



# MAGISTRATES COURT *of* TASMANIA

## CORONIAL DIVISION

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### **Record of Investigation into Death (Without Inquest)**

*Coroners Act 1995*  
*Coroners Rules 2006*  
*Rule 11*

I, Olivia McTaggart, Coroner, having investigated the death of Maurice Gordon Connley

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

- a) The identity of the deceased is Maurice Gordon Connley, date of birth 9 April 1947;
- b) Mr Connley was 76 years of age and lived alone in Havenview, Burnie, his partner having passed away in 2006. He had a medical history of hypertension, dyslipidaemia, osteopenia and stroke. However, prior to his death, he was independent and apparently in reasonable health. On 8 September 2023, Mr Connley was at home and experienced a sudden onset of left-sided abdominal pain, bowel incontinence, nausea and vomiting. He was transported by ambulance to the Emergency Department (ED) of the North West Regional Hospital. In ED he was triaged at 12.22pm as Category 3.<sup>1</sup> At 3.20pm, a CT scan of his abdomen and pelvis was reassuring, showing no current bowel obstruction or oedema. Mr Connley was then reviewed by the Surgical Registrar and was admitted to the Emergency Medical Unit (EMU) for observation. He subsequently had two episodes of vomiting and elevated systolic blood pressure.

At 4.24am on 9 September 2023, Mr Connley was transferred back to ED due to continuing hypertension. At 8.00am he was reviewed by the surgical team and remained in ED. The plan was for further planning after review by the surgical consultant. At 12.15pm the surgical team, including consultant, reviewed Mr Connley. They advised no oral intake and indicated the need for planning a repeat CT scan. At 4.42pm, a CT angiogram of the abdomen and pelvis (triple phase) was performed. It was completed at 7.44pm and showed acute bowel ischaemia, with occlusion of the distal superior mesenteric artery.<sup>2</sup> For this condition, a rapid diagnosis is imperative because the clinical consequences may be catastrophic,

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<sup>1</sup> Triage category 3 (“urgent”) is for serious but stable conditions, such as wounds or abdominal pain. Patients in this category should be seen within 30 minutes of presenting to the emergency department.

<sup>2</sup> Blockage of artery preventing blood flow.

including sepsis, bowel infarction and death. It appears that the CT angiogram result was orally reported by I-MED Radiology to a member of the surgical team at 9.35pm. It appears that the written report may have been available to hospital staff shortly after that time, although it is unclear exactly when it was sent to the hospital. It does not appear that immediate action was taken following the oral report. In any event, at 11.00pm, the written report was seen and reviewed by the surgical night cover registrar. The seriousness of the diagnosis was then appreciated, and Mr Connley was commenced on an anticoagulant and urgently transferred to the Royal Hobart Hospital (RHH) by helicopter.

At the RHH, Mr Connley received a high level of intensive care support. Surgery was performed appropriately on 10 September, 11 September and 12 September 2023. However, his bowel continued to infarct despite relief of the obstruction. He then passed away in hospital on 13 September 2023.

- c) Mr Connley's cause of death was extensive small bowel infarction caused by superior mesenteric artery thrombus. His generalised atherosclerotic vascular disease contributed to the condition that caused his death.
- d) Mr Connley died on 13 September 2023 in Hobart, Tasmania.

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

- The Police Report of Death for the Coroner;
- Tasmanian Health Service Death Report to Coroner;
- Affidavits verifying identity;
- Opinion of the forensic pathologist regarding cause of death;
- Tasmanian Health Service medical records and general practitioner records;
- Final RCA report of Department of Health;
- Medical review by Dr Anthony Bell MD FRACP FCICM, Coronial Medical Consultant; and
- Correspondence of 21 November 2024 from Chief Executive Hospitals and Primary Care – North West, Tasmanian Health Service.

### **Comments and Recommendations**

In this case, I have received a report from Dr Anthony Bell, Coronial Medical Consultant, regarding Mr Connley's treatment. In his report, Dr Bell expressed the opinion that the consideration of the diagnosis of mesenteric ischaemia should have occurred more quickly

than it did. Dr Bell stated that a hallmark of this condition is an extreme level of pain but without abdominal clinical signs. This applied in Mr Connlley's case upon his presentation to hospital. Dr Bell stated that a CT angiogram of the abdomen and pelvis was required to diagnose the condition and should have been ordered shortly after Mr Connlley's presentation to hospital, and at the latest, following his initial unremarkable CT scan. Dr Bell also commented upon the delay of several hours in the passage of information regarding the critical results of the CT angiogram scan. Dr Bell concluded that these issues meant that Mr Connlley lost a significant chance of survival with earlier detection of the condition and treatment. I accept his opinion.

I have also had regard to the Final RCA report in which the independent RCA panel, consistent with Dr Bell's opinion, identified missed opportunities earlier in Mr Connlley's admission to further investigate the cause of his ongoing abdominal pain accompanied by worsening pathology and persistent hypertension. The RCA panel and Dr Bell both acknowledged that mesenteric ischaemia is a difficult diagnosis to make. The panel noted that there were documented concerns by medical staff earlier in his admission that Mr Connlley may have had mesenteric ischaemia. However, this concern was not clearly escalated or communicated between reviewing teams.

The RCA panel also formed the view that the surgical team should have taken over Mr Connlley's treatment at an earlier time in accordance with the relevant protocol, stating that it was almost 24 hours before he was accepted for admission by that team. The panel also commented that the lack of documentation from the surgical team was a cause for concern. I cannot make any specific finding as to whether or how these additional issues contributed to the delay in diagnosing Mr Connlley's life-threatening condition. In general terms, outcomes will be improved with clear and comprehensive documentation and appropriately specialised medical teams.

The RCA panel recommended that the hospital conducts an audit of a random selection of patients admitted to ED (within a north western hospital) with undifferentiated abdominal pain, and review the quality of patient assessment, planning, documentation and transfer to a surgical team. I have received recent correspondence from the Chief Executive Hospitals and Primary Care – North West<sup>3</sup> who indicated that the North West Critical Clinical Incident Review Committee supported the audit recommendations and the process of implementation has commenced.

I **recommend** that the North West Regional Hospital completes the audit and reporting recommendations specified in the RCA report.

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<sup>3</sup> Tasmanian Health Service.

I **recommend** that, upon completing the auditing and reporting recommendations of the RCA panel, the North West Regional Hospital takes any steps it considers necessary to educate or reinforce to clinicians relevant matters regarding timely investigations, diagnosis and treatment of patients presenting with undifferentiated abdominal pain.

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

**Dated:** 21 January 2025 at Hobart in the State of Tasmania.

**Olivia McTaggart**  
Coroner

**These findings have been amended by order dated 9 May 2025 pursuant to section 58(1)(c) of the Coroners Act 1995 and further amended by order dated 21 May 2025 to correct details relating to the relationship status of Mr Connley.**