to his parents. He married his wife, Jane Bennett, on 20 April 1968 and they resided in Bridgewater and had 3 sons.

Mr Bennett worked as a sales representative and as a purchasing office for the Hobart City Council. His final position of employment before he retired in 2003 was as the superintendent in charge of Mountain Park.

Mrs Bennett says that Mr Bennett mainly enjoyed good health through his working life until he was diagnosed with atrial fibrillation in the late 1970s to early 1980s. She says this condition improved after he retired and they moved to Orford to live.

Circumstances Leading to Mr Bennett's Death

Mrs Bennett explains that Mr Bennett had a heart attack in June 2019 while he was at Calvary Hospital seeing his cardiologist. That is confirmed by the Calvary Hospital records. His cardiologist, Dr Bishop, reports Mr Bennett attended the hospital for monitoring and he began to infarct and so Dr Bishop, with the assistance of another cardiologist, deployed a stent in the proximal right coronary artery after which Mr Bennett's health improved. Those records also indicate an echocardiogram was conducted on 7 January 1997, an angiogram was conducted on the 5th and 18th of January 2017, and a further coronary angioplasty was performed on 2 February 2017.

Mrs Bennett says an aneurysm was identified in an x-ray when Mr Bennett saw a vascular surgeon in August 2019. She says Mr Bennett suffered 3 falls in 2020, the first of which occurred in January of that year when he was visiting their son. He couldn't recall what happened to cause the fall and hurt both of his shoulders and suffered grazing to his elbows and arms. The second fall occurred on 29 June 2020 when he was walking the dog. He sustained 2 black eyes, a cut to his nose and broken ribs. The third fall occurred on 11 August 2020 when Mr Bennett was again walking the dog. He suffered injuries to his ribs and a fracture to his spine.

Following this fall he received the diagnosis the aneurysm had increased in size and he was advised that a repair would be a difficult procedure. He was booked in for the surgery on the proviso he received favourable reports from his cardiologist and renal surgeon. The cardiologist gave the all clear for the procedure however the renal surgeon required there to be improvement in Mr Bennett's kidney function prior to being satisfied that the repair of the aneurysm should proceed. Mrs Bennett says a plan was developed to improve kidney function and in early October 2020 the renal surgeon gave the all clear for the aneurysm repair to proceed.

The initial surgeon who was consulted with respect to the aneurysm repair was Dr Walker. Mr Bennett was advised to seek a second opinion and that was obtained from Dr Cottier in

about mid-October 2020. After considering Dr Cottier's advice, Mr Bennett decided to proceed with the surgery which was conducted by Dr Cottier on 5 November 2020. The advice Mrs Bennett initially received was that the procedure went as well as could be expected and *"following the operation the prognosis was day by day."* She says 5 days after the operation she was advised of complications and that further surgery was required. The decision was made on 13 November 2020 to withdraw treatment and Mr Bennett passed away on 14 November 2020.

Post-mortem examination

A post-mortem examination was conducted by the forensic pathologist Dr Christopher Lawrence. In Dr Lawrence's opinion, Mr Bennett died as a result of shock due to bowel ischaemia following massive blood loss due to bleeding of the left internal iliac artery after he had undergone an elective surgery to repair an aortic aneurysm. I accept Dr Lawrence's opinion. Dr Lawrence notes Mr Bennett had a number of other significant conditions including ischaemic heart disease, atrial fibrillation, peripheral vascular disease and end-stage kidney disease. In addition there was a history of chronic obstructive pulmonary disease, type II diabetes, hypertension and he had previously suffered deep vein thrombosis of the left leg.

Examination of the Medical Care Provided to Mr Bennett

Because Mr Bennett passed away following an elective repair of an abdominal aortic aneurysm the coronial consultant, Dr Anthony Bell, examined the medical care which Mr Bennett received. Dr Bell says the surgery was performed uneventfully although he notes it was difficult because there were aneurysms of the infrarenal aorta, bilateral common iliac arteries and bilateral internal iliac arteries. Mr Bennett was hypotensive in the recovery room due to bleeding. He required a transfusion of 6 units of packed red blood cells, 6 litres of crystalloid fluid, cryoprecipitate and fresh frozen plasma. Hyperkalaemia caused pulseless ventricular tachycardia and this was treated in the normal manner.

Mr Bennett was transferred to the Royal Hobart Hospital intensive care unit at approximately 21:00 hours. A further 3 units of packed red blood cells and coagulation factors were administered over 5 hours. A CT aortic angiogram did not reveal the source of blood loss. There were multiple infarcts of the spleen and a shrunken right kidney. Dr Cottier reviewed Mr Bennett and the plan was for re-look surgery. At surgery a large arterial bleed was detected from the primary branch vessel of the left internal iliac artery with back bleeding into the aneurysmal sac. Haemostasis was achieved and Mr Bennett was returned to the intensive care unit.

On 6 November 2020, during the morning ward round, Mr Bennett was found to be stable with some improvement.

By 11 November 2020, although Mr Bennett remained stable, he was on significant life support. There was an ongoing need for dialysis, mechanical ventilation and there was increasing abdominal distension. By 21:15 hours, Mr Bennett had deteriorated significantly and there were signs of sepsis, there was haemodynamic instability, he had an elevated serum lactate and he required increased ventilation support.

On 12 November 2020, a CT scan of the abdomen suggested a bowel perforation. Surgery was planned and at surgery feculent fluid was found in all 4 quadrants with ischaemic colitis and oedematous bowel. A stoma was formed and the damaged bowel resected. Overnight Mr Bennett deteriorated. On 13 November 2020 re-look surgery found further ischaemic changes. He was returned to the intensive care unit at 09:40 hours. There was further deterioration by 13:30 hours and a decision was made by medical staff in consultation with Mr Bennett's family to withdraw all active treatment. Mr Bennett passed away the next day.

Dr Bell says:

> *"Despite the poor outcome the management was of good standard. The initial surgery was difficult and the bleeding was back flow into an aneurysm rather than surgical damage to a vessel. The resuscitation post-surgery was performed well, and despite no obvious sight of bleed on CT scan the correct decision for re-look surgery was performed.*
>
> *Following the re-look surgery the surgeon raised concerns that colonic and buttock ischaemia could occur.*
>
> *In ICU the course was of slow improvement with the expected ups and downs. The management was attentive and appropriate consultations made for expert advice.*
>
> *The not unexpected deterioration occurred and urgent surgery performed on 2 occasions. Both surgeries treated effects of poor blood flow and did not cure the (incurable) problem. The limitation of therapy at the end was a sound decision."*

Dr Bell's conclusion therefore is Mr Bennett's medical management was of a good standard. I accept Dr Bell's opinion.

Comments and Recommendations

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

I convey my sincere condolences to the family and loved ones of Mr Bennett.

Dated: 29 November 2021 at Hobart Coroners Court in the State of Tasmania.

Robert Webster
Coroner