IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: 2008 / 0477

FINDING INTO DEATH WITH INQUEST

Amended pursuant to s.76 of the *Coroners Act 2008* on 30 April 2014

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

Inquest into the Death of: RODNEY MARK MOORE

Delivered On:	17 April 2014
Delivered At:	Coroners Court of Victoria Level 11, 222 Exhibition Street, Melbourne
Hearing Dates:	26 NOVEMBER 2013
Findings of:	JUDGE IAN L GRAY, STATE CORONER
Representation:	Mr SL Keeling appeared on behalf of Associate Professor Danne. Mr M Regos appeared on behalf of Healthscope.
Police Coronial Support Unit	Senior Sergeant D. DIMSEY

I, JUDGE IAN L GRAY State Coroner, having investigated the death of RODNEY MARK MOORE

AND having held an inquest in relation to this death on 26 November 2013

at Melbourne

find that the identity of the deceased was RODNEY MARK MOORE

born on 13 May 1962

and the death occurred 1 February 2008

at 47 Ewing Drive, Romsey

from:

1 SUDDEN DEATH OF UNASCERTAINED CAUSE, OCCURRING EIGHT DAYS AFTER LAPAROSCOPIC CHOLECYSTECTOMY, IN THE SETTING OF POST-OPERATIVE HAEMORRHAGE WITH HAEMOPERITONEUM

in the following circumstances:

Background

1. Rodney Moore was 45 years old when he died. He lived with his wife, Andrea Moore, at 47 Ewing Drive in Romsey. His medical history included gastro-oesophageal reflux. He worked as a paramedic.

2. Mr Moore's general practitioner was Dr Sally Carter at Romsey Medical Centre. Dr Carter prescribed esomeprazole (Nexium), and paracetamol (Dymadon). These prescriptions were dispensed by Romsey Pharmacy on 9 October and 28 December 2007.

3. On 15 September 2007, Mr Moore presented at the Northern Hospital with upper abdominal pain increasing on palpation of his lower abdomen. He was discharged with referral for an out patient abdominal ultrasound and review by his general practitioner.

4. The Western Medical Imaging report dated 17 September 2007 states: "The gallbladder contains several small stones and some polyps".

5. On 18 September 2007, Dr Carter reviewed Mr Moore. As well as the Western Imaging report, Mr Moore reported he had episodes of biliary colic, abdominal pain and gastro-oesophageal reflux as well as a couple of lesions on his scalp that he would like removed. She referred Mr Moore to Associate Professor Peter Danne and prescribed Panadiene Forte.

6. On 26 October 2007, Assoc. Prof. Danne saw Mr Moore. In his notes he recorded a diagnosis of cholecystitis. He booked Mr Moore into John Fawkner Private Hospital for elective laparoscopic surgery on 24 January 2008 to remove his gallbladder and the two lesions from Mr Moore's scalp.

7. At 8.48am on 24 January 2008, Mr Moore was admitted to John Fawkner Private Hospital for day surgery to remove his gallbladder and removal of two lesions from Mr Moore's scalp. The Nurse Unit Manager, Melissa Rossi, says that his blood pressure on admission was 101/68mmHg.

8. At 9.00am on 24 January 2008, Assoc. Prof. Danne performed the surgery. He was assisted by Dr Nicole Rose. The operation took 50 minutes because the liver was quite congested and the gallbladder was quite deep. During surgery, the liver was lacerated by a retractor but the small amount of bleeding ceased spontaneously. A drain was inserted. At 11.00am, Mr Moore was transferred to the Short Stay Unit. Mr Moore's post operative haemoglobin was 104g/L.

9. At 10.00am on 27 January 2008, Mr Moore was discharged home without a drainage tube with a follow up appointment in two weeks. His Nursing Discharge Summary indicated that his condition on discharge was satisfactory. After discharge home, Mr Moore continued to complain of pain at the drain site.

10. At 10.15pm on 31 January 2008, Mr Moore went to bed. He was complaining of mild abdominal pain and took a Codalgin and one paracetamol tablet.

11. At 5.55am on 1 February 2008, Mrs Moore left for work. Mr Moore did not complain about pain. At about 6.55am, he called his children because the pain had increased. They found him unresponsive and contacted their mother who rang a friend and asked her to go to the house.

12. At 7.40am on 1 February 2008, ambulance officers arrived to find Mr Moore had died. Assoc. Prof. Danne formed the opinion that the cause of death was most likely a pulmonary embolus.

Scope of the Inquest

13. The medical cause of death was the central issue in the inquest. A secondary issue was the quality of nursing care. Witnesses were not called on the nursing care issue and I will deal with it relatively briefly.

The Evidence

14. Evidence was called from Dr Sarah Parsons, a forensic pathologist employed the Victorian Institute of Forensic Medicine (VIFM) who conducted the autopsy. Professor AJ Ansford, a forensic pathologist and Dr Peter Crowley an anatomical pathologist provided written reports and gave oral evidence.

15. The Inquest Brief contained a number of other documents, some of them relating to the issue of the quality of nursing care and commentary upon that care.

16. Assoc. Prof Danne, the surgeon who conducted the laparoscopic cholecystectomy provided reports as did Associate Professor Peter Nottle and Professor David Morris. These were contained in the Inquest Brief but not separately tendered.

17. There were no wider or "system" type issues identified for consideration at inquest.

18. Dr Sarah Parsons conducted the post mortem on Mr Moore. She did so on 6 February 2008 and prepared an autopsy report dated 26 February 2008. This was updated with a supplementary report dated 19 May 2008.

19. In her report Dr Parsons stated the cause of death to be Haemoperitoneum following recent laparoscopic cholecystectomy. The full expression of her cause of death conclusion is set out in her report as follows:- "The cause of death in this 45 year old man is haemoperitoneum following recent laparoscopic cholecystectomy. At autopsy approximately 1000ml of blood was identified within the abdominal cavity. Whist in hospital the patient drained over 900ml of blood from his drainage tube. The patient was discharged with a haemoglobin of 90 g/L. This lowered haemoglobin and further 1000ml loss of blood into the abdomen is the presumed cause of death. Examination of the surgical site was made. No definite point of bleeding could be identified however there was recent blood clot surrounding the surgical site."[1]

20. In dealing with the gastro-intestinal tract, and in particular the peritoneal cavity, Dr Parsons' report says "There is 1000ml of fresh and clotted blood within the peritoneal cavity. The majority of the blood is on the left side."[2]

21. Dr Parsons' report, in relation to her examination of the liver, stated "there is some recent haemorrhage adherent to the mid portion of the gallbladder bed"[3] and that examination of the gallbladder and bile ducts showed "There is a fresh blood clot adherent in these areas."[4]

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[1] Autopsy report prepared by Dr Sarah Parsons dated 26 February 2008 page 10 para. 3

[2] Ibid. Page 5

22. At the hearing, Dr Parsons conceded that she did not know when the bleeding was likely to have occurred and that she did not know how old the peritoneal blood was. She sought to remove the words "fresh" and "recent" from her report as she was not able to determine the time at which the blood in Mr Moore's abdomen was shed. In her evidence Dr Parsons further said that:

    (a) 'fresh' blood meant that there was liquid blood present;

    (b) 'liquid' was the more appropriate word for the peritoneal blood, rather than 'fresh';

    (c) the blood clot adherent to Mr Moore's gallbladder and bile duct area, described as 'fresh' by Dr Parsons in her undated corrected report was actually consistent with clot from around the time of the surgery, by reason of the formation of granulation tissue in the clot;

    (d) the word 'recent' ought to be deleted from her report; and

    (e) her use of the word 'further' at page 10 of her report meant 'in addition to' the blood lost via the drain tube post-operatively."[5]

23. In the submission made on behalf of Assoc. Prof. Danne, the "consensus" pathologists' opinion regarding the circumstances of Mr Moore's death was set out as follows:-

    "The consensus pathologist opinion regarding Mr Moore's cause of death is the following.

    Mr Moore's death was a sudden unexpected death, according to Dr Parsons, Professor Ansford, and Dr Peter Crowley.

    The blood loss by Mr Moore at operation and in the immediate post-operative period would have been compensated for by Mr Moore over the following days, according to Dr Parsons, Professor Ansford and Dr Crowley.

    The date and time at which the peritoneal blood was shed into Mr Moore's abdomen cannot be ascertained, as no age can be ascribed to the peritoneal blood, according to Dr Parsons, Professor Ansford and Dr Crowley.

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[3] Ibid. page 6

[4] Ibid. page 6

[5] Submissions on behalf of Associate Professor Peter Danne, page 4, para. 9

A blood clot resolves by granulation tissue forming in the clot over a few days to a week, according to Dr Parsons, Professor Ansford and Dr Crowley.

The peritoneal blood could have been present since the time of operation or shortly thereafter, according to Dr Parsons and Professor Ansford, and since before Mr Moore was discharged from hospital according to Dr Crowley.

Dr Parsons noted at post-mortem examination that the peritoneal blood was predominantly in the left hand side of Mr Moore's abdomen. Mr Moore had a drain tube positioned in the right-hand side of his abdomen following at the time of laparoscopic cholecystectomy. If the peritoneal blood had entered Mr Moore's abdomen at or soon after the operation, the drain tube would have drained liquid blood from the right-hand side of Mr Moore's abdomen, while blood would have remained in the left-hand side of Mr Moore's abdomen, as seen at post-mortem examination, according to Dr Parsons and Professor Ansford. This evidence supports the contention that the peritoneal blood entered Mr Moore's abdomen during surgery or immediately thereafter."[6]

24. This is a fair description of the state of the evidence at the conclusion of the inquest.

25. Dr Parsons appears to have concluded that the fact that 1 litre of blood in the peritoneal cavity, after surgery to remove a gallbladder, in the absence of any other visible or detectable cause of or trigger for death, dictated a conclusion that the death must have been caused by the blood loss. Dr Crowley challenged this reasoning and was an impressive witness. Dr Crowley did not agree with the cause of death determined by Dr Parsons on the basis that the volume of blood in Mr Moore's abdomen was not sufficient in his view to explain the death. I prefer the evidence of Professor Ansford and Dr Crowley over Dr Parsons' on this issue. It follows from my acceptance of the evidence of these two doctors on this point that I ultimately cannot accept Prof. Morris' conclusion that Mr Moore bled to death as a direct or indirect consequence of the gall bladder surgery. I note Prof. Morris' report, but as I indicated at the conclusion of the inquest, it would not be fair to accept his report without him being called for cross examination and it was not necessary for him to be called. The same applied to Prof. Nottle whose statement is also in the brief and who supported the opinions of Dr Crowley and Professor Ansford.

[6] Ibid. pages 5 & 6, para. 12-18

26. All experts agreed that the age of the blood found in the abdomen could not be determined. They also agreed that 1000ml (1 litre of blood) should not kill a healthy 45 year old man.

27. Dr Parsons was prepared to make sensible and constructive concessions in the hearing and ultimately agreed with the proposition that her opinion that Mr Moore died from bleeding was her view of the "best fit" cause of death for Mr Moore. She had believed it was not necessary to determine the age of the peritoneal blood in order to conclude his cause of death.

28. I accept the contention in the submission made on behalf of Assoc. Prof. Danne which states "A summary of the evidence regarding the peritoneal blood is that the peritoneal blood cannot be aged, Mr Moore was well up to the day of his death and the volume of the peritoneal blood is not sufficient to cause death in an otherwise well 45 year old man, as contended by Professor Ansford and Dr Crowley. On the basis of the evidence, the Court cannot conclude on the balance of probabilities that Mr Moore died form blood loss."[7]

29. Ultimately, I accept the argument that no cause for Mr Moore's death can be identified and that it is appropriate in this case to conclude with an unascertained cause of death.

30. I find no basis to criticise the conduct of Assoc. Prof. Danne. I agree with the submission that the opinions of Professor Morris and Associate Professor Nottle should be given no weight on the basis that the "the underlying premise of their reports has been demonstrated through the inquest process to be incorrect once Dr Parsons admitted that the age of the haemoperitoneum cannot be determined and once she withdrew from her report of her use of the words 'fresh' and 'recent' regarding bleeding into Mr Moore's abdomen."[8] In the absence of an ascertainable cause of death, there is no basis to link the conduct of Assoc. Prof. Danne and his performance of the laparoscopic cholecystectomy with Mr Moore's death 8 days later.

31. I accept the evidence of Dr Crowley and his analysis of the cause of death issue. He proposed the formulation:- "Sudden death of unascertained cause, occurring eight days after laparoscopic cholecystectomy, in the setting of post-operative haemorrhage with haemoperitoneum"[9].

32. I note that Healthscope Ltd (Healthscope) the owner and operator of John Fawkner Private Hospital, appeared and was represented as an interested party. A written submission was

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[7] Ibid. page 11, para. 35

[8] Ibid. page 14, para. 44

[9] Exhibit 9, report of Dr Peter Crowley date 4 April 2013 page 4.

provided by Healthscope. Healthscope made no submissions regarding findings as to cause of death.

33. Healthscope's submission is confined to the circumstances surrounding the death and in particular the standard of care provided by its staff, which included the nursing staff caring for Mr Moore.

34. A report was prepared, and is included in the Inquest Brief, by Nurse Robin Fairhill dated 18 February 2011. Her report was prepared at the request of the solicitors for Mr Moore's family. In that report she made a number of comments about the nursing care. She described the care as 'reasonable overall" with some exceptions and then listed the exceptions.

35. In the submission made on behalf of Healthscope, each exception is analysed and responded to. The submission also deals with the opinion expressed by Professor Richard Cade who provided his professional opinion about the care provided by the nursing staff and the submission also notes that Assoc. Prof. Danne himself said that there was no departure from acceptable practice by the nursing staff regarding the care they provided to Mr Moore.

36. The submission made on behalf of Healthscope refers to intensive care unit officer Dr Viviana Ciruelos who was contacted by Nurse Rossi after being concerned about Mr Moore's blood loss at one point. The submission deals with the actions of Dr Ciruelos and the opinion of Prof. Richard Cade about her conduct. He said " Dr Ciruelos' actions have been entirely appropriate".[10]

37. I accept the submission in the absence of direct oral evidence on the point that it would not be fair to make any criticism of Dr Ciruelos' conduct and that it is reasonable to conclude on the written material that she acted in accordance with professional standards.

38. Whether or not there were any departures from the reasonable standard of nursing care (ie. even if there were some "exceptions" to use Ms Fairhills language), it is reasonable to conclude overall that they did not materially alter Mr Moore's medical management and did not contribute to his death. I accept the submission made on behalf of Healthscope to this effect.

I apologise for the lengthy delay in bringing this case to conclusion, and I extend my sympathies to Mr Moore's family.

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[10] Submission on behalf of Healthscope Limited, page 3, para. 10

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

Mrs Andrea Moore

Senior Sergeant David Dimsey

Associate Professor Peter Danne

Mr SL Keeling

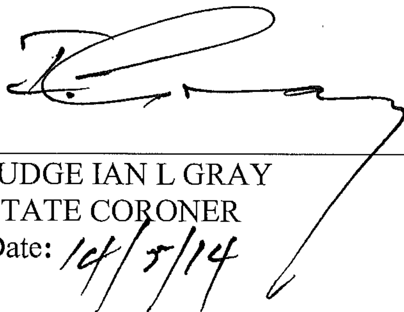
Dr Sally Carter

Ms Janet Van Der Kolk

Mr Michael Regos

Mr John Arranga

Signature:



JUDGE IAN L GRAY
STATE CORONER
Date: 14/5/14