MAGISTRATES COURT TASMANIA

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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 and family by the direction of the Coroner pursuant to s 57(1)(c) of the Coroners Act 1995)

I, Olivia McTaggart, Coroner, having investigated the death of RS

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

a) The identity of the deceased is RS, date of birth 2 October 1954.

b) RS was 68 years of age and lived in Devonport. He had a history of hypertension and back pain but did not have a history of gastrointestinal conditions. At 5.09am on 16 September 2023, RS suffered two bouts of rectal bleeding during the night and presented to the Mersey Community Hospital early in the morning. On medical examination, the blood was fresh, there was a small amount, it was not associated with defecation or constipation, and no clots. RS did not present with any other gastrointestinal symptoms. His vital signs were stable and his abdominal examination was normal. However, his blood urea level was elevated. Digital rectal examination showed no blood. There were no obvious haemorrhoids detected as the source of the bleeding. A formal diagnosis was not made. Haemorrhoid suppositories were prescribed and an outpatient clinic appointment made for him within two weeks. He was then discharged at 7.10am two hours after his presentation.

At 1.45pm that day, 16 September 2023, RS drove to the house of his friend, Darryn French. They both then travelled to Latrobe for an outing. Whilst at a hotel in Latrobe with Mr French, RS complained that he had a gut ache and became sweaty, clammy and pale. He asked Mr French to take him home, which he did. RS told Mr French he would go straight to bed. Mr French and another friend were not able to make contact with RS the following morning. Being concerned, they went to his house but RS did not answer their knocks. They then entered using Mr French's key and discovered RS on his bed, clearly deceased. They called emergency services.

Attending police officers who examined the scene found blood and faeces in the toilet.

c) The forensic pathologist conducting the autopsy, Dr Donald Ritchey, determined that RS died as a result of exsanguination (blood loss) due to a peptic ulcer of the duodenum. He noted that the peptic ulcer identified in the duodenum had eroded into the gastroduodenal artery causing exsanguination and death. Consistent with this conclusion, Dr Ritchey found a large volume of blood in the proximal small bowel. I accept the opinion of Dr Ritchey regarding the cause of death.

d) RS died between 16 and 17 September 2023 at Devonport, Tasmania.

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

- The Police Report of Death for the Coroner;
- Affidavits as to identity;
- Opinion of the forensic pathologist regarding cause of death;
- Medical report from Dr Anthony Bell, MD FRACP FCICM, Coronial Medical Consultant;
- Tasmanian Health Service and general practitioner records;
- Final RCA Report (Tasmanian Health Service);
- Correspondence from Dr Sidney Chandrasiri, Executive Director of Medical Services, Tasmanian Health Service – North West; and
- Affidavit of Darryn French, friend of RS.

Comments and Recommendations

RS was discharged from the emergency department of the hospital without a diagnosis for his recent bouts of rectal bleeding. This investigation focused upon whether upper gastrointestinal bleeding (ultimately the cause of RS's death) should have been considered as a differential diagnosis and advice given to RS to remain in hospital for further investigations.

Dr Anthony Bell, Coronial Medical Consultant, provided a report at my request regarding this issue. In his report, Dr Bell stated that this was a difficult case for the treating clinicians in the emergency department. However, he came to the following conclusions upon his review:

a) The clinicians treating RS should have considered a differential diagnosis of upper gastrointestinal bleeding, particularly having regard to RS's elevated blood urea.
b) The treating clinicians should have continued to take observations regarding the existence of haemodynamic instability, including whether RS had orthostatic hypotension, a finding suggestive of an upper gastrointestinal bleeding source.
c) The history of RS's earlier bleed at home which stopped should have alerted the treating clinicians to the possibility of an arterial upper gastrointestinal bleed given that a key characteristic of such a bleed is that it may stop but is often followed by a rapid blood loss a short time later.

The above views were accepted as correct by the Executive Director of Medical Services Tasmanian Health Service – North West in considering Dr Bell's report.

In the Tasmanian Health Service Final RCA Report of 26 August 2024, it was also identified by the expert panel that a haemodynamic assessment should have been undertaken because further observations could have raised a suspicion of a gastrointestinal bleed. However, the panel ultimately concluded that, based upon RS's lack of symptoms and the clinical findings, it was reasonable to discharge him with a forthcoming specialist review. This conclusion was significantly based upon the panel's retrospective application of the Glasgow-Blatchford Bleeding Score tool.

I find that the clinicians assessing RS in the emergency department should have continued to assess and investigate RS until a diagnosis was formed. Specifically, they should have ascertained the existence of haemodynamic instability with a view to considering the diagnosis of a gastrointestinal bleed (including an arterial bleed). As RS had presented with two separate episodes of fresh bleeding not obviously attributable to haemorrhoids, further investigations were required to determine the source.

Very shortly after his discharge, likely that afternoon, RS suffered a catastrophic arterial bleed, characteristic of his condition, which caused his death by exsanguination. If he had still been in hospital for investigation, the source of the bleeding would have been found with an opportunity for immediate life-saving treatment.

I observe that RS himself had the opportunity later that day to re-present to hospital following his severe "gut ache" and other symptoms. It would have been advisable for him to have done so. If he had, treatment may have stopped his bleeding.

The RCA panel made recommendations relevant to this case. These included the development of guidelines for the management of suspected gastrointestinal haemorrhage, and a review of emergency department criteria and practice around undertaking vital signs of patients.

I comment that the RCA recommendations are reasonable and should be implemented by the hospital and, if appropriate, other THS emergency departments.

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

Dated: 17 June 2025 at Hobart, in the State of Tasmania.

Olivia McTaggart
Coroner