



MAGISTRATES COURT *of* TASMANIA

CORONIAL DIVISION

Record of Investigation into Death (Without Inquest)

*Coroners Act 1995
Coroners Rules 2006
Rule 11*

I, Olivia McTaggart, Coroner, having investigated the death of Robin William Brand

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

- a) The identity of the deceased is Robin William Brand, date of birth 14 July 1962.

- b) Mr Brand was 62 years of age, was single and lived in Kings Meadows. His health was poor, and his medical conditions included severe emphysema, chronic pancreatitis, psoriasis and oesophageal stricture. He was a regular smoker and had a history of heavy cannabis use. The oesophageal stricture involved a severe narrowing of the oesophageal lumen causing Mr Brand difficulty swallowing. This stricture was diagnosed in December 2022 when Mr Brand underwent medical investigation at the Launceston General Hospital (LGH). From that date, he required 2-3 weekly oesophageal dilations. Medical records show that, since that time, he underwent 46 admissions for dilation procedures. The records also indicate that there was often considerable mucosal tearing associated with the dilations. Such tearing is a well-recognised consequence of the procedure, as is oesophageal perforation. The records also indicate that Mr Brand was very poor at consistently taking his prescribed proton pump inhibitor which was designed to prevent continued gastric acid injury to the stricture site.

On 29 August 2024, Mr Brand was admitted to the LGH for a further oesophageal dilation. The dilation was performed with a balloon dilator and resulted in considerable mucosal tearing. No signs or symptoms of perforation were seen following the procedure and Mr Brand was discharged from hospital. On 2 September 2024, he presented at the emergency department of the LGH complaining of vomiting and right-sided abdominal pain and chest pain. He had not tolerated oral intake at home for the previous two or three days. Comprehensive medical investigations took place and an urgent gastroscopy showed two longitudinal

deep tears above the gastro-oesophageal junction, 3 centimetres and 5 centimetres in length respectively. Despite treatment,¹ Mr Brand deteriorated as expected with such a condition. Therefore, on 11 September 2024, active treatment was withdrawn and he was transitioned to palliative care. He passed away that day.

- c) Mr Brand's cause of death was mediastinitis (chest/lung infection) due to perforated oesophagus. His severe emphysema contributed to his death.
- d) Mr Brand died on 11 September 2024 at Launceston, Tasmania.

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

- The Police Report of Death for the Coroner;
- Tasmanian Health Service Death Report to Coroner;
- Affidavits confirming identity;
- Medical records;
- Opinion of the forensic pathologist regarding cause of death; and
- Report from Dr Anthony Bell MD FRACP FCICM, Coronial Medical Consultant.

Comments and Recommendations

In this case, I sought a medical review from Dr Anthony Bell, the coronial medical consultant concerning Mr Brand's treatment and discharge relating to the dilation procedure occurring on 29 August 2024. Dr Bell stated in his report:

"The question remains did the patient suffer an iatrogenic² oesophageal rupture or an effort induced rupture. The medical chronology is not precise enough to make a clear determination. This would depend on when the chest pain began, how much vomiting did occur and when. From

¹ Including stenting, a naso-oesophageal tube, bilateral chest drains, antibiotics, respiratory and cardiovascular support, and intravenous feeding.

² Caused by the procedure.

the post gastroscopy discharge the pain appears to have started after discharge making iatrogenic perforation less likely.

To some degree the difference is irrelevant as the iatrogenic rupture is a well-known complication of oesophageal dilation. The operator was very experienced. The noted mucosal tears were frequently described after the procedure on many of the patient's previous gastroscopies (and is a recognised part of the procedure)."

On the basis of Dr Bell's opinion, I make no criticism of the treatment or discharge of Mr Brand following his dilation procedure. There is no indication that he was discharged with symptoms indicating a perforation. It appears significantly more likely that he vomited at home and this caused the perforation. It is also to be noted that Mr Brand's poor compliance with his proton pump inhibitor exacerbated his condition.

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

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

Dated: 9 December 2024 at Hobart, in the State of Tasmania.

Olivia McTaggart
Coroner