IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2024 003956

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

*Section 67 of the **Coroners Act 2008***

Findings of:	AUDREY JAMIESON, Coroner
Deceased:	Robert John Robinson
Date of birth:	26 September 1949
Date of death:	Between 9 and 11 July 2024
Cause of death:	1a: Pulmonary thromboembolism in the setting of deep leg vein thrombosis 2: Recent umbilical hernia repair surgery
Place of death:	40 Galleon Crescent Sunset Strip Victoria 3922

INTRODUCTION

1. On 11 July 2024, Robert John Robinson was 74 years old when he was found deceased at his home 10 days following surgery for hernia repair. At the time of his death, Robert lived alone in Sunset Strip.

2. Robert's medical history included obesity, sleep apnoea, aortic regurgitation, hypertension, impaired glucose tolerance, hypercholesterolaemia, reflux oesophagitis and osteoarthritis of various joints.

THE CORONIAL INVESTIGATION

3. Robert's death was reported to the coroner as it fell within the definition of a reportable death in the *Coroners Act 2008* (**the Act**). Reportable deaths include deaths that are unexpected, unnatural or violent or result from accident or injury.

4. The role of a coroner is to independently investigate reportable deaths to establish, if possible, identity, medical cause of death, and surrounding circumstances. Surrounding circumstances are limited to events which are sufficiently proximate and causally related to the death. The purpose of a coronial investigation is to establish the facts, not to cast blame or determine criminal or civil liability.

5. Under the Act, coroners also have the important functions of helping to prevent deaths and promoting public health and safety and the administration of justice through the making of comments or recommendations in appropriate cases about any matter connected to the death under investigation.

6. This finding draws on the totality of the coronial investigation into the death of Robert John Robinson. Whilst I have reviewed all the material, I will only refer to that which is directly relevant to my findings or necessary for narrative clarity. In the coronial jurisdiction, facts must be established on the balance of probabilities.[1]

[1] Subject to the principles enunciated in Briginshaw v Briginshaw (1938) 60 CLR 336. The effect of this and similar authorities is that coroners should not make adverse findings against, or comments about, individuals unless the evidence provides a comfortable level of satisfaction as to those matters taking into account the consequences of such findings or comments.

MATTERS IN RELATION TO WHICH A FINDING MUST, IF POSSIBLE, BE MADE

Circumstances in which the death occurred

7. On 2 July 2024, Robert was admitted to Wonthaggi Hospital for an elective spigelian and umbilical hernia repair. The operation was performed by surgeon Dr Chandika Wewelwala and was uncomplicated other than conversion from the planned laparoscopic approach to an open approach. Anaesthesia commenced at 10:15am and finished at 12:45pm.

8. Robert stayed in hospital overnight. He complained of urinary urgency and frequency overnight. A urine test contained nitrites and erythrocytes so he was prescribed antibiotics (Augmentin) for a possible urinary tract infection (**UTI**).

9. Robert was discharged on 3 July 2024. Observations from the morning of discharge were normal, and the discharge instructions included 'mobilise as tolerated' and 'no heavy lifting for 2/52 – max 4kg', with outpatient follow up in two to four weeks.

10. On 4 July 2024, Robert presented to the Bass Coast Urgent Care Centre with an irritable throat post-surgery and a non-healing wound on his right leg. The notes discussed abdominal pain, lack of bowel opening and ongoing consideration of a UTI. The concluding impression was *"Constipation, likely element of ileus post op,' a possible UTI, sore throat due to intubation, and, 'Post op recovery, no major concerns other than above noted."* There was no shortness of breath or breathing issues, oxygen saturations were recorded as normal and his chest was clear on auscultation. No examination of the calves (for the wound or DVT) was noted.

11. According to neighbour Emma, Robert was active following surgery, and she encouraged him to slow down.

12. Robert was last seen at around midday on 7 July 2024 and spoke to his partner on 9 July 2024. He had told his partner he was feeling unwell.

13. Robert was sadly found deceased at his home on 11 July 2024 by police performing a welfare check.

Identity of the deceased

14. On 11 July 2024, Robert John Robinson, born 26 September 1949, was visually identified by his neighbour, Emma Stevens, who completed a Statement of Identification.

15. Identity is not in dispute and requires no further investigation.

Medical cause of death

16. Forensic Pathologist Dr Victoria Francis from the Victorian Institute of Forensic Medicine (**VIFM**) conducted an autopsy on the body of Robert Robinson on 18 July 2024. Dr Francis considered materials including the Victoria Police Report of Death (Form 83), post mortem computed tomography (**CT**) scan, medical records from San Remo Medical Clinic and VIFM toxicology report and provided a written report of her findings dated 8 November 2024.

17. The autopsy showed a pulmonary thromboembolism within the pulmonary trunk and obstructing the pulmonary arteries and deep leg vein thrombosis in the left lower leg. The heart showed cardiac hypertrophy with moderate fibrosis. Hepatic steatosis, benign prostatic hyperplasia, lymphocytic thyroiditis and some inflammation and fibrosis in the left leg skeletal muscle were also identified.

18. Toxicological analysis of post mortem blood samples identified the presence of amlodipine, telmisartan, trimethoprim and a trace amount of paracetamol.

19. Dr Francis provided an opinion that the medical cause of death was 1(a) PULMONARY THROMBOEMBOLISM IN THE SETTING OF DEEP LEG VEIN THROMBOSIS.

REVIEW OF CARE

20. Having regard to the medical cause of death ascribed by Dr Francis, I referred the matter to the Coroners Prevention Unit (**CPU**)[2] and requested they advise me as to whether Robert received prophylactic anticoagulation at Wonthaggi Hospital, whether he should have, and whether his post operative care was reasonable and appropriate.

Initial CPU review

21. The CPU reviewed the medical record from Bass Coast Health (**BCH**) and made the following observations of the medical record.

[2] The Coroners Prevention Unit (CPU) was established in 2008 to strengthen the prevention role of the coroner. The unit assists the Coroner with research in matters related to public health and safety and in relation to the formulation of prevention recommendations. The CPU also reviews medical care and treatment in cases referred by the coroner. The CPU is comprised of health professionals with training in a range of areas including medicine, nursing, public health and mental health.

- The BCH Individualised Comprehensive Care Plan has a section for VTE (venous thromboembolism) Management which says *'VTE prophylaxis indicated on Medication Chart. If not documented refer to MO to update "not required" in EMR'*. This section of the care plan was empty.

- Rather than prescribing in the EMR (Electronic Medical Record), a paper copy of the national standard drug chart appeared to have been used for Robert's admission. The sections on VTE risk assessment and prophylaxis was empty.

- The Operation Report & Post Operative Orders document had a section labelled 'Anaesthetist to Complete', with a subsection 'DVT Prophylaxis'. These sections were empty.

22. There did not appear to be any other VTE prophylaxis risk assessment document in the medical records provided to the Court.

23. Having reviewed the BCH medical record, the CPU initially advised me that Robert was not prescribed VTE prophylaxis, though noted that this was probably reasonable in the circumstances.

24. The CPU commented that peri-operative DVT/PE prophylaxis is remarkably complicated, with a large number of factors to consider and several guidelines available which inform risk assessment, but do not necessarily provide clear instructions to clinicians as to what to do in particular scenarios.

25. The Safer Care Victoria 'Victorian Guideline for the Prevention of Venous Thromboembolism in Adult Hospitalised Patients Guideline 2023' (**the Guideline**) is probably the most relevant, recent applicable guideline.

26. Recognising the importance of VTE risk assessment, 'Quality Statement 1 – Assess and document VTE risk' make the key recommendation 3.1 *'All patients admitted to hospital should receive a VTE prophylaxis risk assessment upon admission.'* This statement specifically includes adult patients admitted for day surgeries and at 3.2 states *'VTE risk assessments should be standardised, using an evidence-based tool or checklist which has been endorsed by your health service, or health service partnership.'*

27. The remaining Quality Statements include:

a) Develop a VTE prevention plan

b) Document and communicate the VTE prevention plan

c) Use appropriate VTE prevention methods

d) Transition from hospital and ongoing care

28. The BCH medical record did not appear to contain any documentation of the above.

29. The CPU considered that it was probably reasonable not to prescribe VTE prophylaxis to Robert, with the rationale being that the surgery was his only new risk factor. His age and obesity were long term factors, unchanged by his admission and surgery, and had not led to VTE in the past so would not be considered to increase his risk from baseline. He was also unlikely to be immobile.

30. Further, had prophylaxis been prescribed, given his length of stay he would have only received one dose on the evening after surgery. The CPU opined that this would not have significantly decreased the risk of DVT/PE.

Response of Bass Coast Health

31. Having considered the CPU's advice, I requested that BCH advise me as to whether a VTE risk assessment was conducted, and whether the Safer Care Guideline was utilised at BCH. Dr Senthilkumar Rajavel Sundaramurthy, Clinical Director of Surgery at BCH, provided a statement in response.

32. Dr Sundaramurthy advised me that Dr Wewelwala conducted a VTE risk assessment on Robert and deemed him to be of low risk, but this was not documented in the medication chart.

33. He further advised that Robert had mechanical protection in the form of anti-embolism stockings and pneumatic calf compressions for the duration of the procedure, and he was given a dose of prophylactic Clexane 40mg at 8pm on 2 July 2024, the evening of surgery. This was documented in the EMR-worklist manager, as the paper medication chart is a record of medications used in theatre only. This section of the EMR did not appear to have been provided to the Court at the time of the CPU's initial review.

34. Dr Sundaramurthy informed me that BCH is aware of the Safer Care Victoria Guideline and complies with it at all times. He noted that BCH adopts the WHO (World Health Organisation)

timeout checklist for surgery which includes VTE prophylaxis, and this is a mandatory requirement prior to the commencement of any surgical procedure.

COMMENTS

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

1. I accept the assertion of Dr Sundaramurthy that a VTE risk assessment was conducted by Dr Wewelwala, despite this not being documented in the medical record, and I consider that the administration of Clexane was appropriate in the circumstances.

2. Clinical documentation is not only a communication tool and integral to patient care, but it is a legal document, an aide-mémoire and protects the clinician in the event of an adverse event. Incomplete documentation allows for misinterpretation and errors and may contribute to substandard patient care.

3. The Australian Commission on Quality and Safety in Healthcare's National Safety and Quality Health Service Standards note that:

   Documentation is an essential component of effective communication. Given the complexity of health care and the fluidity of clinical teams, healthcare records are one of the most important information sources available to clinicians. Undocumented or poorly documented information relies on memory and is less likely to be communicated and retained. This can lead to a loss of information, which can result in misdiagnosis and harm.

4. Ultimately, I do not suggest that the incomplete documentation of the VTE risk assessment was at all contributory to Robert's death. I do, however, feel it is important to note the difficulty it causes to entities such as the Court who are required to interrogate someone's care and management, determine any shortcomings and identify any areas for prevention. Accordingly, I will make a pertinent recommendation.

RECOMMENDATIONS

Pursuant to section 72(2) of the Act, I make the following recommendations:

(i) In the interests of promoting public health and safety, I recommend that Bass Coast Health remind staff members involved in the care of patients of the importance of completing thorough, legible and contemporaneous documentation.

FINDINGS AND CONCLUSION

1. Pursuant to section 67(1) of the *Coroners Act 2008* I make the following findings:

    a) the identity of the deceased was Robert John Robinson, born 26 September 1949;

    b) the death occurred between 9 and 11 July 2024 at 40 Galleon Crescent, Sunset Strip, Victoria 3922;

    c) I accept and adopt the medical cause of death ascribed by Dr Victoria Francis and I find that Robert John Robinson, a man who had recent umbilical hernia repair surgery, died from pulmonary thromboembolism in the setting of deep leg vein thrombosis;

2. AND, save for my above comments regarding documentation, I find that the medical care and management provided by Bass Coast Health was reasonable and appropriate in the circumstances.

I convey my sincere condolences to Robert's family for their loss.

Pursuant to section 73(1A) of the Act, I order that this finding be published on the Coroners Court of Victoria website in accordance with the rules.

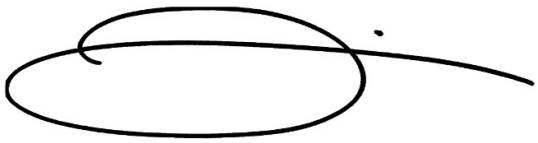
I direct that a copy of this finding be provided to the following:

Julianne Robinson, Senior Next of Kin

Bass Coast Health

Leading Senior Constable Paul Wagner, Coronial Investigator

Signature:



AUDREY JAMIESON

CORONER

Date: 17 September 2025

NOTE: Under section 83 of the ***Coroners Act 2008*** ('the Act'), a person with sufficient interest in an investigation may appeal to the Trial Division of the Supreme Court against the findings of a coroner in respect of a death after an investigation. An appeal must be made within 6 months after the day on which the determination is made, unless the Supreme Court grants leave to appeal out of time under section 86 of the Act.