IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: 721/08

FINDING INTO DEATH WITH INQUEST

Form 37 Rule 60(1)
Section 67 of the ***Coroners Act 2008***

Inquest into the Death of LORRAINE VALERIE MCDONALD

Delivered On:	16 December 2011
Delivered At:	Coroner's Court of Victoria Level 11, 222 Exhibition Street Melbourne Victoria 3000
Hearing Dates:	7 October 2011
Findings of:	CORONER, JOHN OLLE
Place of Death:	Sale Hospital
Police Coronial Support Unit (PCSU):	Leading Senior Constable Tania Cristiano

I, JOHN OLLE, Coroner having investigated the death of LORRAINE MCDONALD

AND having held an inquest in relation to this death on 7 October 2011
at Melbourne

find that the identity of the deceased was LORRAINE VALERIE MCDONALD

born on 11 January 1933

and the death occurred on 18 February 2008

at Gippsland Base Hospital, Guthridge Parade, Sale, Victoria 3850

from:

1a. HYPOVOLAEMIC SHOCK FROM EXCESSIVE BLOOD LOSS AND UNDETERMINED

Purposes of a Coronial Investigation

1. The focus of a coronial investigation is to determine what happened, not to ascribe guilt, attribute blame or apportion liability and, by ascertaining the circumstances of a death, a coroner can identify opportunities to help reduce the likelihood of similar occurrences in future.

Background:

2. Lorraine McDonald was aged 75 years at the time of her death. She lived at Unit 1, 63 King Street in Paynesville.

3. Mrs McDonald was referred to Dr Bob Irungu, General Surgeon, for investigation due to a history of frequent hallucinations and left sided abdominal pain. She was known to have diverticular disease.

4. On the 5 February 2008, Dr Irungu performed a colonoscopy on Mrs McDonald. The procedure revealed a large tumour in the sigmoid colon, which was bleeding. A biopsy of tissue was taken and reported as a villous tumour showing high grade dysplasia.

5. A CT scan performed on the 7 February 2008, revealed a large mass in the rectosigmoid area, with possible (but unascertained) extension into the pelvic area.

6. At review on 12 February 2008, Dr Irungu explained his diagnosis of adenocarcinoma of the sigmoid colon (despite unconfirmed pathology). He recommended surgical removal of the tumour due to the bleeding and imminent obstruction.

7. On the 17 February 2008, Mrs McDonald was admitted to the surgical ward.

> *"Mrs McDonald had routine blood tests and chest x-ray on admission and routine pre-operative procedures. Pre-anaesthetic assessment was undertaken by Dr Poh Ng, a GP anaesthetist, who attended Mrs McDonald during surgery."* [1]

8. Dr Irungu commenced surgery at approximately 10.20am on the 18 February 2008.

Objective of the procedure

9. The objective of the procedure was to perform an interior resection (removal of the rectum and sigmoid colon with an anastomosis-join of the colon to the rectum).[2]

Issues for the Inquest

10. The identity of Mrs McDonald and the medical cause of death are not an issue. They are recorded in the title page of this finding. My focus is on how and why she died.

11. In addition to the coronial brief, I have received reports from the Bairnsdale Hospital, Dr Ng, Mr Crowhurst, Dr Irungu and Associate Professor Waxman.

12. Dr Irungu and Professor Waxman gave evidence at inquest.

Non - contentious Issues

13. I refer to the expert opinions of Dr Crowhurst and Professor Waxman.

14. In evidence Professor Waxman explained that the initiatives undertaken by the Bairnsdale Hospital as result of its review of the medical management of Mrs McDonald are appropriate.

15. Following his review of the medical records and inquest brief, Professor Bruce Waxman, Colorectal Surgeon identified deficiencies in the medical management of Mrs McDonald.

Summary of pre-operative assessment deficiencies

- No preadmission clinic assessment
- No preoperative anaesthetic assessment
- Failure to perform MRI
- Failure to understand the role of MRI in preoperative staging of rectal cancer
- Failure to refer the patient to a Colorectal Specialist

[1] Statement Dr Irungu, Exhibit 1.
[2] Report, Professor Bruce Waxman, Exhibit 4.

- Failure to appreciate the need for High Dependency and Intensive Care management postoperatively
- Failure to obtain blood group and cross matching

16. I have carefully reviewed the Coronial reports of Dr Irungu, and his response to the criticism set out by Professor Waxman. At inquest, to his credit, Dr Irungu acknowledged, in hindsight:

- He incorrectly assumed that appropriate preoperative assessments had been undertaken.
- He should have spoken with the radiologist to understand why the radiologist recommended an MRI be performed following the abnormal CT scan results.
- If an MRI had been performed and shown the true clinical picture, he would not have commenced the procedure. Rather he would have arranged for Mrs McDonald to undergo the procedure in a tertiary hospital, which could offer the full HDU-ICU support.
- In hindsight, had the true clinical picture been known to Dr Irungu, the procedure was too complex to be undertaken at a rural hospital without ICU support, with an inexperienced medical team in support.
- He did not think of seeking advice from a colorectal surgeon once the procedure had commenced.

Nine core competencies of the College of Surgeons

17. Associate Professor Waxman explained the nine core competencies set out by the College were applicable to Dr Irungu. It was incumbent on Dr Irungu to ensure appropriate preoperative procedures had been performed.

18. Upon careful review, I am satisfied the deficiencies in Dr Irungu's management of Mrs McDonald identified by Professor Waxman are accurate.

19. I note the Bairnsdale Hospital system of preoperative checks was inadequate. Since the death of Mrs McDonald, the short-comings have been addressed and appropriate initiatives undertaken.

20. Dr Irungu explained that MRI is not readily available in Bairnsdale. In such circumstances, I accept the finding of Professor Waxman:

> *"It would have been much more relevant for this woman to be referred to a tertiary metropolitan teaching hospital under the care of a consultant colorectal surgeon, where MRI facilities are readily available.*
>
> *Mr Irungu himself states that the preoperative diagnosis was high grade dysplasia not cancer, and therefore was not a major concern 'to delay her management'."*[3]

[3] Report Associate Professor Waxman, Exhibit 5

Surgery - Anterior resection procedure

21. Associate Professor Waxman observed:

> *"I do not doubt that the Bairnsdale Hospital operating room team is highly competent and motivated but may not have had the adequate training to deal with complex colorectal cases and massive intra-abdominal haemorrhage, as would be in the case in a tertiary metropolitan teaching hospital."* [4]

22. Dr Irungu has provided lengthy service to the rural community in general surgery. There is no doubt he undertook the procedure in the belief that Mrs McDonald would have a good outcome.

Mrs McDonald suffered a Grade 4 haemorrhage

23. However, shortly after commencing the procedure, Dr Irungu was confronted by a situation he had not previously experienced. Dr Irungu estimated within 30 minutes, Mrs McDonald had lost in excess of 2 litres of blood.

24. The tumour and colon were adherent to the wall of the uterus. Further, he estimated Mrs McDonald lost in excess of 2 litres of blood inside 30 minutes - a grade four haemorrhage.
Mrs McDonald was in a parlous state.

25. Associate Professor Waxman detailed the clinical picture confronting Dr Irungu:

> *"Mr Irungu concedes that the tumour and colon were adherent to the posterior wall of the uterus. Whether the rest of the colon was freely mobile or not is irrelevant. The issue here is that she had a significant pelvis mass involving the rectosigmoid junction and the uterus and ovary, and I believe that was the time 'to bail out'. Mr Irungu mentions 'I opted to perform a hysterectomy and bilateral oophorectomy for the best outcome'. However, this was done at the time when he was faced with significant haemorrhage and, I believe, inappropriate."*[5]

26. Associate Professor Waxman noted Dr Irungu's attempt to halt the venous bleeding:

> *"Controlling venous bleeding in the pelvis is one of the major challenges general and colorectal surgeons face in managing complex colorectal pathologies. In my report I indicated that when he was first faced with significant venous haemorrhage that was the time to stop and call for help, rather than to continue to proceed and cause more bleeding. This is particularly the case in a patient with a rare blood group and not having access to adequate amounts of cross-matched blood. Again, this was the time to 'bail out' and call for help."* [6]

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[4] Report Associate Professor Waxman, Exhibit 5, Page 4.
[5] Report Associate Professor Waxman, Exhibit 5, Page 5.
[6] Report Associate Professor Waxman, Exhibit 5, Page 5

27. Despite the valiant attempts, Dr Irungu was unable to control the venous bleeding.

28. If appropriate pre-operative procedures had been performed, I accept that Dr Irungu would not have commenced the procedure. He would likely have referred Mrs McDonald to a tertiary hospital with ICU support.

29. Shortly after commencing the procedure, Dr Irungu was aware of the complexity of the clinical picture. It was imperative to pack the bleeding and arrange her urgent transfer.

Speculation

30. It is, however, a matter of speculation:

1. Whether an MRI would have revealed the complexity of clinical picture; or
2. Whether the sad outcome would have been averted had Dr Irungu ended the procedure in a timely manner, and arranged urgent transfer to a tertiary hospital.

31. Dr Irungu lacked the expertise, experience and support necessary to control Mrs McDonald's haemorrhage. I consider his inexperience with massive venous haemorrhage the most likely explanation for failing to:

1. seek expert advice; or
2. grasp the gravity of Mrs McDonald's predicament; or
3. pack the bleed and arrange urgent transfer to a tertiary hospital.

32. Over the course of the procedure, Mrs McDonald lost more than ten litres of blood. Associate Professor Waxman described the clinical challenges facing Dr Irungu as the worst nightmare a surgeon could face. Mrs McDonald's predicament demanded the procedure end as soon as possible, and her urgent transfer arranged.

Conclusion

33. The pre-operative failings were the catalyst for the nightmare to unfold. In any event, the procedure should not have been undertaken at a rural nursing hospital. The procedure should have been concluded as a matter of urgency. Mrs McDonald required her bleeding packed and immediate transfer. If necessary, packing by the surgeon's hand in transit.

34. It must be noted that the system failures at the Bairnsdale Hospital in February 2008, lulled Dr Irungu into a false sense of belief that procedures had been undertaken preoperatively. I commend the Bairnsdale Hospital and Dr Irungu for acknowledging their respective shortcomings.

35. Ultimately, however, as the surgeon performing the procedure the responsibility resided with Dr Irungu. It is palpably inappropriate for surgeons to make assumptions.

Comments:

Pursuant to section 67(3) of the Coroners Act 2008, I make the following comments connected with the death:

1. Associate Professor Waxman, at my invitation, set out a number of lessons which this complex and tragic case presents:

i. The main lesson relates to the responsibilities of a surgeon. A surgeon must be aware of the nine core competencies and Code of Conduct of the College of Surgeons, which governs the performance and competencies of surgeons in surgical practice.

ii. The importance of pre operative diagnosis and the need to discuss abnormal findings on radiology with radiologists is imperative.

iii. A surgical unit must have weekly meetings with radiologists and pathologists to discuss specific cases.

iv. The importance of pre admission assessment of patients, both by anaesthetist and by the surgical teams, is paramount.

v. If pre operative assessment highlights the potential complexity of a case, a surgeon should obtain a second opinion. In the case of a small provincial hospital, the surgeon should consider transferring the patient to a larger centre whether regional or metropolitan.

vi. When a surgeon is faced with a difficult situation in the pelvis, with a potential for both bleeding and injury to other organs, it is preferable to err on the side of caution. Namely do not proceed.

vii. When a surgeon encounters a catastrophic complication such as haemorrhage, the first principle is to involve the team, including anaesthetist and scrub nurses. Always consider calling for expert advice and or assistance.

viii. The final lesson is "damage control". When encountering a complex scenario the preferred course is to undertake damage control rather than fix the overall problem. Namely, implement measures, which will keep the patient alive and return to solve the specific problem on another day.

I direct that a copy of this finding be provided to the following:

The Bairnsdale Hospital;
College of Surgeons,
Senior next of kin;
Investigating member;
Dr Bob Irungu;
Dr Poh Ng;
Associate Professor Bruce Waxman;
Gippsland Pathology Service;
Dr John Crowhurst.

Signature:

JOHN OLLE
CORONER

16 December 2011