

IN THE CORONERS COURT  
OF VICTORIA  
AT MELBOURNE

Court Reference: 1603 / 10

**FINDING INTO DEATH WITHOUT INQUEST**

*Form 38 Rule 60(2)*

*Section 67 of the Coroners Act 2008*

I, Ann McGarvie, Coroner, having investigated the death of Daryl Nankervis without holding an inquest:

find that the identity of the deceased was Daryl Wayne Nankervis

born on 1 April 1946

and the death occurred on 30 April 2010

at the Epworth Eastern Hospital, Box Hill, Victoria

**from:**

1 (a) Ischaemic bowel and spleen infarction secondary to occlusion of splenic artery and superior mesenteric artery by surgical clips complicating laparoscopic and open nephrectomy for renal cell carcinoma

Pursuant to section 67(2) of the **Coroners Act 2008**, I make findings with respect to **the following circumstances:**

1. Mr Nankervis was a 64-year-old married father of two adult children. He had retired and lived in Ringwood with his wife and son.
2. He had previously been diagnosed with Multiple Sclerosis and also had hypertension, vascular disease. He was regularly treated by his local general practitioners in Ringwood.
3. On 27 April 2010 Mr Nankervis was admitted to Epworth Eastern Hospital, Box Hill to have his left kidney removed as he had recently been diagnosed with cancer in that kidney.
4. Associate Professor Damien Bolton conducted the surgery on 28 April 2010. He had presented Mr Nankervis' case at a multi-disciplinary clinical conference at the Austin Hospital on 21 April 2010 and it was agreed that a laparoscopic operation be undertaken, instead of a full surgical opening of the abdomen, because of Mr Nankervis' pulmonary condition.
5. As the laparoscopy started, Dr Bolton observed extensive fibrotic tissue around the kidney and arteries which made it more difficult to locate the left renal vein and artery. He placed surgical clips on a vessel he believed was the left renal artery, cutting off all blood flowing through that artery.
6. After having difficulty finding the left renal vein and observing another arterial vessel visible, the surgeon decided to remove the laparoscope and make an incision in Mr

Nankervis' abdomen. After doing this, he located this other arterial vessel and, believing this was part of the left renal artery, also placed surgical clips on it.

7. The next day after the operation Mr Nankervis had an increased temperature. Dr Bolton ordered blood tests and upon them being negative, he directed that further blood tests be done again the next morning. At 8am on 30 April 2010 Dr Bolton reviewed Mr Nankervis who was sitting out of bed in a chair and whose nursing observations were satisfactory.
8. At about 12.22pm nursing staff found Mr Nankervis in a slumped over position and an emergency resuscitation were called, however Mr Nankervis could not be revived and died at 1.17pm.
9. An autopsy concluded that surgical clips had wrongly been placed on the artery supplying blood to the spleen and the superior mesenteric artery which supplies blood to the small intestine and colon.
10. I find that the cause of Mr Nankervis' death was ischaemic bowel and spleen infarction secondary to occlusion of splenic artery and superior mesenteric artery by surgical clips complicating laparoscopic and open nephrectomy for renal cell carcinoma.
11. Dr Bolton has admitted that he mis-identified major blood vessels and incorrectly placed surgical clips onto the wrong arteries and that this caused Mr Nankervis' death. He agrees that the laparoscopic surgery became more difficult as a result of the extensive fibroid tissue and that he should have reverted to open surgery sooner. He has expressed his remorse and sadness for Mr Nankervis' family as a result of his error and has changed his surgical and teaching practices as a result.

## RECOMMENDATIONS

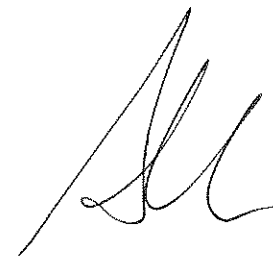
Pursuant to section 72(2) of the **Coroners Act 2008**, I make the following recommendation(s) connected with the death:

1. That post-operative file notes detail the complexities that arose during the operation and as a result appropriate post-operative monitoring can be undertaken.

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

1. **Mrs Roslyn Nankervis**
2. **Associate Professor Damien Bolton**
3. **Epworth Eastern Hospital, Box Hill**
4. **North Ringwood Medical Clinic**
5. **Maurice Blackburn, solicitors**
6. **Avant Law**

Signature:



**Ann McGarvie**

Date: **22 January 2013**

