MAGISTRATES COURT *of* TASMANIA

CORONIAL DIVISION

Record of Investigation into Death (Without Inquest)

Coroners Act 1995
Coroners Rules 2006
Rule 11

(These findings have been de-identified in relation to the name of the deceased, family, friends and others by direction of the Coroner pursuant to s57(1)(c) of the Coroners Act 1995)

I, Simon Cooper, Coroner, having investigated the death of LA

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

a) The identity of the deceased is LA;
b) LA died following laparoscopic surgery as a result of which he developed sepsis and acute kidney failure;
c) The cause of LA's death was acute gastrointestinal haemorrhage; and
d) LA died on 27 August 2019 at the Royal Hobart Hospital, Hobart, Tasmania.

Introduction

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

- Police Report of Death for the Coroner;
- Royal Hobart Hospital – Death Report to Coroner;
- Affidavits establishing identity and life extinct;
- Report – Office of the State Forensic Pathologist;
- Affidavit from family, sworn 19 January 2020;
- Medical records – Tasmanian Health Service – Royal Hobart Hospital;
- Medical records – Hobart Private Hospital;
- Précis of medical records prepared by Forensic Nurse Ms L Newman; and
- Report – Dr AJ Bell – Medical Advisor to the Coronial Division.

Circumstances of death

LA was admitted to the Royal Hobart Hospital on 3 July 2019, with a diagnosis of recurrent diverticulitis for which on the same day he underwent laparoscopic Hartmann's procedure (procto-sigmoidectomy). Post-operatively, he developed faecal peritonitis caused by dehiscence

of a bowel surgical anastomosis. He was transferred, post operatively, and on the same day, to the Hobart Private Hospital.

However, because his post-operative course was complex, he was transferred back to the Royal Hobart Hospital on 5 July 2019. The anastomotic region was resected late in the evening/early morning of 8- 9 July 2019. An end colostomy was placed and the peritoneum was lavaged. His post-operative course was marked by sepsis and acute kidney failure requiring dialysis. Thereafter, LA had a prolonged stay in the Intensive Care Unit.

By 10 July 2019, LA's cardiovascular system was, in effect, failing. The following day, 11 July 2019, a re-look laparotomy was performed, and his abdomen left open.

A further re-look surgery was performed on 15 July 2019, after which LA's abdomen was closed. He remained gravely ill in the ICU with acute renal failure and a problematic neurological state. Serotonin syndrome was suspected by his treating team.

His course of treatment included antibiotics, diagnostic scans and the testing of various sites and specimens for infection.

LA was transferred to a surgical ward from the ICU on 5 August 2019.

It was not until 9 August 2019 that LA was diagnosed as being in septic shock. Thereafter, Mr LA's treatment involving blood transfusions, inotropic and high strength antibiotic medication and efforts to treat his sepsis continued, but without significant improvement.

On 27 August 2019 LA developed haematemesis (that is he began vomiting blood) and hypotension. He required an urgent blood transfusion and fluid resuscitation. He underwent an emergency gastroscopy with finding of a duodenal ulcer. During the procedure, Mr LA developed ST elevation myocardial infarction and became hemodynamically unstable. Haemorrhage from the duodenal ulcer could not be controlled endoscopically; therefore a laparotomy was performed with the intent to stop bleeding, however he suffered cardiac arrest from which he could not be resuscitated.

Mr LA had known reflux oesophagitis and took the medication Rabeprazole (a proton pump inhibitor) regularly prior to admission. In hospital he was administered a similar medication, Esomeprazole, either orally or intravenously, until 6 August 2019. It is unclear why the medication was not continued from 6 August 2019. On the day of his death he was administered intravenous Esomeprazole as part of the management of his haematemesis.

Investigation

The fact of his death was reported in accordance with the requirements of the *Coroners Act* 1995 by both Tasmania Police and the Royal Hobart Hospital. His body was formally identified and then transferred to the hospital's mortuary. At the mortuary experienced forensic pathologist Dr Donald Ritchey performed an autopsy. Dr Ritchey said in his report:

> *"The cause of death of this 67 year old man, LA, was acute gastrointestinal haemorrhage complicating peptic ulcer of the duodenum with erosion into gastro-duodenal artery. Significant contributing factors were recent Hartmann's resection of recto-sigmoid colon for diverticular disease with post-surgical complications and atherosclerotic coronary vascular disease".*

I accept Dr Ritchey's opinion. In summary, I am satisfied that LA died because of a major gastrointestinal bleed. He died despite appropriate emergency treatment.

Because of the circumstances in which Mr LA died, that is to say following a relatively routine surgical procedure, further investigations were carried out to determine "how" Mr LA's death occurred, as required by section 28 (1) (b) of the *Coroners Act* 1995. His medical records were obtained and reviewed.

It is apparent from his medical records that Mr LA had known reflux oesophagitis and took the medication Rabeprazole (a proton pump inhibitor) regularly prior to admission. In hospital, he was administered a similar medication, Esomeprazole, either orally or intravenously, until 6 August 2019. It is unclear why the medication was not continued from 6 August 2019. That Mr LA needed the Esomeprazole is evidenced by the fact that, on the day of his death, he was administered intravenous Esomeprazole as part of the management of his haematemesis.

A report was sought, and received from Dr Anthony J Bell MD MB BS FRACP FCICM, Medical Advisor to the Coroners Division.

Dr Bell critically analysed Mr LA's care. He said, and I accept, that Mr LA's treatment after 9 August 2019 was of a high standard. However, before 9 August 2019, Dr Bell said it was apparent there were two major factors in Mr LA's death that could, or should, have been avoided. The first was a delay in the diagnosis of an anastomic leak leading to severe illness. Second, was an inaccuracy in drug charts transcription in respect of the Esomeprazole, and a failure of multiple medical practitioners to recognise the fact that there had been such a failure. This failure, I think, speaks for itself.

So far as the first aspect is concerned, it is evident in the medical records that there was a delay of five days post-surgery in the diagnosis of an anastomotic leak. Moreover, there were ample indicators in the form of early and persistent elevated C-reactive protein (CRP) post-surgery. Early and persistent elevation of CRP after colorectal surgery is a recognised marker of anastomotic leakage.

This finding, in draft, was sent to both the Hobart Private Hospital and the Royal Hobart Hospital for comment. Comments were received from both entities and I have had specific regard to them in finalising this finding. Specifically, notwithstanding the comprehensive submissions on behalf of the Royal Hobart Hospital, I am satisfied there was a delay in diagnosing Mr LA's anastomotic leak. I also am quite satisfied there was a failure to chart Esomeprazole (and not prescribe it as the Royal Hobart Hospital's submissions seem to suggest). I note the failure to chart is something expressly acknowledged in those submissions.

Comments and recommendations

The circumstances of Mr LA'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 LA.

Dated 20 August 2021 at Hobart in the State of Tasmania.

Simon Cooper
Coroner