CITATION:	*Inquest into the death of Maureen Caroline Thomson* [2009] NTMC 058
TITLE OF COURT:	Coroner's Court
JURISDICTION:	Darwin
FILE NO(s):	D0064/2008
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HEARING DATE(s):	13 – 15 July 2009
FINDING OF:	Mr Greg Cavanagh SM
CATCHWORDS:	Unexpected hospital death, communication with patient's family

REPRESENTATION:

Counsel:

Assisting:	Jodi Truman
Department of Health:	Kelvin Currie
Mr David Read:	Mr Mark Livesey QC

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IN THE CORONERS COURT
AT DARWIN IN THE NORTHERN
TERRITORY OF AUSTRALIA

No. D0064/2008

In the matter of an Inquest into the death of
MAUREEN CAROLINE THOMSON
ON 27 MARCH 2008
AT THE INTENSIVE CARE UNIT -
ROYAL DARWIN HOSPITAL

FINDINGS

24 November 2009

Introduction

1. Maureen Caroline Thomson ("the deceased") was a Caucasian female born on 2 March 1950 at Suva in Fiji. The deceased was admitted to the Darwin Private Hospital (DPH) on 4 March 2008 for an elective surgery to remove diverticulum that had been found in her duodenum. The deceased had been suffering symptoms consistent with diverticulum disease since about 2005.

2. Following surgery on 4 March 2008 the deceased's condition deteriorated significantly and she underwent a further surgery on 7 March 2008. Immediately prior to that second surgery the deceased was admitted to the Royal Darwin Hospital (RDH) and following the surgery was placed in their Intensive Care Unit (ICU).

3. Despite occasional, but limited, improvement to her condition, the condition of the deceased further deteriorated. At approximately 2.07pm on 27 March 2008, despite a third surgery on 25 March 2008, the deceased died in the ICU at the RDH. The cause of death found at autopsy by Forensic Pathologist, Dr Terrence Sinton was acute peritonitis following her abdominal surgery.

4. Ms Jodi Truman appeared as Counsel assisting me on each day of this inquest from 13 to 15 July 2009. Mr Kelvin Currie was granted leave to

appear as Counsel for the Department of Health and Families. Mr Mark Livesey QC was granted leave to appear as Counsel for Mr David Read. I thank all counsel for their assistance in this matter.

Formal Findings

5. Pursuant to section 34 of the *Coroners Act* ("the Act"), I find, as a result of evidence adduced at the public inquest as follows:

   i. The identity of the deceased person was Maureen Caroline Thomson born on 2 March 1950 at Suva in Fiji.

   ii. The time and place of death was in the ICU at RDH at 2.07pm on 27 March 2008.

   iii. The cause of death was acute peritonitis, which led to the development of acute septicaemia following abdominal surgery.

   iv. Particulars required to register the death:

      a. The deceased was female.

      b. The deceased's name was Maureen Caroline Thomson.

      c. The deceased was of Caucasian descent.

      d. The cause of death was reported to the Coroner.

      e. The cause of death was confirmed by post mortem examination carried out by Dr Terrence Sinton.

      f. The deceased lived at Unit 1/22 Grasslands Crescent, Leanyer in the Northern Territory.

      g. The deceased was employed as a switchboard operator at the Charles Darwin University at the time of her death.

h. The deceased was in a de facto relationship with Keith Ross Jelley.

i. The deceased's parents were Arthur and Eileen Freeman.

6. I note that section 34(2) of the *Act* provides that I may comment on a matter including public health or safety connected with the death being investigated. Additionally, I may make recommendations pursuant to section 35 as follows:

> "(1) A Coroner may report to the Attorney General on a death or disaster investigated by the Coroner.
>
> (2) A Coroner may make recommendations to the Attorney General on a matter, including public health or safety or the administration of justice connected with a death or disaster investigated by the Coroner.
>
> (3) A Coroner shall report to the Commissioner of Police and Director of Public Prosecutions appointed under the *Director of Public Prosecutions Act* if the Coroner believes that a crime may have been committed in connection with a death or disaster investigated by the Coroner"

The Conduct of the Inquest

7. Brevet Sergeant Anne Lade investigated this death. I have before me a coronial brief in relation to the investigation compiled by Sergeant Lade (Exhibit 1). I also have the following additional exhibits:

a. Medical files consisting of 1 file from the DPH, 2 files from the RDH and 1 file from the Northlakes Medical Centre (Exhibit 2).

b. Autopsy Report of Dr Terrence Sinton dated 13 August 2008 (Exhibit 3).

c. Report of Professor Christophi dated 22 January 2009 (Exhibit 4).

d. Curriculum Vitae of Mr David Read (Exhibit 5).

e. Copy of letter from Mr David Read to Dr Andrew McDonald dated 9 January 2008 (Exhibit 6).

f. Head of Staple and Diagram of use of the staple (Exhibit 7).

g. Photos taken by Mr Read during a gastroscopy procedure of the duodenum of the deceased (Exhibit 8).

h. Copy of letter from Mr David Read to Dr Andrew McDonald dated 28 April 2008 (Exhibit 9).

i. Diagram of anatomy as marked by Mr David Read (Exhibit 10).

j. Photocopy of first page of passport belonging to the deceased (Exhibit 11).

8. I heard oral evidence from Sergeant Anne Lade. I thank Sergeant Lade for her detailed investigation in relation to this matter. I also heard oral evidence from Mr Keith Ross Jelley (also known as Ross) who is the former partner of the deceased, and also from the deceased's oldest daughter, namely Mrs Toni Carbone. I also note that present in court throughout the inquest were the deceased's other children, namely her daughter Deanna Thomson and her son Wayne Thomson. Also present was Mrs Carbone's husband, namely Paul Carbone, and the deceased's former husband, namely Stuart Thomson. I thank Mrs Carbone and Mr Jelley for the evidence they provided to me. I commend the entire family for the respect they have shown to this process and the assistance they have given to the court, in what was clearly still very difficult circumstances for them.

9. I also heard oral evidence from the two surgeons involved directly with the deceased, namely Mr David Read and Mr Peter John Treacy. Each of the surgeons was part of a surgical unit at the DPH and RDH at the time of the deceased's death, and remains so now. I also heard from Dr Brian Spain, who was the anaesthetist involved in the first surgery, and Dr Martin Sterba who was the staff specialist at the ICU at the RDH at the time of the deceased's admission.

10. Finally, I also heard from Professor Christopher Christophi, Professor of the University of Melbourne Department of Surgery at Austin Hospital in Heidelberg, Victoria. Professor Christophi's evidence, particularly his report (exhibit 4), was extremely helpful in this inquest.

Circumstances surrounding the death

Events leading up to hospitalisation

11. At the time of her death the deceased was 58 years of age. She was employed as a switchboard operator at the Charles Darwin University and had been employed in that capacity for approximately 6 or 7 years. She had been in a de facto relationship with Mr Ross Jelley for approximately 5 years. It is clear that their relationship was a committed and loving one.

12. I heard evidence that the deceased was a very fit and active woman prior to her death. According to Mr Jelley and Mrs Carbone, the deceased walked approximately 5kms every afternoon of the week and did laps of the Casuarina Pool on weekends. She was careful with what she ate, drank only a little and enjoyed working in her garden.

13. Despite this care and attention to her health, in or about 2005 the deceased started suffering from nausea and diarrhoea. She complained that when she ate, she did not feel that the food was going into her stomach properly. I had tendered in evidence before me (as part of exhibit 2) the medical records of her general practitioner Dr Brian Reid. As a result of her symptoms, a number of tests, including ultrasounds and blood tests, were conducted over a lengthy period of time.

14. On 27 October 2005 a CT Scan was performed upon the deceased, which showed some minor sigmoid colonic diverticulum disease, but no evidence to suggest an active inflammation or abscess. I heard evidence that diverticulum are bulging pockets of tissue, or sacs, that are an unusual condition, but when they occur they are usually found in the colon, or large intestine. I heard evidence that diverticulum of the duodenum, which is where it was subsequently found in the deceased, is even more uncommon. In particular I received evidence from Professor Christophi, consistent with the evidence given earlier by Mr Read, that suffering symptoms from duodenal diverticulum was not particularly common with a percentage range

of approximately 1 to 3% of people actually suffering symptoms from duodenal diverticulum. I heard evidence from Mr Read that the vast majority of persons in fact only discover that they are suffering from duodenal diverticulum as a result of x-rays taken for some other reason.

15. Because of continuing symptoms, in December 2005 the deceased had a gastroscopy and colonoscopy at the RDH. The results of those tests found some irregularities. As a result biopsies were taken for pathology. It was suspected at that time that perhaps the deceased might have been suffering from gastroparesis, which is also known as delayed gastric emptying, where the stomach takes too long to empty its contents. There were also some diverticuli found, but again there was nothing significant and conservative treatment with medication continued.

16. Another colonoscopy was performed on 3 March 2006. This time at the Darwin Private Hospital (DPH). In September 2006 the deceased started seeing Dr Andrew McDonald at the Northlakes Medical Centre still complaining of bowel problems, bloating etc. Dr McDonald saw the deceased regularly over the following months with various testing and changing of diet, but she continued to complain of symptoms.

17. On 7 November 2007, the deceased was referred by Dr McDonald to see surgeon Mr David Read. At that time, and to this day, Mr Read held rooms at the DPH and also undertook surgeries at the RDH. In his referral Dr McDonald referred to a recent CT scan performed on 19 October 2007. The report from that scan formed part of the evidence tendered before me (Exhibit 2). The scan reported that there was *"a large complex duodenal diverticulum arising from the 2nd part which partly lies within the pancreatic head and extends inferiorly"*. It also stated that *"advanced diverticulosis is noted within the sigmoid colon"*. As a result, Dr McDonald suggested in his referral to Mr Read that perhaps this was *"obstructing the outflow of food from the stomach"*.

18. Mr Read gave evidence that following the initial referral he commenced a trial of conservative treatment upon the deceased with the use of antibiotics. Mr Read stated that this was done firstly to determine whether there was a bacterial overgrowth and to try and improve the deceased's symptoms. Mr Read noted that most people with duodenal diverticulum do not need to be operated upon and that a course of antibiotics is enough.

19. Mr Read also performed a gastroscopy on 20 November 2007, which located at least 2, and possibly 3, diverticuli within the duodenum. On 9 January 2008 Mr Read again saw the deceased and noted that although there had been some improvement with antibiotics, this had been short lived.

20. Further consultation occurred on 24 January 2008, at which time the deceased advised that she had had *"another bad attack"*. Mr Read determined that the initial conservative treatment had failed. Mr Read gave evidence that by then he had already had a conversation with Mr Treacy about the deceased. Mr Read stated that he discussed with Mr Treacy whether the symptoms suffered by the deceased were consistent with suffering from duodenum diverticulosis, and the technical aspects of how best to perform a surgery to remove and staple the diverticulum.

21. After discussing the matter with Mr Treacy, Mr Read gave evidence that he began providing information to the deceased in relation to such a surgery, and provided her with advice as to the problems and complications of such surgery, particularly given that it was a surgery one taking place in or near the duodenum and the pancreas, which are particularly sensitive organs.

22. I heard evidence from Mr Read, which was consistent with a recollection by Mr Jelley, that Mr Read provided advice to the deceased that the risk of death from such a surgery was approximately 5%. Mr Read gave evidence, again consistent with a recollection of Mr Jelley, that he specifically told the deceased that such a surgery was rare and that as a result he had obtained a second opinion from Mr Treacy.

23. Mr Read also gave evidence that he told the deceased that he had ensured that if he required assistance during the surgery, Mr Treacy had indicated that he would be available. I note that one of the concerns raised by Mr Jelley was that his recollection was that both he and the deceased were told that Mr Treacy would be present for the first operation. In this regard I find that I accept the evidence of Mr Read that what he told the deceased and Mr Jelley was that "if required" Mr Treacy would be present, but that it was never his intention for Mr Treacy to be present from the commencement of the operation. I find that Mr Jelley's recollection in this regard is an understandable reconstruction following the traumatic event of the death of his partner.

24. I heard evidence from Mr Read that there was no final decision whether to have the surgery by the deceased during that meeting on 24 January 2008. In fact Mr Read met once more with the deceased on 4 February 2008 to discuss such an operation. Mr Read gave evidence that during that consultation the deceased indicated that she was extremely keen to do the operation and said words to the effect of "Just do it". During that consultation the deceased also signed the consent form for the operation.

Events during Hospitalisation

25. The records show, and I heard evidence, that the deceased was admitted to the DPH on 4 March 2008 for a laparotomy and resection, or stapling, of the duodenal diverticulum. Mr Read performed that surgery at approximately 1.30pm on that day, with the assistance of Dr Brian Spain as the anaesthetist.

26. I heard evidence from Mr Read that during the surgery he discovered 2 diverticulum; 1 being approximately 1 to 2cms in length, and the other being approximately 3cms in length. Mr Read gave evidence that the larger diverticulum was located at the junction of the first and second part of the duodenum and that the smaller diverticulum was *"close to"* the junction of

the first and second part. During this inquest Mr Read was very helpful in bringing an anatomical model with him to show the various parts of the duodenum that he was referring to in this regard.

27. Mr Read gave evidence, and I accept, that he did not find the surgery particularly difficult. He therefore did not call in the assistance of Mr Treacy. Mr Read gave evidence that as a result of his stapling, there was a 1cm staple line left on the duodenum that was associated with the removal of the smaller diverticuli, and a 2 to 3cm staple line on the duodenum associated with the removal of the larger diverticuli. Mr Read also gave evidence that he put in some extra stitches for the smaller diverticuli because he was concerned that the staple line associated with that removal was *"not quite as low"* as it could have been.

28. Mr Read gave evidence that one of the risks associated with the removal of diverticuli near the duodenum is damage to other structures, such as the common bile duct. I heard evidence that this is a risk because of the close location of the duodenum to the vicinity of the common bile duct, with the duct being located on the medial (or inside) of the duodenum.

29. Despite this, Mr Read gave evidence that the distance of the two diverticuli from the bile duct was equal, at approximately 2 to 3cms, and that he did not see anything during the course of his surgery to indicate that the bile duct had been affected. Mr Read was clear in his evidence that he was *"absolutely conscious"* of the bile duct throughout the operation, because *"it is an organ that is not something that you would like to compromise"* and it was a *"recognised danger"*. I accept Mr Read's evidence in this regard.

30. Mr Read gave evidence that the operation took less time than he had expected, however he had set aside a longer period as he did not wish to "feel rushed" during the surgery. Mr Read gave evidence that he saw the deceased in the recovery ward after he had completed writing his notes

following the surgery. One of the concerns raised by the family was the lack of contact that Mr Read appeared to have with the deceased following that first surgery on 4 March 2008. Mr Read gave evidence that following the surgery, in addition to attending on the deceased in the recovery ward, he also saw the deceased on 5 and 6 March 2008 on his ward rounds, and again recalls a second occasion on each of those days, which is also in accordance with his routine following a laparotomy.

31. I note that the hospital records only document one attendance by Mr Read on the deceased on 5 March 2008 in Mr Read's own hand. It is indeed unfortunately that Mr Read did not ensure that his attendances upon the deceased were properly and contemporaneously recorded by him, or on his behalf. I have previously noted in other inquests that better note taking assists in inquiries such as this. It assists the family in coming to terms with the death of a loved one and accepting the evidence that is given, sometimes many years later, in relation to the treatment of their loved one and whether it was appropriate and sufficient in all of the circumstances.

32. A failure of adequate and appropriate notes leave families very often, and sometimes the courts, to be extremely suspicious about the quality of the care that has been given to a patient when there is no contemporaneous record of the same. Although the record itself may make no difference to the outcome to the deceased, it could very well assist those who are assessing the actions taken by the medical practitioner in accepting the evidence that is given.

33. Despite the failure to record each of the attendances by Mr Read, I do accept his evidence that he attended upon the deceased on the occasions stated by him prior to his departure at midnight on 6 March 2008. I also note Mr Read's appropriate and spontaneous acceptance that better note taking is always important and I encourage him to do this in future.

34. Dr Brian Spain also gave evidence before me. He was the anaesthetist during the surgery on 4 March 2008 and corroborated the evidence given by Mr Read as to the events during that surgery. Of particular note was Dr Spain's specific recollection that during the operation he asked numerous questions of Mr Read about the circumstances of the operation and the deceased's anatomy, because of his knowledge that there can be complications associated with the bile duct. Dr Spain gave evidence that he specifically recalled Mr Read noting that the location of the staple lines were a sufficient distance away from the common bile duct and therefore such a complication was unlikely. Dr Spain also gave evidence that although the deceased had spent far longer in the recovery room following surgery, her condition following surgery was *"not beyond normal expectations"*.

35. Mr Read gave evidence that on the evening of 6 March 2008 he conducted a hand over of the care of the deceased to Mr Treacy. Mr Read gave evidence that at the time of the hand over he had the results of some tests that had been conducted, which showed that the bilirubin levels for the deceased were a little over double of what was to be normally expected, which showed evidence of a mild impairment of the deceased's liver function.

36. Mr Read gave evidence however that it could be expected that there would be a mild impact of liver function following such a surgery because the duodenum "*does tend to swell*". Mr Read gave evidence, and I accept, that although this test result existed, it was not something that raised in him any real concern that day. Mr Read also noted that although there was evidence suggesting damage to the liver, it was not a firm conclusion of those tests and because at that time it was "*mild*", he expected it would settle as was usually the case.

37. One of the concerns raised by the family was the departure of Mr Read from Darwin shortly after conducting the surgery upon the deceased on 4 March

2008. It was said in evidence before me that the information provided to the family was that Mr Read had in fact left on the evening of the surgery, and that his departure was for the purpose of attending a birthday party. Mr Read gave evidence that the trip he undertook was one that did not depart Darwin until midnight on 6 March 2008 and that it had been one booked for several months and was associated with seeking permission to marry his fiancée. Mr Read appeared genuinely surprised at the suggestion that he had been away from 4 March 2008 and I accept Mr Read's evidence that he did not leave until midnight on 6 March 2008.

38. A further concern raised by the family is that nursing staff had told them they had endeavoured to try and contact Mr Read following his departure and were unable to do so. Mr Read gave evidence that at no time following his departure did he have any messages on his mobile phone from any nurse, and in fact the only time he was contacted whilst he was away was by Mr Treacy, with whom he did in fact communicate. I again accept Mr Read's evidence in this regard.

39. In my opinion, although Mr Read properly conceded that it would have been better if he were present in Darwin, he cannot be criticised for taking scheduled leave, particularly in light of the fact that at the time of his departure there were no concrete signs of any significant problems associated with the deceased, and particularly where he had made appropriate arrangements for the hand over of her care to an experienced surgeon who was aware of her circumstances.

40. I heard evidence from Mr Read that he felt terrible when he discovered on Friday 7 March 2008, via discussion with Mr Treacy, that "such a change" had occurred in the status of the deceased. Mr Read gave evidence that when he spoke to Mr Treacy he was advised that it was Mr Treacy's suspicion that the bile duct may be blocked because of a staple of the bile duct. Mr Read indicated that he informed Mr Treacy that he believed that

that would be highly unusual because the staple lines were away from the common bile duct.

41. Mr Treacy also gave evidence before me on this issue. It is important to note that Mr Treacy considers that his involvement with the deceased commenced upon the hand over, which he conceded was likely to have occurred on the late evening of 6 March 2008, and when Mr Read returned on Monday 10 March 2008. Mr Treacy stated that he remained involved in the care of the deceased because he was concerned for her, however it is clear that it was Mr Read who was far more significantly involved, and for whom (understandably) the recollection of events is far clearer. There were occasions where Mr Treacy quite simply did not have a clear recollection of what had occurred in terms of the specifics of events and in those areas I prefer the evidence of Mr Read.

42. Mr Treacy confirmed that on 7 March 2008 he suspected that the common bile duct had been blocked, possibly from a staple from the earlier surgery. He confirmed that he had discussions with Mr Read on that day, but was unable to recall if it was before or after the surgery. Mr Treacy stated that Mr Read was concerned about any changes related to the deceased and wanted to be involved and to be notified as to what was occurring. I find that Mr Read was concerned for the deceased and was attempting at all times to act in her best interests even though he was not physically present in Darwin. However, as stated by Mr Read in his own evidence, I do not consider that Mr Read’s physical presence in Darwin would have changed the final outcome for the deceased, and I note that Mr Read stated that he would not have done anything different to what was done by Mr Treacy during his absence.

43. On 7 March 2008 the deceased returned to surgery for the performance of another urgent laparotomy and possible biliary bypass. I heard evidence that within the RDH notes the biliary bypass was also referred to as a

choledochoduodenostomy. Mr Treacy gave evidence that during that surgery he found that the lower part of the common bile duct was blocked and he was unable to get a probe from the common bile duct into the intestine. Mr Treacy gave evidence that he also found that the common bile duct was dilated or larger. Mr Treacy gave evidence that he was not able to establish if there had been a staple of the common bile duct, but as a result of the blockage he performed a bypass, which meant joining the bile duct to the duodenum in a different location. Mr Treacy also placed a feeding tube into the deceased's intestine beyond the site of the surgery to provide her with nutrition so as to assist in her recovery.

44. I heard evidence that following the bypass conducted by Mr Treacy it was anticipated that the obstruction of the common bile duct would no longer remain a concern and that the deceased was expected to have some resolution of her symptoms within 2 to 3 days.

45. Dr Sterba, staff specialist of the ICU, was in charge of the ICU when the deceased was admitted and became involved in her care. I heard evidence at this inquest, consistent with evidence from other inquests, that there is often a divergence of opinion between surgical specialists and intensive care specialists as to the prognosis for patients admitted into intensive care. It was acknowledged by Mr Read, Mr Treacy and Dr Sterba that this was a universal phenomenon and that intensive care specialists tended to have a far more pessimistic view of the prognosis for a patient in intensive care, compared to the views of the surgical consultants.

46. Dr Sterba gave evidence that he became involved in a family conference on 9 March 2008 as a result of concerns that he had when informed by a nurse of information being provided by Mr Treacy to the family of the deceased. Dr Sterba stated that he perceived the information as being "*very optimistic*" and inappropriately so. I pause to note here that this was an interesting point in the evidence given that it is clearly the view of the family, via the

evidence of Mr Jelley and Mrs Carbone, that it was Mr Read and Mr Read alone who they considered had been far too optimistic with them in terms of his opinion of the prognosis of their loved one. Dr Sterba was asked directly if he had formed a similar view of the information being provided by Mr Read and he stated "*no*".

47. It is clear from the evidence given before me that following the second surgery of 7 March 2008, and the endeavours of Mr Treacy, that there were still significant problems associated with the prognosis of the deceased and that these difficulties did not appear supportive of simply an obstruction to the common bile duct. Mr Read gave evidence that some of the test results for the deceased revealed that perhaps there was an interruption to the blood supply to the liver. I note that this appeared consistent with the evidence given by Dr Sterba. Over a period of time however, there was a small quantity of stability however this was in the context of significant life support being provided by the ICU at the time. In spite of this stability, it appeared that there were still ongoing difficulties associated with the liver.

48. I also heard evidence that once a patient was admitted to the ICU, their day-to-day management and the decisions associated with their care are made by the ICU and the surgeons take on a "*consultative role*". I therefore find that the decisions made in relation to the treatment of Ms Thomson were, and remained, in the domain of the intensive care specialists, although Mr Read and Mr Treacy continued to consult and to provide their opinion as to appropriate care.

49. Mr Read gave evidence that during the period 10 to 18 March 2008, the deceased's condition fluctuated throughout. He stated that there were *"two steps forward, and one step back"*. Mr Read stated that at certain periods there was a call for optimism and other times not. I note the family indicated concern at the outset of this inquest that they felt they were not getting a clear picture as to what was happening to their loved one. In this

regard I find that at the relevant time there was, quite simply, not a clear picture even for the experts as to what was going on.

50. Mr Read gave evidence that, in relation to the different information being provided to the family, the deceased's condition was changing all the time and so there were occasions where different information was being provided simply because there had been changes from one minute to the next.

51. Mr Read gave evidence that around 18 March 2008 the deceased began to once again rapidly deteriorate. It was at this time that there was an increase in the output from the various drains that had been put in place during the surgeries, which suggested leakage from the joins made during both surgeries. Mr Read and Mr Treacy gave evidence that during this time they continued to consult with one another as to the possible problems being suffered by the deceased and possible treatment.

52. I note that leakage from the staple lines was one of the complications identified from the outset by Mr Read to the deceased as a common complication following such surgery. Mr Read gave evidence that following 18 March 2008 the steps being taken were to try and control the leakage and any likely infection with drains, and not to operate because the deceased was so unwell and deteriorating.

53. Mr Read gave evidence that on 25 March 2008 he had a conference with Mr Treacy and they discussed the fact that treatment for the deceased was not working and they considered further surgery necessary. This is reflected in the hospital notes tendered before me in Exhibit 2.

54. Mr Read gave evidence that prior to the operation on 25 March 2008 he considered that the prognosis for the deceased was very grim but he was hopeful that he might find something during the surgery that "*could turn the situation around*" for the deceased. He stated that at that stage he was *"simply unable to rule out all optimism",* and that if he had had no hope for

the deceased at that time, then he would not have conducted that third operation and put her through further surgery. I find that Mr Read's final attempt at surgery on 25 March 2008 was a surgery done with the intent and hope of improving the deceased's condition and was heroic.

55. During that surgery Mr Read gave evidence that he found the gall bladder was gangrenous and that this was completely unexpected. Mr Read gave evidence that although there had been an increase in the output from the drains, which indicated sepsis or infection, this did not mean that any of the organs were gangrenous. All it meant was that there was an internal leak that the deceased's body was unable to drain by itself.

56. Mr Read gave evidence there is no test or scan that can be conducted to diagnose gangrene of any organs, without actually conducting surgery.

57. Mr Read stated that despite the gangrenous gall bladder this did not mean all hope was lost. Mr Read noted that a gangrenous gall bladder was not unusual for a person in the ICU and that a person can survive without a gall bladder. Mr Read also gave evidence that he had personally experienced people surviving such an operation and the removal of the gall bladder. Mr Read stated that the gangrene from the gall bladder had also spread to the bile duct, which was an unusual situation. Mr Read stated that although a person could survive the removal of their bile duct, it would require further surgery at a later time.

58. Mr Read gave evidence that following the surgery on 25 March 2008 he met with the family in the conference room of the ICU. Mr Read stated that on this occasion Dr Sterba was present with him, but he was unable to recall the presence of any other specialists. I note that neither Dr Sterba nor Mr Treacy were able to recall whether they were present in this meeting immediately following the surgery. Mr Read stated that he informed the family that there had been findings of note and that he believed that they now had control of the leaks.

59. Mr Read stated that he informed the family that it was his experience that when a person's gall bladder was gangrenous, and was removed, that there was often a turn around in that person's condition and he did not think it was appropriate at that stage to rule out all hope. Mr Read stated, and I find, that at all times when he spoke to the family he was speaking honestly with them and attempting to give them his honest opinion.

60. Unfortunately despite the hopes of Mr Read for an improvement in her condition, the deceased continued to deteriorate.

61. Dr Sterba gave evidence that on 26 March 2008 he undertook a meeting with the family at which time he advised them that there was uncontrolled infection going on inside the abdomen of the deceased, which was causing failure of all her important organs, and that he considered they were *"approaching the limits of sustainable support for the deceased and further escalation in her treatment would be of no benefit"*. Dr Sterba stated that the family appeared to understand the seriousness of the deceased's condition and agreed in avoiding a *"futile case"*.

62. Dr Sterba gave evidence that there was a further meeting in the early hours of 27 March 2008 and that the family was with the deceased when she continued to deteriorate and sadly passed away on that day at 2.07pm.

63. Mr Read gave evidence that following the passing of the deceased he conducted his own audit or review of the treatment and management of her. He stated that he was trying to work out why the deceased had died, because he could not understand what had gone wrong. Mr Read gave evidence that it appeared that perhaps the deceased had had an unusual reaction to medication known as Clexane, or Heparin, that is given to most patients to prevent deep vein thrombosis. Mr Read gave evidence that a reaction to such medication can occur "out of the blue", and that the only thing that can be done is to withdraw the administration of that medication and "wait it out" with supportive therapy.

64. The reaction to the medication is such that the very medication that is suppose to prevent the development of deep vein thrombosis in fact develops clots in the blood. Mr Read suggested that this may have been part of a "complex of symptoms" that could have explained interference in the supply of blood to the various organs, resulting in the multiple organ failure. I will refer to this evidence later in these findings.

65. As stated previously, Professor Christophi gave oral evidence in addition to his extremely detailed and helpful report dated 22 January 2009 (exhibit 4). I thank Professor Christophi for his evidence, detailed report, and the dedication he has made in analysing a great deal of medical material to conduct an audit (or review) of the treatment provided to the deceased.

66. Professor Christophi gave evidence that his current specialty is hepatobiliary and transplant surgery. It was accepted by all present that Professor Christophi was eminently qualified to provide his opinion for the purpose of this inquest. Professor Christophi gave evidence that diverticulum are small bulging pockets of tissue or sacs that form in the inner lining and push outwards from an organ. Professor Christophi confirmed that diverticulum could occur throughout the whole body, but generally occur in the colon.

67. Professor Christophi gave evidence that diverticulum of the duodenum is an uncommon condition and that only approximately 1% of all duodenal diverticula require treatment. Professor Christophi gave evidence that the surgery that can be utilised for the treatment of diverticula is a laparotomy and stapled excision of the diverticulum, or endoscopic or surgical inversion of the diverticulum. Professor Christophi stated that neither procedure was more risky than the other and that the suitability of either treatment depended upon the size and symptoms associated with the diverticulum. Professor Christophi stated that the larger the diverticula, or the more infected, the more appropriate to undertake a laparotomy and stapled excision.

68. Professor Christophi agreed that in summary, duodenal diverticulum is an unusual condition and if someone does actually suffer from the condition then it is even more unusual to require treatment.

69. Professor Christophi also gave evidence that the overall mortality (or death) rate following such operations is significant and varies between 2 to 3%, with a morbidity (or complication) ranging from 10 to 15%. I pause to note here that the evidence before me was that the information provided by Mr Read to the deceased was that there was a 5% risk of dying from the procedure. I note that Professor Christophi indicated that he considered that this was a fair estimate to provide to a patient and that it was difficult to give an accurate figure because the condition was so rare.

70. The thrust of the evidence given by Professor Christophi, which supported the findings of his report, was that in his opinion the assessment and treatment of the deceased was appropriate overall. Professor Christophi noted that he felt for the family, but in his opinion he did not think that the timing of intervention had been unduly delayed. Professor Christophi gave evidence that the deceased's condition fluctuated throughout and that he did not consider that early intervention via surgery would have made any difference to the ultimate outcome, because it was really a judgement call on whether to intervene with surgery against the risk of further operations upon her condition.

71. Professor Christophi opined that there were two significant events that occurred leading to the deterioration of the deceased's condition:

    (a) Probable occlusion (blockage) to the distal end of the common bile duct; and

    (b) The onset of acute liver failure, secondary to ischemic (a restriction in the blood supply) hepatitis.

Professor Christophi however indicated that it was his opinion that it was the latter complication of acute liver failure that was primarily responsible for the deteriorating clinical course and ultimate cause of death of the deceased. Professor Christophi stated that blockage of the common bile duct was a common complication following such a surgery and that although liver failure was an uncommon complication, it was still a possibility from such a surgery.

72. Professor Christophi stated that in his opinion the cause of the acute liver failure was either by an embolus or thrombus (clot) in the blood vessel. Professor Christophi stated that in his opinion the cause of a thrombosis for the deceased was multiple and could have been caused by either the pancreas, sepsis, or as a result of the administration of the Heparin, or Clexane. Quite simply Professor Christophi stated that he was unable to find what had caused the blockage to the blood supply to the liver.

73. Professor Christophi was specifically asked whether he considered there was anything further that could have been done to prevent or avoid the onset of acute hepatic failure and he stated quite simply *"No, this was a nightmare situation"* and that all that could be done was the provision of supportive therapy which was, and had been, provided to the deceased throughout.

74. Professor Christophi summarised that duodenal diverticulum was a rare condition and even rarer to require an operation. He stated however that he considered that the decision to operate was one taken with appropriate caution and that the preparation was sufficient. Professor Christophi stated that the procedure undertaken was standard and done correctly and that there was no way, in his opinion, to have avoided the complications that subsequently occurred.

General Comments

75. After hearing all of the evidence from the medical practitioners, I was impressed with the sustained effort made by both the surgical consultants and the ICU consultants in relation to the care of the deceased and their efforts to support and improve her condition. It was clear that both surgeons involved appeared generally shocked and surprised that the deceased's condition was not improving despite their best efforts.

76. Unfortunately, however, for reasons not entirely clear then, or even now, the deceased appears to have fallen within the small percentage of persons who do not survive this kind of surgery. It appears more likely than not that something went very wrong with her liver and that there was an unexpected block in the blood supply. Unfortunately despite all the evidence before me, it cannot be revealed as to when this occurred precisely or by what specific method.

77. As noted previously, there was speculation in the evidence that perhaps an allergic reaction may have occurred to the Heparin or Clexane that was administered to the deceased. That speculation came out of the blue, and I do not consider that I have sufficient evidence before me to substantiate such speculation. Therefore I do not find that the problems associated with the liver were related to the administration of such thromboprophylactic treatment.

78. Quite simply, it appears that no one, despite a detailed review of the treatment, is able to provide any concrete view as to why the deceased did not improve despite all the very best efforts that were made in relation to her. As I said at the conclusion of the inquest it was against all the odds that the deceased did not get well.

79. Based on the evidence before me I find that there is no evidence to suggest that either the surgeons did anything inappropriate, improper or wayward, or

the ICU, in relation to the care provided to the deceased. I agree with the conclusions reached by Professor Christophi, and I cannot find, and I do not find, any evidence to criticise the hospital or either of the surgeons in relation to the care they provided.

80. Equally I am unable to make a finding that Mr Read stapled the common bile duct during the first surgery on 4 March 2008. I can understand the initial suspicion held by Mr Treacy when the deceased's condition began to deteriorate. Such a suspicion was reasonably held given the close proximity of the common bile duct to the duodenum, however I do not find that this is what occurred. As was stated in the evidence of Professor Christophi this was a nightmare situation during which I find that the surgeons, and Mr Read in particular, were trying to do all that they could to fix things as they perceived them at the time, but unfortunately it was to no avail.

81. I also do not accept that Mr Read acted dishonestly at any time in his dealings with the family. I find that at all times Mr Read was honest and forthright with the family in difficult circumstances that were frequently changing.

82. It is clear however that the information that was being provided was confusing to the family. This is no real surprise given the deterioration in the deceased's condition was confusing in light of all the treatment being provided. There were times when her condition was improving, and there were times when it was not. Prognosis was difficult in such circumstances.

83. Communication with family in these sorts of situations is an extremely important component of assisting families during such traumatic events. It is important that medical practitioners do all they can to try and ensure that the information being provided by them to the family is consistent with the circumstances as they exist for the patient at that time.

84. I find that in this situation Mr Read, Mr Treacy and Dr Sterba were doing all that they could to ensure that the information they provided individually to the family was consistent with the circumstances as they saw them existing for the deceased that time. Of course this information differed according to the condition of the deceased and the individual perspective of the medical practitioner involved.

85. It is also important to recognise that very often what family members take away from such meetings in such traumatic circumstances can be misconstrued, their recollections can differ, and any ambiguous words can be misinterpreted leading to further, and unnecessary, confusion and angst.

86. It is clear that the surgeons involved in this inquest have learnt valuable lessons already from the deceased's death about the importance of communication with the family and an awareness that when there are so many different medical practitioners involved messages can differ as the conditions change and that it is important to be clear as to their various perspectives at the relevant times.

87. On the evidence before me, I am unable to find that the death could have been prevented or avoided by the administration of any other treatment or procedure by those involved in her care. Unfortunately, it is a simple fact that deaths do occur following surgery and there are those persons who fall within the small percentage who die from complications associated with this treatment. Most unfortunately the deceased was one.

88. As a result of this finding I have no recommendations to make arising from the proceedings of this inquest.

Dated this 24th day of November 2009.

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GREG CAVANAGH
TERRITORY CORONER