MAGISTRATES COURT
TASMANIA

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 David Ian Whitney

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

a) The identity of the deceased is David Ian Whitney, date of birth 3 March 1952.

b) Mr Whitney was aged 73 years, was a retired business owner and lived in Cressy. His medical history included type II diabetes, obesity, hypertension and ischaemic heart disease. He also had a history of being non-compliant with diabetes medications and was a smoker.

Just after midnight on 10 March 2022, Mr Whitney was taken by ambulance to the Launceston General Hospital (LGH) Emergency Department (ED). He complained of tearing abdominal pain, being the worst pain he had ever experienced. An urgent CT angiogram was performed which confirmed no aortic dissection and was reported as otherwise normal. With ongoing suspicion of bowel ischemia, a repeat CT angiogram was performed a few hours later. This was also reported as essentially normal. At 4.45am, after ongoing review, a mesenteric artery occlusion was detected on the original CT scan by the senior surgical fellow. The original CT report was later amended by the radiologist to include this obstruction in the comments and findings. Exploratory laparotomy was performed at the LGH, and the decision then made to escalate Mr Whitney to the Royal Hobart Hospital (RHH) for ongoing specialist treatment.

He was admitted as a patient of the RHH at 2.00pm. Later in the afternoon, a mesenteric angiogram and *EKOS* thrombolysis were performed. However, the following morning, 11 March 2022, Mr Whitney became unstable due to an ischaemic bowel, coagulopathy and possible sepsis. He was reviewed by a vascular surgeon and underwent a re-look laparotomy. During this procedure it was determined that his right colon, ileum and distal jejunum were non-viable. It was determined that the remaining viable bowel was not compatible with life and that further attempts at revascularisation would be futile. Mr Whitney was therefore

returned to the intensive care unit for palliation. Mr Whitney's family from interstate arrived at the hospital and Mr Whitney passed away in the early hours of 12 March 2022.

c) Mr Whitney's cause of death was sepsis due to ischemic gut due to occlusion of the superior mesenteric artery.

d) Mr Whitney died on 12 March 2022 at Hobart, Tasmania.

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

- The Police Report of Death for the Coroner;
- Tasmanian Health Service Death Report to Coroner;
- Tasmanian Health Service records;
- Review of hospital records by the Coronial Nurse Specialist, Mr Kevin Egan;
- Review by Coronial Medical Consultant, Dr Anthony Bell;
- Response from Deputy Executive Director of Medical Services LGH, Dr Lucy Reed;
- Response from Dr Stuart Day, Director of Surgery and Perioperative Services LGH; and
- Response from Dr Wen Kan, Radiologist LGH.

Comments and Recommendations

This case was reported to the Coroner two weeks after Mr Whitney died. The issue for investigation primarily concerned an apparent delay in identifying Mr Whitney's superior mesenteric artery (SMA) occlusion from the initial CT angiogram occurring at 12:30am, shortly after Mr Whitney's arrival at the LGH. It was over four hours later that the general surgical registrar and general surgical fellow reviewed the radiology and identified the possible SMA occlusion, which prompted the exploratory laparotomy. This, in turn, confirmed the diagnosis.

Dr Bell, Coronial Medical Consultant, highlighted that rapid diagnosis of acute mesenteric arterial occlusion is essential to prevent catastrophic events associated with intestinal infarction. Dr Bell highlighted the following matters in his review:

- That the clinicians in the ED might have requested the radiologist to consider possible mesenteric ischemia, which may then have led the radiologist to detect the thrombus in the mid-SMA which was present on the scan;

- The delay in diagnosing the SMA occlusion resulted in a lost opportunity to have Mr Whitney re-vascularised surgically; and
- The laparotomy occurring at the LGH once the diagnosis of SMA occlusion had occurred was unnecessary as there was no ability at the LGH to fix the underlying problem. The surgical equipment needed was not available.

In response, the relevant LGH specialists (referred to in the above evidence list) provided helpful reports regarding Mr Whitney's hospitalisation, diagnosis and course of treatment. They noted that the diagnosis of mesenteric ischemia is a notoriously difficult one to make. Further, the SMA thrombus was in an unusual position, some distance away from the SMA ostia (which is routinely checked by the radiologist). They acknowledged that a request was not made by the ED team to the radiologist prior to the initial scan listing this possible diagnosis. However, Dr Reed explained that, in an extremely busy ED department, the primary intent is to focus upon immediate life threats. In the case of acute onset abdominal pain, she indicated that this would normally be an aortic catastrophe. Further, both Dr Reed and Dr Day noted that the ED clinicians raised the differential diagnosis of ischaemic bowel at an early time after Mr Whitney presented to hospital, despite the initial CT scan report and lactate levels not supporting that diagnosis. In the ongoing consideration of this differential diagnosis, the surgical fellow later identified the diagnosis and cause (distal superior mesenteric artery occlusion) from rising lactate levels and consideration of the radiology.

Dr Reed and Dr Day also stated in their reports that the LGH surgical team *did* refer Mr Whitney to the on-call vascular surgeon at the RHH but that he declined patient transfer due to the high likelihood of Mr Whitney's death at that time with or without the specialist treatment that could be undertaken at that hospital. Therefore, the laparotomy occurred at the LGH conducted by the surgical fellow with the on-site visiting vascular surgeon attending the operation. Dr Reed indicated that, although the role of the laparotomy was to determine the extent of the ischaemic bowel, the LGH had the surgical expertise to perform a surgical thrombectomy at the same time. However, in consultation with the visiting vascular surgeon, it was determined that there should be a transfer of Mr Whitney to the Royal Hobart Hospital for specialised revascularisation.

The LGH specialists provided the opinion that the management of Mr Whitney at the LGH was sound and timely, and that the laparotomy was appropriate following the RHH vascular surgeon declining to accept Mr Whitney for treatment at that time.

I note that the LGH records do not reflect that a discussion with the RHH vascular surgeon occurred *before* the laparotomy and that treatment was declined. This discussion is also not

found in the RHH records, although it is apparent that a discussion had occurred before the laparotomy between clinicians at the LGH and the RHH vascular surgeon whereby he requested the visiting vascular surgeon to attend the planned laparotomy at the LGH. It therefore appears that the urgent transfer of Mr Whitney before laparotomy *was* declined as indicated by the LGH specialists. This fact should have been documented contemporaneously in the hospital records.

In conclusion, I find that the LGH clinicians treating Mr Whitney were diligent in their consideration of Mr Whitney's diagnosis and his treatment from the time of his presentation in ED. However, a statement or request to the radiologist regarding the possibility of mesenteric ischemia/ischemic bowel may have resulted in a definitive diagnosis several hours earlier. If this had occurred, earlier surgery at the RHH (if accepted) might have taken place before Mr Whitney's bowel became widely ischemic and incompatible with life. It is entirely possible that Mr Whitney may have died regardless of the treatment provided to him. Given the difficulty of the diagnosis and the attempt to transfer Mr Whitney to the RHH at an early stage, I do not consider criticism of the medical decisions and treatment at the LGH is warranted.

I **comment** that hospital clinicians requesting radiological investigations should, whenever possible, bring to the attention of the radiologist all relevant differential diagnoses for investigation and reporting.

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

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

Dated: 5 August 2024 at Hobart in the State of Tasmania.

Olivia McTaggart
Coroner